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Planning for the elderly

Achieving a balance of care

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ACHIEVING A BALANCE OF CARE

Designing successful studies in joint health and local authority planning

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Preface

Health and local authorities are faced with a rising demand for services from an ageing population. In a climate of financial and manpower constraints, an effective approach to joint planning is a prerequisite to obtaining value for money.

Over the last ten years we have been involved in a series of projects designed to develop quantitative methods of service planning based on the 'balance of care' approach. This booklet draws on that experience to offer local authority and health service planners our views on how joint planning studies should be set up and conducted.

We assume the methods will be further refined as more authorities adopt a balance of care approach. In particular, as readers will note, we believe that the model developed during our Audit Commission projects should be extended to cover NHS services. In addition, good practice identified in projects should be collected and disseminated by a national centre; computerised community information systems which will greatly assist local data handling should be developed; and further work is required to identify the role of relatives and friends in providing support to the elderly.

None the less, the work done to date has produced methods and approaches which can be adopted now by authorities who are committed to joint planning for the elderly. We hope that this booklet will help such authorities to think about the issues involved and assist them in avoiding the pitfalls and difficulties which were identified in the development work. Quantitative approaches to joint planning are useful but, unless studies are well thought out and energetically progressed, their benefits will not be realised.

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1 Introduction

Quantitative approaches to the joint planning of health and social services care for client groups such as the elderly and mentally ill have changed over the last ten years, both to meet the requirements of a shifting financial and political climate and to take advantage of the experience gained in tackling planning issues at national and local level. In the early 1970s, planners were mainly concerned with growth. The emphasis was on developing plans based directly or indirectly on the perceptions of health and social services professionals of what would be best in a relatively unconstrained financial environment. It was in this climate that the balance of care approach was originally developed by the DHSS. By the early 1980s, with severe constraints on finance and manpower in the public sector, the management objectives had shifted towards achieving value for money. This change in emphasis was illustrated by a series of projects concerned with value for money in social services conducted by the Audit Inspectorate (now the Audit Commission).

Although the planning environment and management objectives have changed over time, the basic approach has been the same: to obtain a balance between different ways of caring for a group of people — in short, to achieve a balance of care.

Our firm, Arthur Andersen & Co Management Consultants (AAMC) was involved in both the DHSS and Audit Commission projects, and has also worked on the problem with a number of health and local authorities. As a result, we have become increasingly aware that joint planning projects require an orderly and structured approach if they are to come to grips with local issues in the limited time available. This booklet describes the components which we now believe make up a successful joint planning exercise. Its purpose is to present some lessons and thoughts evolved from our experience in the hope that they may be of help to authorities wishing to perform such exercises efficiently and effectively.

Balance of care

The main objective of the balance of care approach to joint planning has been to assist local health and social services authorities to achieve a balance between institutional and community services on the one hand, and health and local authority funded services on the other. Although the importance of the contribution made by private and voluntary services is recognised, they were not explicitly included in the planning approach.

The balance between institutional and community care is a major planning concern because:

1 professional opinion often suggests that community care, when feasible, is usually preferable;

2 institutional care is expensive; and

3 changing the levels of institutional care requires good planning and long lead times.

The balance of care approach can be used to tackle these issues either in a single health or local authority, or in the context of a joint planning exercise, by investigating three areas.

1 Provision issues — how much of which services to provide.

2 Allocation issues — who should receive what for a given level and pattern of services.

3 Co-ordination issues — how the delivery of individual services should be co-ordinated.

Most studies have been concerned with the elderly, although the approach may be applicable to other client groups. A review of the balance of care for the elderly might, for example, address the following questions.

1 Which groups of elderly really need to be in hospital or residential accommodation (a problem of provision and use of resources)?

2 What is the purpose of individual community services and towards whom should they be directed (problems of allocation of services)?

3 For particular groups of the elderly, what combination of community services is required or desired (a problem of co-ordination between services)?

Balance of care does not directly address:

1 the implementation of policies (although it is recognised that in the development of policies it is essential to consider their implementation and the systems which will be required for managing the rate and effectiveness of change); or

2 the efficiency and economy with which individual services are provided.

The approach is based on the following principles.

1 The planning of services involves consideration of groups of people with similar needs for care. These groups are defined by combinations of classification factors (such as physical disability) and client group (such as the elderly). The groupings are primarily for planning purposes and, although their use may inform, they should not determine an individual professional's decisions.

2 Different methods of care are considered rather than each service individually. A method of care may comprise a single service (such as a hospital bed) or a combination of services (for example, community nurse and home help).

3 A picture of the current situation — 'what is' — is built up from national and local data. This picture shows the number of people with similar needs who are receiving a particular method of care. It is conveniently represented by a matrix which has different methods of care described along one axis and different groups of people with similar needs along a second axis.

4 Some notions of 'what ought to be', based on local and national professional views and observed practice elsewhere, are developed. These notions are represented on a matrix similar to that for the current situation.

5 Comparisons are made between 'what is' and 'what ought to be', the major differences are identified and policies for change developed.

The analytical structure is set out in detail in appendix A.

We now recognise that there are several prerequisites for any balance of care project to be successful. These are discussed in section 3. Drawing on the lessons of the completed projects, recommendations are made about the most effective way to tackle joint planning issues. How an authority should go about a joint planning exercise will depend on local circumstances such as the nature of the local problems, the level of commitment to joint planning and the availability of time. In section 4 there is a description of the three approaches we have developed, called 'reference framework', 'local data' and 'individual problem', and our view on which approach is most appropriate in particular circumstances. Finally, section 5 discusses what authorities might do to continue the planning and monitoring of service provision, subsequent to an initial balance of care exercise.

2 The five studies

AAMC has been involved over the last ten years with five projects concerned with the planning of health and social services:

1 DHSS Operational Research Service (ORS) balance of care model;

2 pilot trials of the balance of care model in Wiltshire and East Sussex;

3 Audit Commission value-for-money work connected with the local authority social services departments;

4 Bath Health District;

5 Kingston and Esher Health District.

DHSS ORS balance of care model

One of the early major projects carried out by ORS was the development of an approach for assessing the balance of care which should be sought nationally for non-acute health services and local authority services.[1] The approach covered the major client groups, such as the elderly, mentally ill and mentally handicapped, and the commonly used resources, such as hospital beds, residential home places, community nurses and home helps. It involved the use of a complex computer model to perform the quantitative analysis.

Use of this approach informed the national debate about care provision for particular client groups and reinforced the public and political pressures towards developing community-based care. Another outcome was the recognition that quantitative techniques might contribute to local as well as national planning.

In the mid 70s, following the setting up of area health authorities and the introduction of formal planning arrangements in the NHS, interest concentrated on using the approach for the planning of non-acute care

for the elderly. During this time DHSS ORS assisted some health and local authorities to develop joint strategies for the care of the elderly.

Local use of the approach revealed a number of aspects which required improvements. The original computer model used non-linear mathematical programming to infer the values put by health professionals on different methods of care. This model was complex and required considerable expert ORS support to interpret results. Local staff sometimes perceived the model as a 'black box' performing calculations which they did not understand, even in principle. They were therefore sceptical about the credibility of plans based on its use.

A review of the original ORS model, made jointly with ORS, led us to conclude that a major assumption inherent within it was not well founded at the local level. Because of the difficulties at national level in obtaining agreed professional judgments about the appropriateness of particular methods of care for particular groups of people, the assumptions were made that fieldworkers were currently making the best use of available resources and the methods of care currently used adequately reflected professional opinion about the 'best'. These assumptions were not only incorrect but they also limited the model to dealing solely with changes to the level and mix of existing resources. The problem was perceived as one of resource availability rather than allocation and co-ordination of services.

Building on the experience gained, DHSS ORS undertook further work in the late 1970s with AAMC to develop a model more suitable for local use.[2,3,4] The assumption that best practice could be inferred from what fieldworkers currently did was replaced by the use of local professionals' opinions on which methods of care were appropriate for different groups of patients and clients.

Pilot trials

Once the modelling approach had been redesigned, pilot projects were set up in the East Sussex and Wiltshire area health authorities and the corresponding local authorities. The projects were intended to support

the respective joint consultative committees (JCCs) and joint care planning teams (JCPTs) in developing strategies for the care of the elderly.

The local judgmental input required by the new approach was provided by a professional advisory group (PAG) drawn from all the key health and local authority disciplines. The group discussed and agreed 'ideal levels' of provision to provide a roughly equivalent quality of care, with the alternative methods of care proposed, for people with different types of needs. Each alternative method of care for a particular type of elderly person was also described as acceptable or undesirable.

Detailed surveys of over 5,000 people were undertaken in each area to estimate the number of clients of each type, the amount of each kind of resource which each client was receiving, and the methods of care actually being provided. These were then compared with the PAG's recommended levels.

The pilot projects showed that there was substantial potential for improving the allocation and use made of existing resources. The revised model led to the development of joint strategies for the future care of the elderly. The strategy developed in Wiltshire was formally adopted by both health and local authorities.

However, in the retrospect we feel that the pilot method was not suitable for an initial approach in many authorities. The main drawbacks were:

1 the projects took too long to complete;

2 the JCPT and PAG had difficulty in identifying general policy themes from the very detailed analysis of local data; and

3 the simultaneous consideration of the many issues relating to a client group made it difficult to understand their relative local importance and applicability.

We therefore decided that future projects should adopt a structured approach to the analysis so that attention might be drawn quickly to areas of concern.

The Audit Commission

Our next opportunity came in the early 1980s when we assisted the Audit Inspectorate (subsequently the Audit Commission) to develop an approach for analysing value for money in social services which might be used by local authorities themselves, but would also be particularly useful to their external auditors. As well as general matters such as organisation and management processes, this work covered policies and practices for three client groups — children in care, the mentally handicapped, and the elderly. [5,6,7,8,9]

The purpose of the work was to help auditors review the amount and use of local resources, and, where necessary, to challenge the authority to re-examine them in the light of practices in other authorities. This was a very different purpose from the projects already described but one which used many of the same underlying concepts. For each client group, national data were analysed and discussed with professionals. Comparative statistics were used as a powerful tool in focusing discussion. Additional data were collected in a number of local authorities to identify the factors underlying differences in the patterns of care provided.

This work resulted in reports which discussed major initiatives that might be considered in order to improve value for money; they also described potential barriers to implementing these initiatives successfully. The project also led to the development of structured sequences of questions. Their answers guide auditors quickly to areas of a department's performance where further investigation is merited and improvement in value for money may be possible.

We believe that this approach represents an improvement on previous balance of care work. The structuring of the questions allows the user to concentrate attention on those areas with most scope for

improvement. By adopting a top-down approach to the analysis it is possible to complete quickly the investigation of areas where policies, procedures and use of resources appear to be well planned and managed. If it appears that there might be substantive issues to investigate, the user is led through more questions to help either to specify the issue in more detail or to make some assessment of why a problem appears to exist. This exploration might involve further collection and analysis of data.

During this work it was important to separate the distinct roles of political and professional judgment in making policy. It should be clear that political judgment is primarily concerned with what the authority is trying to achieve (for example, the relative importance of physical security against accident compared with communication between an elderly person and family and friends) and how much it is willing to spend to achieve it (for example, the level of day care expenditure for less dependent elderly). Professional judgment should be primarily concerned with the services needed in order to achieve these objectives cost-effectively. Of course, professional judgments will influence the climate of opinion, and thus political judgments.

Kingston and Esher Health District

In 1985, AAMC completed the first phase of work on a joint planning project in Kingston and Esher Health District. The principal need was to develop an appropriate forum (a subgroup of the JCPT) and a language (based on the concepts of the revised balance of care model) so that issues could be discussed and views shared. Data gathering was limited to a survey of a few hundred clients and patients and these results were analysed very simply, combining manual methods with presentation on a microcomputer spreadsheet.

Bath Health District

In 1987 AAMC completed a project with the Bath Health District which had taken part in the Wiltshire project and thus had available the results of the survey carried out in the pilot study. The district's

aim was to provide a tool to help obtain local professional agreement and commitment to the strategic directions for joint planning.

The balance of care model developed for Wiltshire was further refined, and, to enable local data analysis, selected parts of the model were rewritten to run on an IBM microcomputer using R:base 5000.

3 Designing a successful project

The studies described in the previous section provided valuable experience of both the content and process of joint care planning. A number of management issues relating to the planning and delivery of joint care have been highlighted (see appendix B). Lessons have also been learnt about the balance of care approach and how to set up successful projects; these are discussed in this section.

The five studies have shown that issues whose solution is essential to a successful balance of care project are:

1 appropriate management arrangements for building commitment and encouraging purposeful multi-disciplinary discussion;

2 a suitable analytical framework for discussion and analysis;

3 the identification of the planning problems to be tackled first; and

4 the choice of an approach to planning.

This section considers ways of tackling the first three issues. The choice of an appropriate planning approach is discussed in section 4.

Management arrangements

Joint planning requires a proper management focus and a commitment by management, professionals and authority members. The arrangements for health and local authority liaison are a joint consultative committee (JCC), which includes members of the health and local authorities, the family practitioner committee(s) and representatives from voluntary organisations. A JCC is supported by one or more joint care planning teams (JCPTs) composed of corresponding officers of the different organisations.

An appropriate focus for joint planning for a particular client group is the JCPT or a working sub-group set up by it, which we refer to as a joint management team (JMT). If this responsibility is delegated to a sub-group, the members must be of adequate seniority to generate the commitment of their top management and through them to obtain the backing of their respective parent organisations. Before the planning process can start, soundings should be taken to establish the required degree of commitment by all parties concerned.

As well as management commitment, there is a need to obtain the involvement and support of the wide range of professions concerned with a client group. Professionals can be co-opted to the JMT, or a

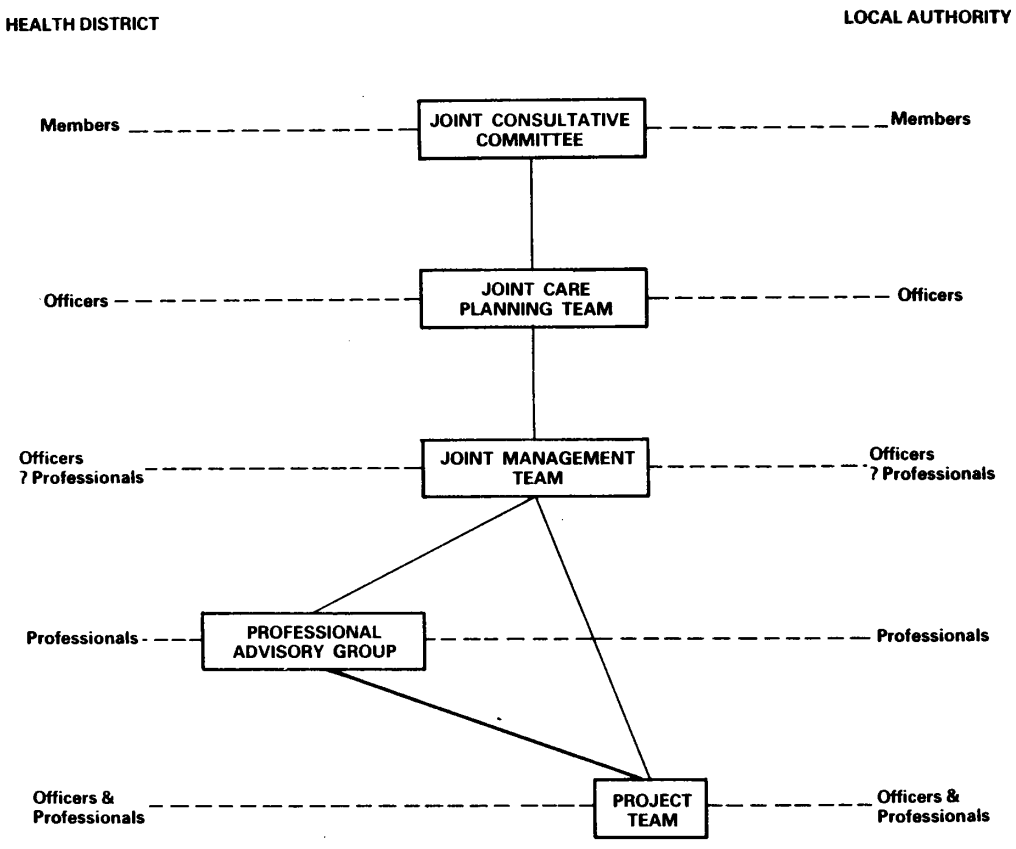


Figure 1 Management arrangements for joint planning

separate professional advisory group (PAG) can be formed. The purpose of the professional forum is to build a common local understanding and to share professional views both between and within organisations so as to provide a basis for joint policies and plans. The forum should include representatives of all the major organisations and services involved in providing care (for example, hospital consultants, general practitioners, the family practitioner committee, community nurses, residential home managers, home help managers). These representatives should have sufficient standing in their discipline to gain their colleagues' acceptance of the professional input to the planning process.

In order to maintain the momentum of the planning process it is important to set up a project team to support the JMT. The team should contain at least one member who has substantial time available for the project and a clear responsibility to carry work forward between the meetings of the various groups involved. It has also been found useful to have an outsider with experience in joint planning methods to help guide and structure the discussions of the JMT and associated groups. The relationship between these various bodies is shown in Figure 1.

Analytical structure

The key elements of the structure are:

1 *client groups,* identified groups of people for whom a range of services is being jointly planned (for example non-acute services for elderly people);

2 *classification factors,* used to subdivide a client group into smaller subgroups or categories with similar needs for care. For the elderly, the major factors are physical disability, incontinence, mental disability, social circumstances and housing conditions;

3 *categories,* composed of people judged to have similar needs for care and defined by classification factors;

4 *resources,* services received which are allocated or managed by a single relatively autonomous group of staff (such as home help visits or hospital beds in long-stay wards for the elderly);

5 *methods of care,* combinations of one or more resources available or planned to provide care to a category of people.

This structure is described in more detail in appendix A.

Particular problems arising in the studies have included:

1 defining client group boundaries;

2 defining the classification factors;

3 defining the categories within the client group;

4 deciding which resources to include, and

5 deciding the most appropriate methods of care for particular categories.

These problems are discussed in appendix C.

The collection and storage of data needs to be done at the detailed level of individual categories and methods of care. But, when analysing the data and presenting results, we have found it useful to operate at a higher level of aggregation. Otherwise, the level of detail is too great for ready understanding and major issues tend to be obscured. Policies and procedures are also best defined in terms of a small number of aggregations of categories if they are to be understood and accepted by field staff. For example, many provision issues only require analysis at the level of care setting (hospital, residential, or community) rather than using all the different community methods of care. Similarly, we have amalgamated individual categories into broader groups — from four to about a dozen as compared with the thirty or so originally defined — depending on the purpose of the analysis.

Identification of planning issues

In the initial phase of a balance of care project, we have seen that the emphasis should be on identifying issues which are likely to be important locally. During the work for the Audit Commission, an audit guide was developed to aid this process.[9] The guide contains

preliminary screening questions, a series of 'structured trees' of questions and answers, designed to focus attention on areas of concern. An example is shown in Figure 2. The issues identified by this initial review can usefully be grouped into five major types as follows.

1 *Policies for provision of resources:* how much of each kind should be provided (for example, residential homes or community nurses)?

2 *Policies for allocation of resources:* for whom should the resources which are provided be used (for example, residential homes for the moderately dependent with inadequate support from friends and relatives)?

3 *Overcoming barriers to change:* what are the barriers, and how can they be overcome (such as difficulty in recruiting home helps)?

4 *Management arrangements for securing implementation:* how can agreed policies be put into effect quickly and progress be monitored (by project management techniques such as formalising plans and timetables for change, assigning responsibilities and the reporting of progress against targets)?

5 *Availability of information:* how do local professionals obtain access to information about their clients, their needs and the services they are receiving; and how does management monitor the effects of policies and the use of resources (for instance, through computer-based client registers and community nurse diary systems on microcomputers)?

AAMC and others have developed a number of tools and techniques which can be used to address the issues arising from the initial review. Different tools fom the 'toolkit' will be appropriate for different issues. Section 4 discusses some of the tools available for addressing issues 1 and 2 (the provision and allocation of services); they take the form of a number of planning approaches. Tools appropriate for issues 3, 4 and 5 are not discussed. If the predominant concerns are specified to organisations individually (rather than jointly), the appropriateness of a joint planning exercise should be reconsidered.

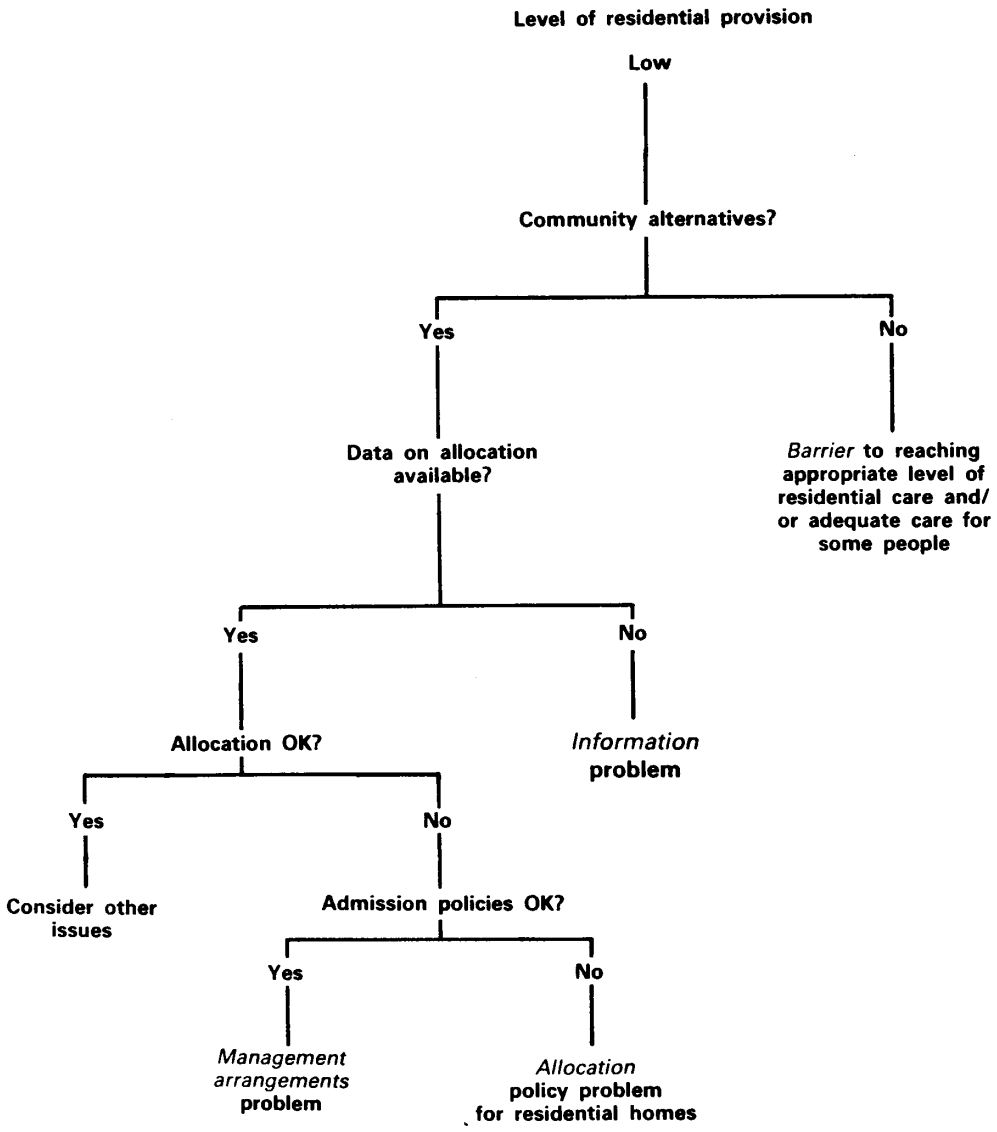
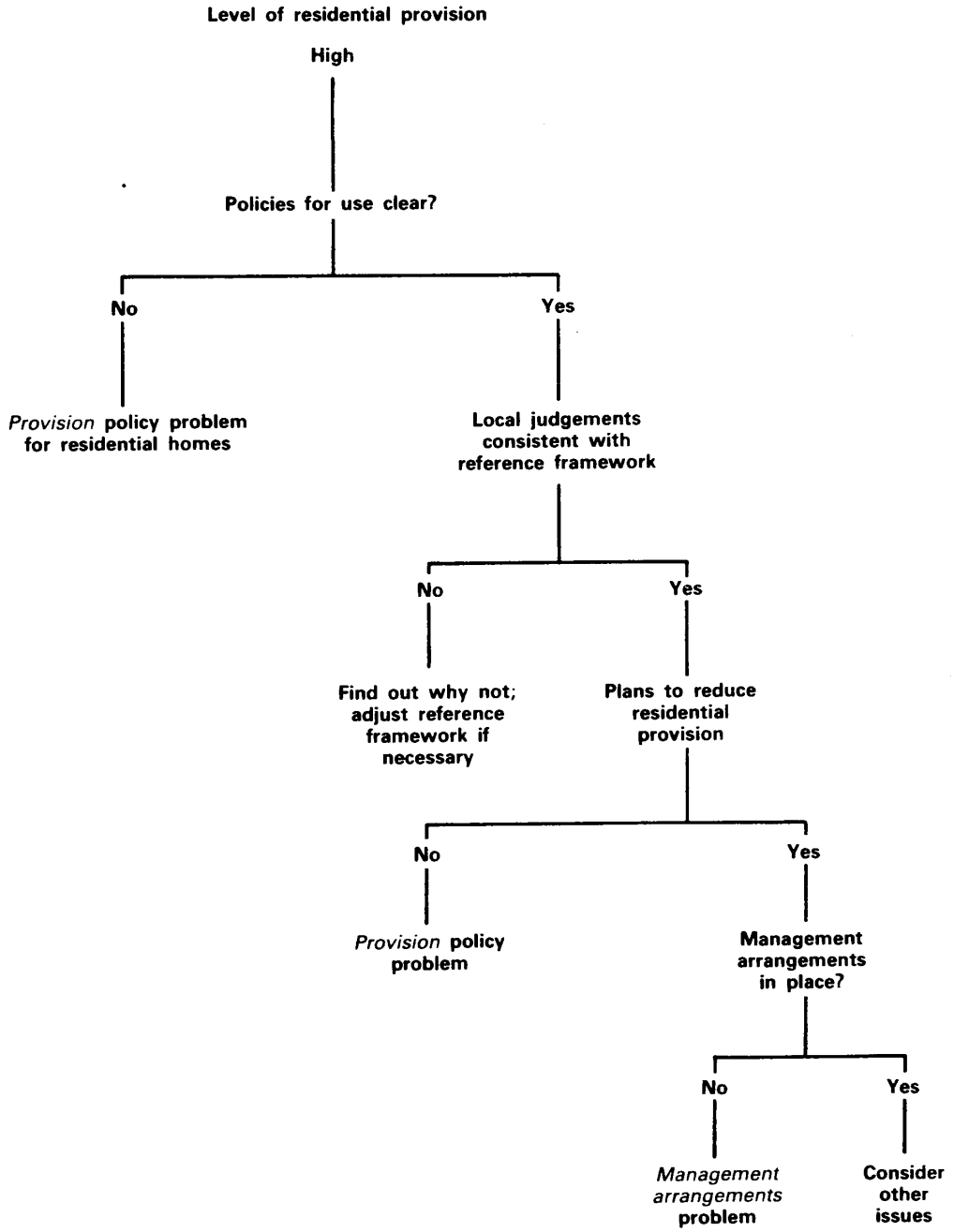


Figure 2 **Residential care for the elderly — simplified illustration of preliminary screening process**


Level of residential provision
High
Policies for use clear?
No
Yes
Provision policy problem for residential homes
Local judgements consistent with reference framework
No
Yes
Find out why not; adjust reference framework if necessary
Plans to reduce residential provision
No
Yes
Provision policy problem
Management arrangements in place?
No
Yes
Management arrangements problem
Consider other issues

4 The planning approaches and their selection

Having identified the issues to be tackled and found that joint planning is appropriate, an approach must be chosen. Different approaches will be applicable in different local situations and the choice of an inappropriate approach will cause time to be wasted and may result in important local issues being obscured. We identify the following three distinct approaches.

1 'Reference framework' approach, using readily available data.

2 'Local data' approach, requiring ad hoc local surveys.

3 'Individual problem' approach.

A description of these three approaches and the factors which we believe should be considered in choosing between them are discussed in this section. A key principle, common to all three approaches, is the comparison of 'what ought to be' with 'what is'. Each involves taking the screening process to a lower level of detail, refining and adjusting 'what ought to be' and 'what is' as appropriate.

The reference framework approach

This approach uses readily available comparative statistics on demography and service provision, together with an explicit reference framework such as that developed for the Audit Commission. Issues are identified and recommendations can be developed in selected areas on the basis of good practice elsewhere. There are two main components.

1 A reference framework made up of some quantitative statements about cost-effective service provision.

2 A series of structured questions and suggestions for consideration based on comparisons with the reference framework.

The reference framework provides:

1 national estimates of the proportions of elderly people in each category of dependency;

2 a process for adjusting national estimates for local circumstances using publicly available data; and

3 explicit assumptions about the appropriateness of different methods of care for different categories.

The reference framework provides a base on which to superimpose any known local differences and against which local provision can be tested. The assumptions in the reference framework have been made on the basis of our experience in the projects described in section 2 and on the many professional views expressed during them. It is easy to agree or disagree with them and vary them accordingly because their rationale is explicitly defined in understandable terms. For example, the assumptions about the level and use of residential care for elderly people are based on the following obervations.

1 Some categories of the elderly really need residential or hospital care.

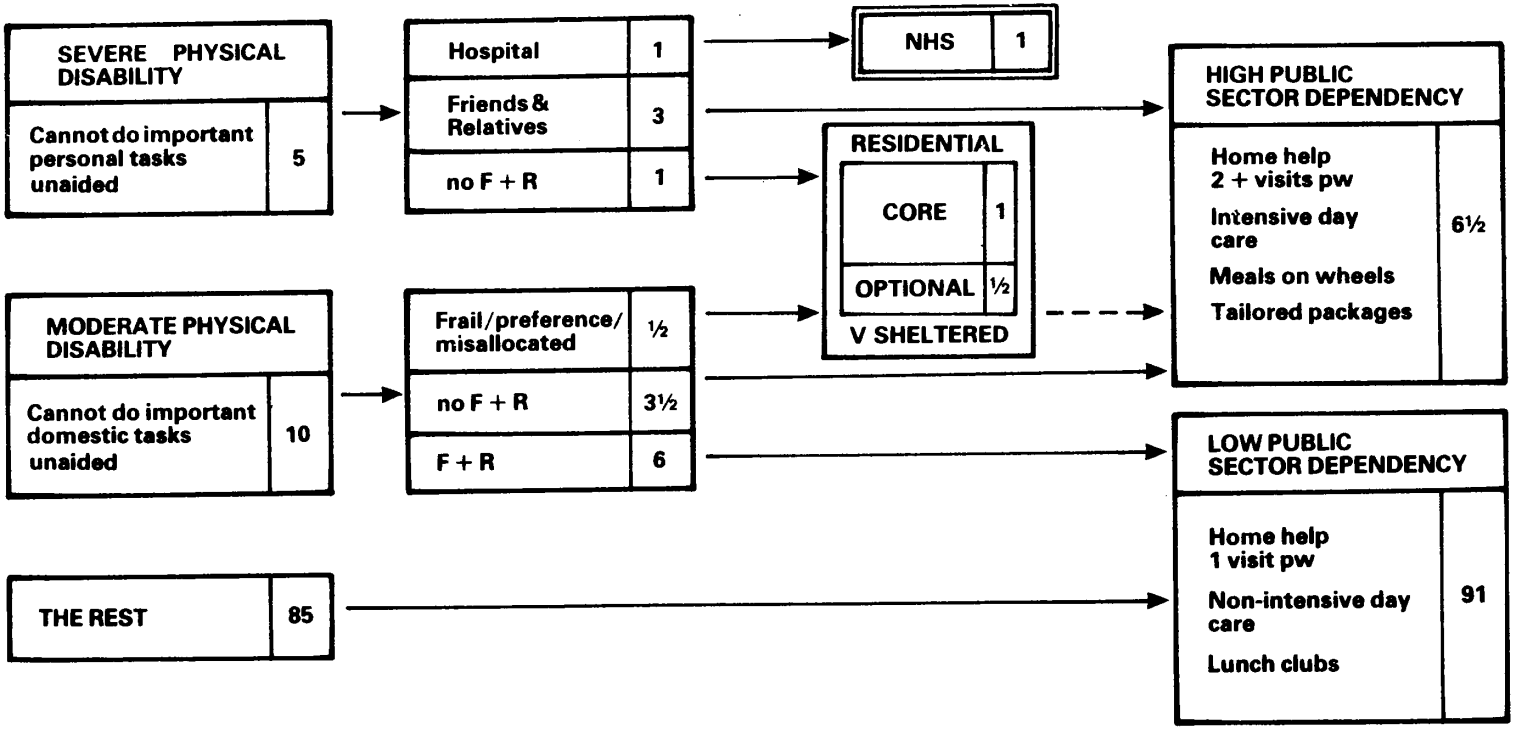
2 Others can be successfully supported in the community if the requisite community services can be effectively provided and co-ordinated.

3 In the view of many professionals, expensive residential care should be concentrated only on those who really need it.

4 There are particular sections of the elderly for whom the judgment of whether or not they really need residential care depends on:

   —the local view of the relative importance of security against undetected illness or accident compared with the availability and accessibility of social contact; and

   —the extent to which local community-based alternatives to residential care are provided.



The figures are percentages and are broad estimates for the elderly, nationally

Figure 3 High level reference framework for care of the elderly

Figure 3 shows a high level national reference framework for the care of the elderly. Proportions are given for the incidence of disability, presence or absence of support and dependence on public sector services, and the relationship between these factors. The figures are expressed in percentages and can be adjusted for local circumstances. The 'core' of the residential component applies to those who for dependency reasons are obliged to be in residential or very sheltered accommodation.

The structured questions and suggestions for consideration go further than the preliminary screening questions used to identify the issues to be tackled first. They guide planners towards a more detailed definition of the issues to a point where suggestions can be put forward for consideration, based on other authorities' experience.

The reference framework approach uses an analysis of good practice elsewhere as a basis for challenging what is happening locally. Using the structured questions, quantitative information is obtained about local resource levels. Qualitative information is also sought about the extent to which indicators of good practice are present or certain policies are being followed locally. Use of the approach can have a number of possible outcomes:

1 Professional staff disagree with the assumptions in the reference framework. Time must be allowed for professionals to understand the underlying analytical structure and the range of services and issues being tackled. If there is still disagreement, then the nationally based reference framework can be modified for local circumstances or the local data approach should be considered.

2 If the reference framework is accepted, directions for change in service provision and use may be suggested. Consequences of this might include carrying out limited local surveys of a particular service or making political judgments about the value and cost of additional services for particular categories.

We recommend that most authorities start their planning process using this approach, unless the preliminary phase has suggested that a specific problem should be tackled first. It usually involves least effort and produces results quickly and on a broad front. Although work on this approach has been mainly concentrated on social services rather than the NHS, a number of NHS and joint planning issues have already been included. Even in its present form the reference framework should be useful to authorities for joint planning purposes.

A variant on the reference framework approach has just become available from DHSS ORS. A micro computer model developed in Lotus Symphony (version 1.1 or later) provides a number of detailed descriptions of ways in which services for elderly people could be provided. It is based in part on earlier work on balance of care studies in Wiltshire and East Sussex, in which Arthur Andersen & Co were involved, and on work in Dudley which was supported by DHSS ORS and West Midlands Operational Research Unit.

The local data approach

This approach focuses primarily on understanding the issues and options and provides a comprehensive modelling tool for assessing different joint care policies. It is a flexible approach so that a wide range of issues can be covered in progressively greater depth and it allows alternative options to be explored both in terms of their care consequences and resource implications. It does, however, take significantly more time and effort than the reference framework approach before coming to conclusions. The approach is particularly appropriate if:

1 a previous study has identified a limited number of issues which need to be pursued in greater detail within a comprehensive and coherent analytical structure;

2 professional commitment can only be obtained by extensive discussion, supplemented by specific local data on the population by category and the allocation of different resources to each category;

3 there is a need to estimate the impact of introducing pioneering forms of care.

It differs from the reference framework approach in that:

1 local professional judgements are required to define the categories of planning interest, and the costs and relative effectiveness of alternative methods of care for each category. Thus a specifically local and comprehensive view of 'what ought to be' is developed.

2 local sample survey data is required about the proportions of people in different categories and about the average amounts of resource currently received per person in each category for each method of care. Thus a local and comprehensive view of 'what is' is obtained.

Professional views are incorporated through discussion at the professional advisory group (PAG). Initially, attention should be focused on defining classification factors, and as much use as possible should be made of the results of previous work. Once classification factors have been agreed, attention can turn to the major groups whose needs for care have been found to be distinctly different. The reference framework should provide a useful starting point for discussion. Potential care settings for each category should be agreed, without at this stage getting into too much detail on particular methods of care. The PAG should not be unduly restricted by existing limitations on particular resources, and should be encouraged to consider, for example, forms of domiciliary care with high inputs of resources per person if those would provide suitable care, even if they are not currently available.

Once the categories and appropriate alternative methods of care have been agreed, survey questionnaires and sample design can be considered. Practical considerations which should be taken into account in designing, carrying out and analysing data collection exercises are discussed in appendix D.

Individual problem approach

This approach involves using the results of studies elsewhere to identify methods for resolving specific problems. A list of potential planning issues is obtained from previous studies and after discussion, agreement is reached about those which are believed to be locally relevant. Only these issues are pursued using methods and data specific to them and making appropriate use of the balance of care analytical framework. This approach is particularly appropriate if:

1 there is already an established commitment to joint planning and joint implementation of change;

2 the issues are readily recognised as relevant and important locally, and worth tackling immediately; or

3 it is seen as more urgent and important to make some clearly needed changes quickly than to identify additional issues or to develop a comprehensive plan.

A further round of planning, say in the following year, using the reference framework or local data approach could well follow an initial study using the individual problem approach.

Major issues identified from previous studies of the elderly include:

1 assessing whether there is a strong case for significant change to the level of institutional provision;

2 promoting clear understanding of policies at the operational level;

3 promoting management reporting and other mechanisms to ensure that agreed policies are implemented over an agreed time scale;

4 ensuring properly co-ordinated domiciliary services for elderly people;

5 ensuring more appropriate allocation of individual services according to assessed needs and degree of dependency; and

6 developing clearer target categories for users of residential homes, day hospitals and day centres.

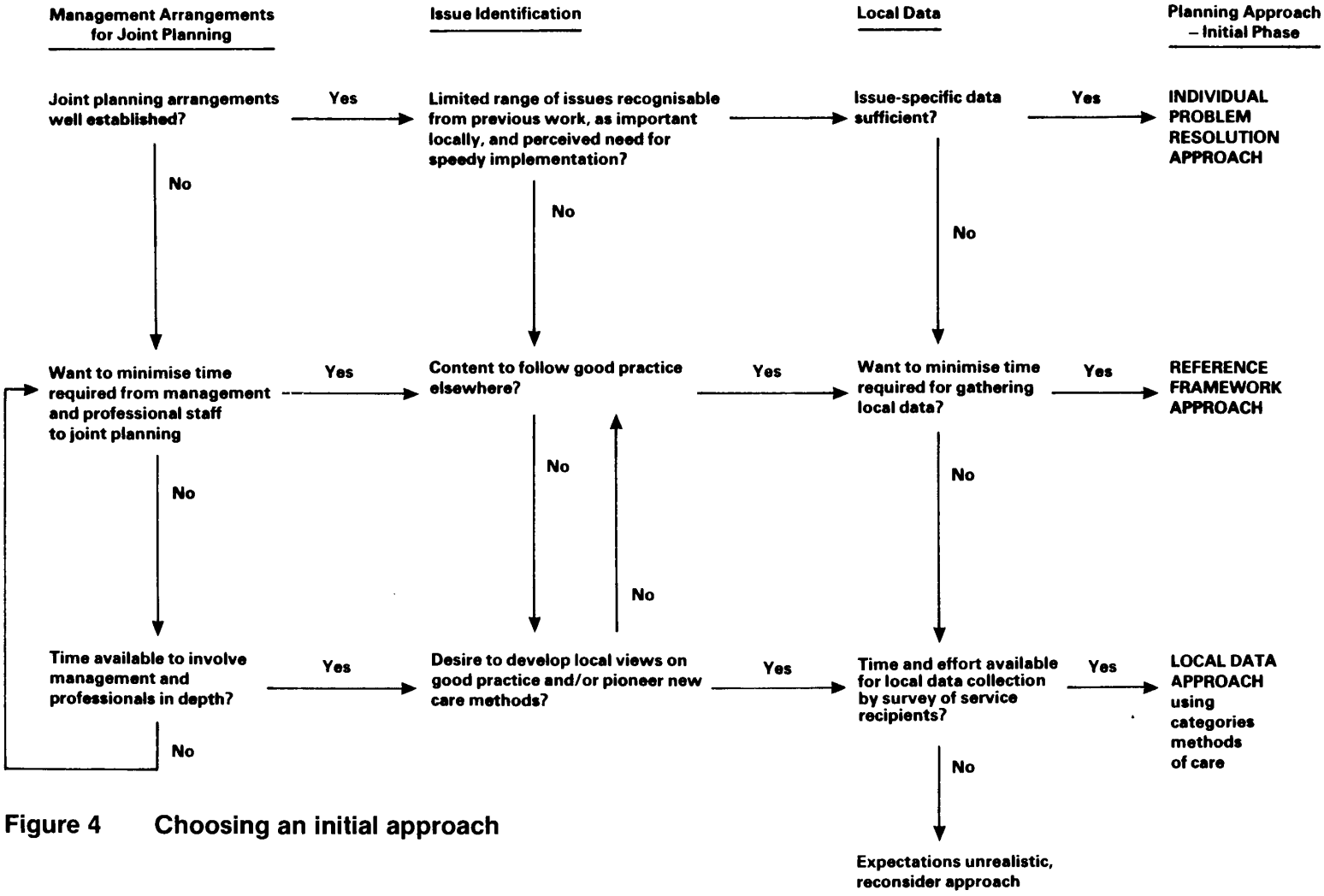


Figure 4 Choosing an initial approach

Ways of tackling these issues have been suggested in previous studies. Some involve using parts of the balance of care analytical framework, others use part of the reference framework or specific methods which have not been discussed in this booklet. Examples of the approach to resolving individual problems are shown in appendix E.

Choosing an approach

We believe that most authorities should start their planning process using the reference framework approach. But there are a number of situations where one of the other approaches might be more appropriate. Some factors involved in making this decision are shown in Figure 4. Continuing the planning process beyond the initial project into later rounds of planning is considered in the next section.

5 Continuing the planning process

Authorities involved in planning together should establish a multi-stage programme. The first steps are to establish management arrangements, to identify the issues to be tackled first and to choose the approach to be taken. Many authorities will find it most cost-effective to start with the reference framework approach which will provide a comprehensive picture of how present services compare with good practice elsewhere. However, if authorities are to use it to best effect, the work already done for the Audit Commission will need to be extended to cover NHS services at a corresponding level of detail.

It is possible to start with any of the three approaches, and move on in subsequent years to another or to use the same approach for different issues. The reference framework approach should be used repeatedly in successive years if its initial use quickly reveals major issues; each iteration should reveal further areas of concern to be addressed as the problems of previous years are resolved.

The range of issues which can be tackled by the individual problem approach should expand as more solutions become available from completed work. We believe that the collection of examples of good practice would be facilitated if a national centre took on responsibility for reviewing and summarising the results of joint planning exercises.

Specific projects

Once preparatory arrangements have been completed, a variety of projects may be set up to resolve the issues identified. In previous studies these have included:

1 developing or changing policies;

2 improving management arrangements; and

3 improving or introducing information systems.

Projects to develop or change policies include:

1 confirming or setting directions for change in the allocation of resources;

2 clarifying those areas which require taking account of both political and professional judgments;

3 developing bases for common assessment by care professionals; and

4 establishing or modifying criteria to guide decisions on access to services.

The improvement of management arrangements includes:

1 clarifying or defining areas of responsibility;

2 establishing internal management structures;

3 setting up effective joint working arrangements;

4 providing an effective process for implementing policy changes; and

5 monitoring the achievement of desired changes.

The improvement of information systems both for operational management and for the monitoring of resource usage includes:

1 setting up systems for recording usage of resources by different groups of patient and client;

2 setting up a community patient or client register; and

3 establishing computerised patient-based information and communication systems.

The introduction of the computerised community information systems now being developed will enable closer integration between planning and operational systems and provide the data required for management processes such as management budgeting and performance indicators. The incorporation of data about classification factors and other indicators of dependency and the ability to identify which services are received by individuals will diminish the need for ad hoc surveys and greatly facilitate the use of the local data approach.

Conclusion

Effective joint planning is a necessity for health and local authorities faced with the pressures of severe financial and manpower constraints and an increasing demand for services. We believe that a structured approach is necessary in order to ensure that:

1 commitment is secured to the activity and the implementation of the plans which are its product;

2 as much advantage as possible is taken of appropriate experience obtained elsewhere;

3 problems are sharply focused by defining groups in the population with similar care needs;

4 estimates of group sizes and of the costs of different methods of care are only made with such accuracy as is required to differentiate between alternative balances of care; and

5 problems which matter most are recognised quickly and addressed as a priority.

The use of the approaches we have described will help extend the process beyond the narrow confines of bargaining over the use of joint finance to a shared consideration of plans across the wide range of needs and services. We believe that the methods are now good enough to be used by any authorities who wish to take a structured approach to achieving a balance of care.

APPENDIX A

The analytical structure — glossary of terms

Client group

Identified group of people for whom a range of services is being jointly planned, for example

- non-acute services for elderly people
- mentally handicapped people
- mentally ill people.

Classification factor

Used to divide a client group into smaller sub-groups or categories with similar needs for care. Factors used in studies described in this booklet included

- physical disability
- mental disability
- incontinence
- social circumstances (level of support from friends or relatives)
- housing conditions.

Category

Sub-group of people, defined by combination(s) of classification factors, judged to have similar needs for care.

Resources

Service allocated and/or managed by a single relatively autonomous group of (often professional) staff. Principal resources can include

- hospital bed in long-stay ward for the elderly, or in psycho-geriatric long-stay ward
- local authority funded residential home place
- private or voluntary sector residential or nursing home place
- very sheltered housing and sheltered housing place

- day hospital care (NHS) } with or without
- day centre care (local authority) } transport provided
- community nursing and community psychiatric nursing visits
- home help or home care assistant visits
- meals on wheels
- short-stay relief care in hospital or residential home.

Care setting

Predominant location of type of care provided, for example

- hospital
- residential home
- day hospital or day centre care with domiciliary care
- domiciliary care without day care.

Method of care

Combination of one or more resources available (or planned) to provide care to a category of people. There may be several methods of care judged suitable for any particular category. Each distinctly different combination of resources constitutes a separate method. Methods can be grouped into care settings. Examples of methods in each care setting include the following (not exhaustive).

CARE SETTING	METHODS
• hospital	1) long-stay geriatric bed 2) long-stay psycho-geriatric bed 3) assessment ward bed
• residential home	1) local authority Part III place 2) very sheltered housing place
• day hospital	1) day hospital place with transport and community nursing visits 2) day hospital place with transport and home help visits
• domiciliary	1) community nurse visits only 2) home help visits only 3) community nurse visits and home help visits 4) community nurse visits and meals on wheels.

APPENDIX B

Management issues identified

The studies have shown that authorities frequently lacked:

1 clear policies about

— the provision of resources (how much of each kind should be provided);

— the allocation of resources (for whom should the resources be used).

2 effective arrangements for securing implementation.

In many cases there were no policies for the use of particular services. Day hospitals and day centres, for example, were thus underused or filled by people who might be more appropriately cared for in other ways. As a result many of the more dependent elderly who would benefit most from such services could not do so.

Where there were policies, there was frequently confusion about the respective inputs of political and professional judgments. We think attempts should be made to ensure that political judgments are primarily concerned with what the authority is trying to achieve and how much it is willing to spend to achieve it. Professional judgments, on the other hand, should be concerned primarily with what services to provide in order to achieve these objectives cost-effectively. In those areas of care where one form is felt to be both better and cheaper than the alternatives, political judgments should not influence the choice directly. By contrast, in those areas of provision where one form of care is better but more expensive than the alternatives, it is important to separate the roles of political and professional judgments because it is essentially a political matter to decide the sums of money to be spent on professionally preferred options.

A particular difficulty encountered in a number of the studies was the lack of explicit recognition that there are different criteria involved in assessing alternative methods of care, and that some options may be better on some criteria, worse on others. For example, one criterion might be physical security against accident, another the extent of communication with family and neighbours. The former will usually be enhanced at the expense of the latter by care in old people's homes. The reverse will usually be true for care provided at home.

Many of the wide variations between authorities for the provision of some services did not appear to be the result of informed political and professional judgments. For example, in some authorities up to 40 per cent of total home help hours were devoted to types of people who in other authorities received little or no service.

On occasion, there were significant differences between the care being provided and that considered as appropriate by the professionals. For example, in one study a large number of elderly people with little or no evident dependency were receiving twice the number of community nursing visits that the professional advisory group felt necessary. In the same authority the severely physically disabled elderly living at home were receiving less than a third of the visits thought to be required.

The studies revealed that areas for improvement can lie as much in the success or failure of implementing local policies as in the policies themselves. Management arrangements for securing implementation, particularly those to improve the co-ordination of services, were often deficient. For example, domiciliary services were frequently set up and provided ineffectively because of a lack of project management techniques such as the formalisation of plans and timetables, the assignment of responsibilities and the monitoring of progress against targets. As part of the Audit Commission work, a set of guidelines for identifying and managing implementation tasks has been developed.

APPENDIX C

The analytical structure — problems arising in the studies of the care of the elderly

Defining client group boundaries

In defining the elderly client group, age is clearly the most important element and can be taken to be, for example, 'all those over 65' or 'all over pensionable age'. In the studies, those elderly people who had longstanding mental illness or mental handicap not related to age were excluded. Elderly people suffering from episodes of acute illness were also excluded although the importance of good discharge procedures and the identification of any barriers preventing discharge were acknowledged as deserving separate study.

Defining the classification factors

In defining classification factors, particular difficulties have arisen with mental disability and social circumstances. In mental disability, dementia is a most important factor, and one which is particularly liable to overtax friends' and relatives' ability to cope without outside help. It is hard for non-medical staff to recognise reliably. Previous research has established an approximate relationship between the prevalence of confusion and of dementia for each level of physical disability. Questions can be asked in surveys about confused behaviour and from these results the extent of dementia in a sample population can be estimated.

Social circumstances (the extent of support available from friends and relatives) has a very important effect on estimates of the need for other resources, particularly of long-stay hospital beds and residential home places. We now think that previous studies have not gone far enough into this issue either to define different degrees of support or, very importantly, to analyse the extent to which the provision of some or further help can enable relatives or friends to continue caring at home. More work is needed on this aspect in future planning studies.

Defining the categories within each client group

It is essential for planning purposes to subdivide the population into groups whose needs for care are similar within each, but different between them. They are defined in ways which are independent of the services received, being based on the characteristics of the patients or clients themselves. These categories provide the building blocks through which care needs are linked to methods of care and resources. A particular category will typically have several methods of care which are appropriate to it.

Deciding which resources to include

Initially, it is only worth including those resources which require significant proportions of total client group spending and which can be used to meet a range of needs. Resources used only for a single type of condition and for which there are no effective substitutes or complementary resources should not be included. So, for example, incontinence laundry services or chiropody services are not strong candidates for initial inclusion in a balance of care study.

Deciding the most appropriate methods of care

A major concern for most planning groups is the level of institutional care required for the future. The studies have identified the following key factors which govern the need for institutional care for the elderly.

1 The authorities' view of what types of elderly people can *only* be cared for satisfactorily in institutional accommodation. The Audit Commission work provides a starting point for discussion and includes estimates of the proportion of elderly of each type in the population. Different authorities may take different views on the relative importance of the criteria for assessing alternative methods of care (such as minimising risks of accident as opposed to facilitating communication with friends and neighbours) and hence differ in which types of people they think must have institutional care.

2 The size of the future elderly population for whom care will have to be provided by the public sector. This is affected not only by demographic change but also by the size and nature of present and future local private and voluntary residential services.

3 The extent to which a satisfactory alternative to institutional accommodation exists, or could be made to exist, for those who do not have it but for whom it is a satisfactory form of care.

4 The effectiveness of the assessment, admission, discharge and transfer policies of the authorities in ensuring that expensive institutional resources are made available to and used by those for whom they are primarily intended.

5 The extent of available support from friends and relatives willing and able to provide adequate levels of care at home. This is affected by family structure and can also be influenced by authorities' policies such as the provision of domiciliary support to carers.

The relative importance of these factors will differ between authorities.

APPENDIX D

Ad hoc local surveys

Questionnaire and survey design should not be attempted lightly; they require expertise and should draw on the results and experience of previous work. The joint management team should approve the content of the data to be collected, the sample sizes and the method of analysis.

Data are required about the resources available and their use, client categories and methods of care. Information is also required about the approximate unit cost of resources.

Surveys should be designed to obtain sufficient information about the amount of resource provided to each person sampled so as to be able to estimate in total the resource consumption by each category. The sampled total of resources used can then be reconciled with the actual total of resources available. In particular, it is important to collect data about the usual frequency of visiting by domiciliary service providers.

Initially, data about care settings should be gathered and only later is it worthwhile to go into detail about specific modes of care.

A great deal of information can be gained from well designed samples of less than a thousand people. Sample design requires statistical expertise as well as a practical feel for the range of differences between the potential sampling units such as wards or community nurses. If sampling units of any one type are relatively similar, it is possible to sample from a small number of units. However, if there are significant differences between sampling units of the same type (age/sex or case-mix difference between wards), then a part of the sample will need to be drawn from each unit, of an adequate size to give representative results from each one separately as well as collectively. Within each sampling unit, the people to be surveyed should be chosen by unbiased selection methods in order to obtain a sufficiently random sample.

Most of the data gathering will be done by professional staff. To gain their commitment, it is important to explain the purpose of the exercise and to ensure the confidentiality of identifiable patient or client data. The results of the survey should also be fed back to health professionals in an interesting and relevant format.

The number of categories or combinations of categories to be used for analysis is an important decision because at least a few dozen respondents in each category chosen are required if the survey results are to have credibility. Around ten to twelve groupings seems sufficient for initial analysis with perhaps twenty to thirty at most for the subsequent analysis of more detailed issues.

Microcomputers can assist in summarising the results of surveys. For large surveys such as those done in Wiltshire and East Sussex, details of each answer on the questionnaire should be entered on the computer, validated, corrected if necessary and summarised. However, for small samples of a few hundred people it has been found to be quicker to perform the basic analysis manually to avoid the considerable effort of data entry which would otherwise be required. Once totals have been obtained by category for each survey, a microcomputer can also be used to cross check for duplication of patients in different surveys by entering the survey identifier, date of birth and the first three letters of the patients' names.

APPENDIX E

Illustrations of the individual problem approach

a) **Problem:** Ensuring properly co-ordinated domiciliary services for the more dependent elderly.

1 Agree target categories for intensive, co-ordinated domiciliary services.

2 Focus individual service resource allocations towards high dependency target categories.

3 Focus co-ordinated action on, for example:
— severely disabled wishing to remain at home or to return home
— those whose relatïves are seeking admission for them to institutional care
— known high-risk cases.

This may involve the development of common assessment forms, clear communications links, patient-based techniques, joint assessment panels for selected categories.

4 Design and implemented patient-centred community information systems to record basic patient details and maintain up-to-date information on services provided or requested.

b) **Problem:** Ensuring more appropriate allocation of individual services according to assessed need and degree of dependency.

1 Survey users of existing services tc establish degree of dependency and resources provided.

2 Review in the light of findings from previous studies and PAG judgments.

3 Develop plans for any necessary changes, implement plans and monitor progress.

4 Design and implement management information systems for tracking resource use within each service.

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