



Community care in South Thames (West) Region: is needs assessment working?

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The objective of this study was to review the processes by which individuals' needs are being assessed and related to local eligibility criteria under the new arrangements for community care. An audit of the assessment process, definitions and measurement of need against Department of Health guidance was undertaken across the eight social services departments in South Thames (West) region. The results showed there is no standard approach to assessing needs: all social services have developed different assessment processes and different criteria for identifying needs. None use standardised measures of dependency such as the Barthel Index. Scales for measuring dependency have been developed locally so are not comparable between local authorities. Whilst local authorities have published eligibility criteria, in the main, these are purely descriptive accounts with considerable variation in practice in how local authorities are determining eligibility for services. In many authorities there remains ambiguity as to whether published eligibility criteria relate to eligibility for assessment or eligibility for services. Only one authority had attempted to quantify population needs and service provision in advance of setting its eligibility criteria. In conclusion, information collected on individuals cannot be aggregated for use in population-based planning, nor for monitoring purposes in any of the eight local authorities. National guidance is required on definitions of need and eligibility criteria. There is a need for a standardised core community data set, which embraces both health and social care.

Key words: community care, needs assessment, local eligibility criteria, community data set, planning.

Introduction

Since April 1993 with the implementation of the NHS and Community Care Act (1990), local authorities are required to provide social care services on the basis of individually assessed needs. Although the assessment of need is the cornerstone of the Community Care Act, Department of Health (DoH) Guidance issued in 1991 to facilitate implementation of the Act left it to local authorities to determine local definitions of need and eligibility for services and the process of assessment and care management in gaining access to services.^{1,2} As a result people presenting for services in different parts of the country are being assessed and provided for in different ways and to different levels. Local eligibility criteria for services are emerging and individuals requiring community care services now face three hurdles. In order to gain access to social services successfully, they must first show that they are eligible to have their needs assessed. If they pass this hurdle they must then demonstrate their eligibility for services and finally they may face a financial hurdle of means testing for any services they are offered.

Despite the deluge of DoH guidance to facilitate the implementation of the Act, the emphasis is on description rather than the methodologies and processes required. Thus the guidance on gaining access to assessment described no less than seven levels of assessment, which ranged in complexity.¹ However, no details were provided as to how staff would orchestrate and individuals negotiate the process of assessment. Similarly, in the guidance on assessing needs, the DoH presented a fulsome description of the ten domains of need to be

assessed but neglected to provide guidance on which information items were essential for monitoring and planning and how the information should be standardised and collected.²

Local authorities have had to produce community care plans since 1992. However, DoH guidance on planning and population needs assessment was not forthcoming until January 1994.³ The overall aim of this guidance was to show how 'aggregated information from individuals can be combined with broad population needs to allow authorities to make better informed planning decisions and where variances occur to identify areas where changes to service provision may be required'. However, the methodologies and the data required to achieve this aim were not described, leaving it unclear how local authorities would actually take this work forward.

The recently proposed core community data set for community health services does little to alleviate the vacuum. It will collect neither information on needs nor dependency, nor will it be integrated with social services and primary care.⁴ In 1995, the need for a joint health and social services data set has become acute, with the publication of two sets of guidance on continuing care and on joint commissioning of health housing and social care.^{5,6} The guidance on continuing care requires GP fundholders, local authorities and health authorities to draw up joint eligibility criteria for continuing care. Although the emphasis has mainly been on long term residential care, changing trends in patterns of care including the shift of both acute and longstay hospital care in the community will mean that joint eligibility criteria for domiciliary and shorter term care needs will need to be established. The guidance on joint commissioning stresses the need for jointly agreed information requirements across agencies, but fails to identify what these requirements should be.

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Accepted 11th September 1995.

In 1994, concerns about the lack of central guidance on information to inform community care planning and monitoring led to the formation of a South Thames (West) regionwide group comprising public health representatives and key people in the eight departments of social services. During the initial discussions, it emerged that health and social services had different perceptions of the terms 'needs assessment' and 'unmet need'. In order to gain a common understanding of these issues, it was decided to undertake a review of the processes by which social services were determining needs and eligibility criteria and second to review how needs were being defined, measured, monitored and evaluated for planning purposes.

Methods

Each department of social services in the South Thames (West) region was visited during April and May 1994 and a representative social services officer interviewed using a semi-structured questionnaire. Using interviews and local guidelines, flow diagrams of the assessment process in each social services department were constructed.

For each SSD the most current assessment forms were analysed, checking their contents against a template based on the domains of need set out in the DoH guidance and described in Table I. Where social services departments (SSDs) had employed objective measures of dependency and need, the scales were recorded. Each SSD was asked to provide and illustrate the information currently gathered from the assessment for monitoring and planning purposes. Finally, local eligibility criteria were reviewed against local information on services and population needs.

Results

Assessment process

In all SSDs, referrals were made via hospitals, GPs, voluntary organisations and other individuals. Basic client

details and the presenting problem were registered on the departmental computer.

Four SSDs screened individuals prior to formal assessment: in two SSDs a screening questionnaire was used while the remaining two used their written local eligibility criteria. Where individuals fulfilled the screening criteria a care manager was allocated, who assigned the individuals to the appropriate level of assessment. Where criteria were not met the individuals were given advice or referred elsewhere, e.g. voluntary agencies.

Five of the eight SSDs used two levels of assessment: simple and complex, depending on the range of needs presenting. Simple assessments usually resulted in some home care provision, meals on wheels or day centre attendance but did not involve other agencies. Complex assessments, on the other hand, resulted in the provision of intensive domiciliary care, respite care or residential care and often involved input from other (mainly health care) professionals. Of the remaining three SSDs, two had three levels of assessment and one had four levels. An illustration of the two-step process of assessment is shown in Figure 1.

In most social services a range of staff undertook the first level assessment including social workers, assistant social workers, administrative staff and OT's. Only in one department were all assessments carried out exclusively by social workers. Some departments were concerned at the amount of time taken to do assessments, leaving little time for social workers to carry out their more traditional tasks. This was particularly the case in three SSDs where training was reported to be inadequate.

Analysis of forms

In all SSDs the number of forms used corresponded to the number of levels of assessment. Most departments used additional forms for specialist assessments, for instance for Occupational Therapy.

As Table I shows SSDs had included most of the ten categories of need outlined by the DoH guidance in

Table I Summary of findings from assessment forms across eight social services departments in South Thames (West) region

DoH guidance need category	Number of SSDs Recording	Numbers of SSDs using scales to measure level of need
Basic client details	8	not applicable
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	not applicable
Carer needs: Time caring	2	2
Care needs: Type of caring	6	6
Risk assessment	4	4
Summary	5	not applicable
Level of need	4	4
Outcome	8	not applicable

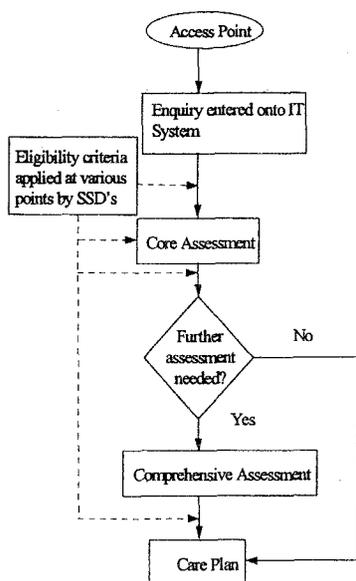


Figure 1 Two-step process of assessment used in most SSDs

their assessment forms. While some SSDs had attempted to use standardised measures of dependency or need within each category of need the measures used varied across departments. Basic details about clients were recorded by all the SSDs studied including postcode. Other needs, such as continence and communication problems, were not included in the guidance but were assessed by some departments. Basic information about carers was not routinely recorded. In most authorities the emphasis was on data gathering with little attention to formulating a hypothesis for action.

Eligibility criteria

Most SSDs had written eligibility criteria but as Table II shows, there was variation across SSDs in how eligibility criteria were defined and applied to individuals. In these examples, eligibility criteria are no more than descriptions of different levels of need. They are not consistent across SSDs, for example elder abuse puts a person into high need in Richmond, but is not included by Surrey. Nor is it clear how the criteria are applied. Only by interviewing officers was it possible to ascertain that in some departments eligibility criteria were applied to individuals prior to assessment, with the effect that they determined eligibility for assessment. In others, they were used after assessment and defined eligibility for services. Thus only people defined as high need by one SSD were eligible for services and these were means-tested. People deemed to be in moderate or low need were referred to outside agencies and unless on income support, paid the full cost of their services. At the time of this investigation, the remaining SSDs were providing some services to people in moderate and low need.

Only one SSD had attempted to quantify the population needs and service implications in advance of setting their eligibility criteria. In this authority, levels of need had been derived by applying OPCS disability prevalence rates to the local population estimates. The OPCS disability scores for the individuals within the population had been aggregated to give quantifiable population estimates of levels of dependency in three categories mild, moderate and severe. By predicting the

numbers of individuals within each category and the potential impact on local services and resources, eligibility criteria had then been derived. The failure to quantify local populations' needs in other SSDs meant that the extent to which the local eligibility criteria met need could not be quantified nor compared across departments.

Monitoring arrangements

While some authorities were attempting to quantify needs which could not be met by existing services there was no evidence of other unmet need in the population being quantified. Only one SSD had information available in a form which made it possible to audit the numbers of people being assessed by different categories of need and their outcome in terms of services received. In this department there was confusion over definitions of need being used, which meant that the extent to which needs were met and set in priority order could not be established.

Discussion

In South Thames West Region all SSDs have streamlined the seven levels of assessment recommended in the DoH guidance to an average of two. This mirrors findings of a national study on assessment procedures.⁷ However, there is great variation in the processes of assessment and the staff employed. For instance, four departments have a screening process where either social workers or administrative staff identify individuals as being eligible for formal assessment. No evaluation of these processes has been carried out to date. The variations in the processes of assessment are matched by variations in the assessment forms, the data gathering, and eligibility criteria.

Our review of the assessment forms found that some SSDs had attempted to use standardised objective measures of need and dependency. In some areas of need, such as 'social support' and 'employment' needs, some SSDs had developed their own measures. However for those domains of need, such as activities of daily living (ADL), mental health and sensory impairment where there are validated dependency measures such as the Barthel Index (for ADL),⁸ some SSDs had chosen to construct their own scales. Further investigation is required to establish the validity of these scales and their ability to discriminate between high, medium and low categories of social care need.

The different approaches to assessing, measuring and monitoring of needs being met, meant that information on needs and service provision recorded could not be compared between local authorities.

DoH guidance on eligibility criteria requires them to be expressed in terms of needs eligible for assistance and to be set in priority order.^{1,2} Only one SSD had done this, the rest failing to set out the extent to which individuals could expect to have their needs met on the basis of published eligibility criteria. Thus people defined as low need by one SSD could still have their service needs met whereas in another SSD, the policy aimed to target only those defined as high need.

The failure to quantify and define eligibility for services has implications both for the population and for the individual. From the population perspective, the

Table II Eligibility criteria as defined in four local authorities in South Thames (West) region

	High Need	Moderate Need	Low Need
Surrey	Need assistance every day to: get in and out of bed eat and drink prepare light snacks get to and use WC/commode get dressed wash hands and face and/or mentally infirm and may be incontinent and people who would not be able to function safely or lead independent lifestyles unless they receive the provision of equipment or adaptations	Need assistance several times per week to: bath/strip wash do the shopping do light household cleaning cook meals and/or are mildly confused	People who have some disability but do not need help more than once a week
Richmond	People who need frequent assistance throughout the day with personal care tasks including: getting in and out of bed bathing and washing hands and face using the WC or commode assistance in maintaining continence getting dressed eating and drinking Also people with the following problems: dementia or disorientation severely restricted	People who need assistance on a daily basis with the following tasks: preparation of light snacks getting dressed Also people with the following problems: mild confusion/disorientation	People who need assistance with some or all of the following tasks at least 3 times per week: bathing /strip washing preparation of meals household cleaning shopping/ important visits, e.g. dentist, chiropodist
Kingston	People who without assistance would not be able to undertake the following activities of daily living: personal care tasks such as washing, dressing, getting up/going to bed, assistance with medication and practical tasks such as shopping, domestic cleaning, payment of bills, pension collection	People who retain some capacity to undertake daily living tasks but need assistance to maintain their level of functioning. This will include people with severe disabilities who are able to undertake most personal care tasks but need assistance with practical tasks such as cleaning, meal preparation and some personal tasks such as bathing, hair-washing.	People who are able to care for themselves but who because of physical impairment or mental problems, will benefit from assistance with tasks such as pension collection, cleaning, shopping or getting in and out of the bath.
Croydon	Same as Surrey plus people who are at serious risk due to physical and/or mental frailty, e.g. falling wandering etc. People who are at serious risk due to suspected physical, emotional or financial abuse	Same as Surrey plus people who require assistance or support due to social isolation and/or lack of motivation People who require assistance or support due to the stresses of caring relationships	Same as Surrey

descriptive nature of the eligibility criteria meant that it was impossible to quantify the number of people likely to fulfil the criteria and the levels of services they could expect. Similarly, it was difficult to tell how levels of service provision varied across SSDs although there was some indication from the range of needs assessed, e.g. for incontinence services, that needs were being met to differing extents across authorities. For individuals, because the eligibility criteria do not set out whether and how needs will be met, they have no idea of what they are entitled to and what they can expect. Unless entitlement to services is stated explicitly, it will be impossible to monitor the performance of SSDs and the effectiveness of community care.

Finally there are implications for equity of access to services. Since social services did not implement the community care reforms from a level playing field, eligibility criteria and entitlement to services will be applied in different ways. Variations in service provision and funding at local level will make it difficult to agree joint eligibility criteria with GP fundholders and health authorities, particularly where they relate to a number of local authorities. Without national definitions of need and levels of service to be provided for these levels, it is likely that the new continuing care guidance on joint eligibility criteria⁵ will only serve to perpetuate inequities.

Conclusions

This investigation led to a better understanding between health and social services of the current arrangements for community care and the need for a population perspective in planning. It also highlighted how the variations in the process of needs assessment and application of eligibility criteria across the eight SSDs in the South Thames (West) region renders the task of agreeing meaningful joint eligibility criteria between health and social services by September 1995 (in line with DoH guidance) impossible. The primitive nature of monitoring systems and the lack of standardised data for planning means that health and social services can not yet document how current provision relates to need, let alone how future changes in the needs of people being referred to social services will impact on health and social services.

If joint commissioning is to adhere to the principle of equal access for equal need, national guidance is required on definitions of need, eligibility criteria and entitlement to care. People seeking community care must know what to expect and how this varies across the country. The first steps must be to standardise monitoring information and include validated measures of need in a minimum core data set for community care, which encompasses health, social services and primary care.

Acknowledgements

Members of the South West Regional Health and Social Services Group on Population Needs Assessment, in particular:

Nigel Plummer, Croydon Social Services; Jane Bearman, Kingston Social Services; Mavis Sutter, Merton Social Services; Margaret Edwards, Richmond Social Services; Jan Burt, South Thames RHA; Karin Janzon, Surrey Social Services; Joan Gibson, Sutton Social Services; Alan Young, Wandsworth Social Services; Catherine Sweeney, West Sussex Social Services.

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