Kings Fund
London Commission
Older People Work Programme

TOWARDS AN ANALYSIS OF THE HEALTH AND SOCIAL CARE NEEDS OF OLDER LONDONERS

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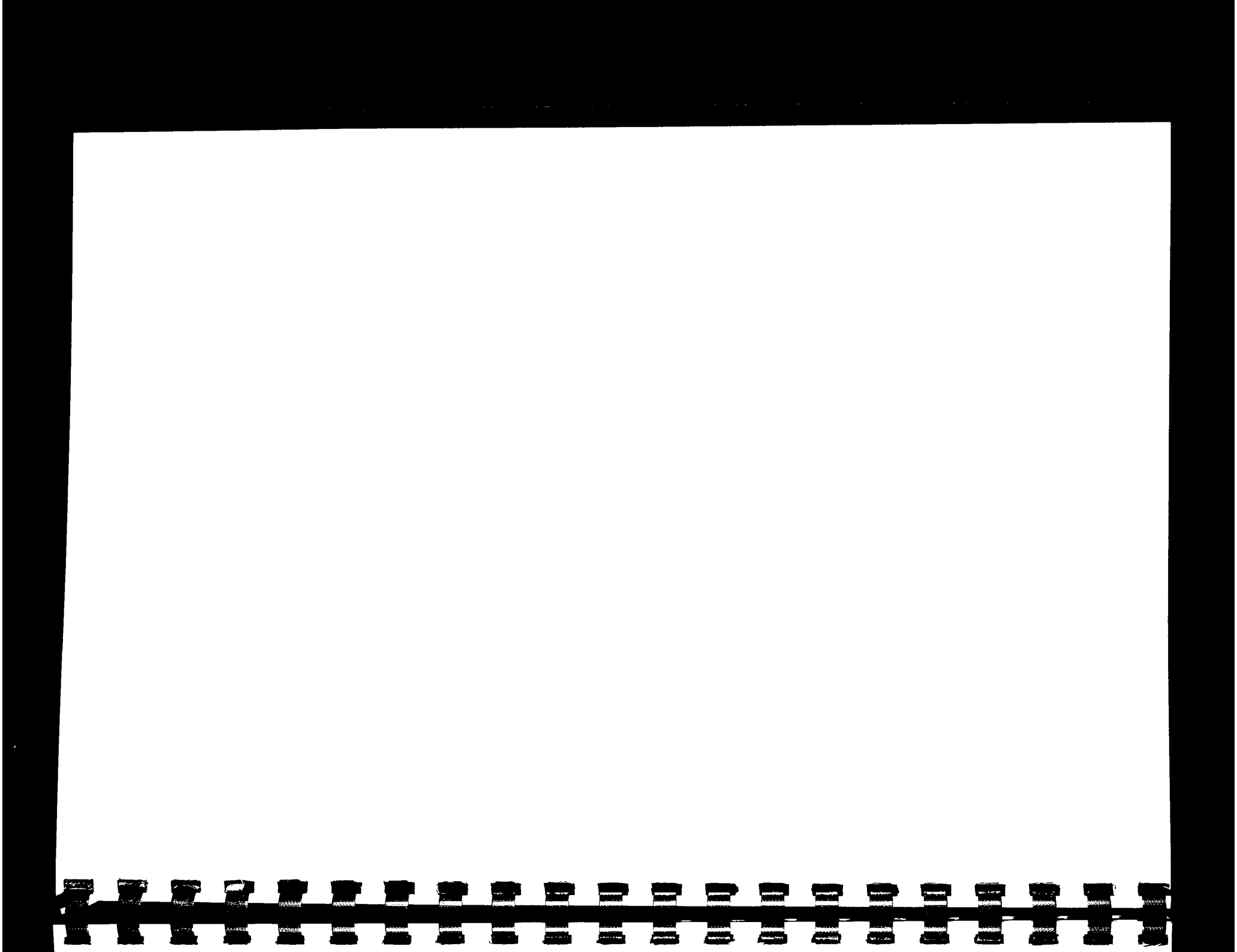


Part 1

Introduction: The Concept of Need

Need, as a word, is much overused and, as a concept, is much misunderstood. It is however, central to policy making at national and local levels.

Culyer et al argued, in the early 1970s, that we had reached a point where the word was positively unhelpful:

> "...the word need ought to be banished from discussion of public policy partly because of its ambiguity but also because...the word is frequently used in arbitrary senses. Indeed in many public discussions it is difficult to tell when someone says that society needs whether he means he needs it, whether he means society ought to get it in his opinion, whether a majority of members of society want it, or all of them want it. Nor is it clear whether it is needed regardless of the cost to society."

Bradshaw's taxonomy of social need, published in 1972, has been extremely influential in the development of the concept. Bradshaw differentiated between normative, felt, expressed, and relative need. These categories were as follows :

- *Normative need* is the expert, professional, or administrative definition of need in any given situation. A desirable standard is laid down as the minimum level of adequacy and then compared with the standard that exists. If an individual or group falls short of this level, then the individual or group is identified as being in need, e.g. Townsend's poverty line.

- *Felt need* is need equated with want, and involves individuals' subjective perceptions of need. For example, when assessing the need for something people are asked whether they feel they want it.

- *Expressed need* is felt need turned into action, that is if an individual feels a need for a service and takes action to request or demand that their need be met, then this is identified as expressed need. For example, waiting lists can be taken as examples of expressed need.

- *Comparative need* which is the measure found by studying characteristics of those in receipt of a service. If people in similar situations or with similar characteristics are not in receipt of the same service, then they are identified as being in need.

In Bradshaw's taxonomy these four categories of need are inter related, and can be applied to individuals where 'need' is identified as present or absent by each of the four definitions. There are twelve possible categories which can be illustrated by the following figure, where+ denotes the presence of need, and - denotes the absence of need.

Normative Need	Felt Need	Expressed Need	Comparative Need	Outcome and Examples
+	+	+	+	All definitions overlap (least controversial case)
+	+	-	+	Individual has not expressed their need e.g. non take up of means tested benefit or demand is limited by difficulties of access to a service (e.g. stigma, geographical distance, charging policy, or ignorance of the service etc.)
+	+	-	-	No demand as well as or because of absence of supply of service = unmet need
-	+	+	+	No expert definition of need e.g. cosmetic surgery
+	+	+	-	Need is felt, demanded and defined by expert but not supplied e.g. wage related pensions
+	-	-	+	Need defined and supplied but not felt or demanded e.g. non take up of health visitors ante natal services
+	-	-	-	Expert definition only e.g. preventative medicine e.g. fluoride in water supply
-	-	-	+	Service - oriented services supplied despite absence of need e.g. outdated charities
-	+	+	-	Need felt and demanded but not supplied e.g. demand for bandages from GP
-	+	-	-	Felt needs e.g. loneliness or emotional needs
-	+	-	+	Felt and supplied need e.g. need to make contributions for private insurance
-	-	-	-	Absence of need in any category

from Bradshaw, J. " The Concept of Social Need " New Society 30.3.72 pp 640 -43

Clayton, in *Social Need Revisited* (1983), assessed the strengths and weaknesses of Bradshaw's approach in a practical policy making setting - the assessment of need for sheltered housing for elderly people. Clayton criticised normative need for presuming the impartiality and validity of the experts' advice:

> " experts' assessments of need are influenced to some extent by such factors as demand for the service, political feasibility, and financial and manpower restraints ... they also play a major role in educating elderly people as to their needs, via the advice they give. "

Clayton went on to say that:

> " there is no clear consensus in society as to what constitutes needs which the state should meet, and groups with different perspectives compete with each other to impose their views. Their debates and power struggles continually modify perceptions of need. Indeed it might be

> argued that statements concerning need say more about the speaker, or dominant groups in society than about the conditions of the subjects "

The criticisms of the taxonomy were that it failed to identify classes of need precisely enough to make it possible to use in practice, for example in real life being 'not in need' or 'in need' is seldom clear cut, and that it failed to recognise that the policy makers cannot help but be influenced by the social, political, and economic climate within which they operate.

In the social policy literature, need is intimately bound up with the wider questions of equity and social justice. State action, most notably in the form of the welfare state, is concerned with meeting basic human need which cannot be satisfied through market systems or individual or family endeavour. Such views are vulnerable to attack by arguments that needs are relative to particular cultures (Alcock et al, 1989) but Doyal and Gough (1984) argue that needs " ...are the universal preconditions for creative and fulfilling human action. All people whatever their gender, age, nation, class, religion, ethnicity have basic needs which, if unsatisfied, will prevent them acting successfully within the society where they live. ". This formulation is in part intended to distinguish needs from wants. Wants, which may be frivolous or idiosyncratic, but which are backed by purchasing power, are satisfied through markets. Doyal and Gough propose the idea that need is no more than a preference shared by many people:

> "...social needs are demands which have been defined by society as sufficiently important to qualify for social recognition as goods or services which should be met by government intervention."

However, in practical terms, meeting need, even where this is a duty enshrined in statute, leaves plenty of room for interpretation by local administrators (Spicker 1987). The concept of *health* needs, within the context of care for older people is particularly difficult to pin down because it is now generally agreed that health and social care overlap and that the boundaries between the two, never very clear, are becoming more blurred as greater emphasis is placed upon user definitions of need and as the connections between medical conditions and social conditions become more apparent. Sidell (1995) argues that one of the major myths is that 'the elderly' are a homogeneous group in spite of obvious differences in, for example, class and cultural experience. She also questions the 'medical myth', based on the use of morbidity statistics, that disease and chronic conditions become more common as people get older. Sidell cites studies from the UK and the US which have found that older people consistently rate their own health as good in response to questions which are designed to elicit a self assessment of health even where morbidity data suggests that their health is poor. In other words, 'health' is a contested concept, and if that is correct then so too is 'health need'.

Pickin and St Leger (1993) suggest that:

> " health needs assessment is the process of exploring the relationship between health problems in a community and the resources available to address those problems in order to achieve a desired outcome."

They see there as being two main approaches to needs assessment, a dominant model which starts with the present health care services and then goes on to assess how many and what sort of people are in need of them, and a population based model which starts with the need characteristics of populations and then explores which services or policies would best meet these needs. They identify some basic elements of health needs assessment:

- the **measurement of health status** and identification of health problems
  - epidemiological measures of mortality, disease incidence and prevalence as well as measures of perceived health
  - also measures of positive health indicators;
- the **assessment of health resources**
  - resources currently available to a community (individuals, families etc. and primary and secondary care services);
- the **maximisation of health gain.**

A framework for health needs assessment, using the population based model, requires the division of the population into meaningful groups. In the past such groups have been of two main sorts, either ***client groups*** (eg. elderly people, people with disabilities, people with mental health problems, etc.) or ***disease groups*** (e.g. diabetes, dementia, cancer, etc.). But using these groupings presents difficulties: there will be overlapping groups; exclusion of the needs of the majority of the population; and the focus on users of services rather than all people in the community with the problem.

Another model is the ***locality*** needs assessment, where the population is divided into geographical groups.This approach identifies geographical variations in health and allows them to be related to other demographic and social variables, e.g. the rate of unemployment, the proportion of the population which is accounted for by people over retirement age, and measures of social deprivation. Health resources can be measured and correlated on a geographical basis. Such an approach, say Pickin and St Leger, allows for targeted resource allocation but the population must still be divided by age and gender in order to assess comprehensively their health needs. The authors propose a ***life cycle framework.*** They argue that age and gender are two of the main determinants of both health and the use of health services. Unless they are taken into account then making services or policies appropriate to the needs of the local population will not be possible. The life cycle framework divides the population into nine life cycle stages from before birth to old age. From 15 years old the stages are divided by gender. Its value is that it takes into account the biological, psychological and social determinants of health. The life stages include 65 to 74 years, and over 74 years.

The life cycle framework starts from the medical model of disease and illness. It recognises that illness and the potential for illness are always at least partially explicable in biological terms, but there are other determinants which include factors such as socio - economic ones, environmental and ethnic factors, and cultural ones. The authors claim a number of advantages for this framework:

- it forces detailed examination of the needs of different groups in a coherent way;
- it determines what information is required and does not constrain thinking what information currently happens to be available;
- it allows the linking of information, planning and resource allocation in a more coherent way;
- it allows health influences to be related to service provision either current or proposed, health service or non health service, curative or preventative;
- it explains rather than describes the health of a community;
- it easily accommodates any increase in knowledge of the determinants of health and health service utilisation in a population.

Ann Bowling writing in 1991 outlined a range of scales which measure social health, functional ability, activities of daily living, etc. and a later publication (1995) sets out scales for assessing needs, particularly needs for psychiatric services. She referred to Bigelow et al (1991):

> "...quality of life , as we view it, comes out of a social contract - fulfilment of needs in exchange for meeting of demands which society places upon it members. Needs are fulfilled through opportunities presented by the social environment. Demands are met through the exercise of basic psychological abilities - cognition, affect, perception, and motor. For example, a work role demands concentration and stress tolerance while it provides opportunities for meeting self esteem, social affiliation and basic needs."

The next part of this paper considers the definition and assessment of need in more detail but it takes as its starting points the views which have been briefly outlined here. Not only is 'need' a slippery concept but so too is 'the elderly', and so is 'health'. Need, we are advised by the literature, is not the same as want or demand; there are different kinds of needs; there is a close connection between need and equity. Old age, we are advised is not a straightforward matter of the passage of years, it is socially constructed and situated; psychological gerontologists (Erikson for example) have emphasised the significance of individual response to biological ageing. Health we are informed is a contested concept where the 'objectively' unhealthy report themselves as healthy and vice versa; where the connection between morbidity and functional ability is unclear, and where there is no really agreed definition of what ageing is. Add to this the significance of policy, politics and economics, for example the view that one response to the perceived crisis of the welfare state in recent years has been to see need as a basis for rationing rather than as a principle of redistribution, and one has a bewildering array of complexity which the next part of this paper attempts to examine.

Part 2

Towards an Integrated Approach to Need Definition

If need is to be used as a basis for policy formulation there has to be a way firstly, of identifying and describing what the needs are and secondly, a way of measuring their intensity and prevalence. Identification and measurement must both be able to be done at national, regional and local levels. Of course in practical terms identification is intimately tied to description and in turn is closely linked to measurement, but conceptually they are distinct and it may be that if we wish to create more sensitive ways of determining need and break away from traditional definitions, we have to keep the distinctions clear at all times. For example, the description of need has often been couched in terms which have reflected the administrative arrangements for the delivery of public care, ie. they have been described as health needs because traditionally it has been the health service which has tried to meet whatever the particular deficit is and similarly, for example, for social, housing, employment, and financial needs. A description of need underpinned by public agencies' fairly narrow understanding of need, and investing the same agencies with responsibility for identifying such organisationally determined need, was bound to lead to what has come to be known as a 'service driven' approach. Such approaches are also heavily reliant upon current ideas about minimum standards, and consequently do not take into account the fact that minima change over time and that for some purposes, for example an estimate of service shortfall which can be met by non public agencies, we might be interested in a wider range of needs than that implied by the application of a basic minimum.

Perhaps a richer and more flexible framework for defining and measuring need is one which distinguishes more sharply between the features of deficit and the units within which the features are manifest. Within the literature on need we can detect two main approaches to identification, namely that which focuses on the basic and intermediate needs which people have and that which uses current services as the means by which need is identified. However, we also find identification of needs being carried out at different levels, sometimes it is an individual person who is the focal unit, sometimes a locality, sometimes an age group, sometimes an ethnic group, and so on.

Person based definition of need: an individual's wants and needs

Everybody has needs. These needs have been seen by some writers as being of two kinds - basic needs and intermediate needs.

Basic needs are the universal pre requisites for successful participation in a social form of life, that is physical health and autonomy, or more specifially, for production, reproduction, cultural transmission and politcal authority (Percy - Smith and Sanderson 1992).

Intermediate needs were described by Percy-Smith and Sanderson as those characteristics of need satisfiers which everywhere contribute to improved physical health and autonomy. i.e. adequate nutrition and water, adequate protective housing , non hazardous work environments, non hazardous physical environments, appropriate health care, security in child hood, significant primary relationships, physical security, economic security, safe birth control and child bearing and basic education.

Other writers, Wing for example (1991), have drawn a distinction between primary and secondary needs or between final and intermediate needs (Taylor Gooby and Dale 1981) but the main point for present purposes is that we all have needs which flow from our physical nature and from our social roles. These needs give rise to other needs; to be fully functioning people we require a wide range of things from freedom from oppression to nourishing food, from independent living to home care. This is the point which underpins Maslow's hierarchy of needs (Maslow ...). Although this may seem a simple and uncontestable notion at this very general level of discussion the picture becomes very much more complicated once we accept that the specifics of need are socially and personally constructed ie. as individuals we may interpret our particular circumstances as requiring very different remedies, so that meeting need always involves making choices.

The translation of individual wants into needs is not a simple process.

The identification of an individual as someone who may need help can be made by one or more of the following agents:

- the old person
- a carer or other informal individual
- a professional

For the individual the journey to recognising that they need help, beyond what they are able to provide for themselves, can be a tortuous one. An older person may be aware that they cannot perform the self care tasks which, only a few weeks ago, posed no difficulty but they may be reluctant to ask for help for a variety of reasons which range from wishful thinking that it may simply sort itself out through to a determinaton not to ask for charity or be a burden on relatives. Similarly, an old person may be aware of physical symptoms which they fear may be significant and serious but which they will not acknowledge because they dread control being taken from them by professionals who are unlikely to understand.

The interplay between recognition, knowledge and acceptance or denial is complex and not one which can be explored in depth here, but it does

underline the mercurial quality of 'need' and 'unmet need'. When we add to that an understanding that people's tolerance of their situation is very varied and that what one person would find severely disabling is of little significance to another, one begins to appreciate that 'objective' statements about need are probably far from being what they purport to be.

But just as there is a problem with discovering unmet or unacknowledged need, so there is a problem in deciding which of the wants that an individual may have are 'legitimate'. In other words, how are we to sort out the wishes from the needs, the merely desirable from the essential, or perhaps more pertinently, the moderately useful from the highly effective? When an old person says they would like someone to keep the garden in good shape are they expressing a want or a need? The pragmatic, but flawed, answer to this is that it will depend upon the effect that an untended garden has upon the person's wellbeing and that can only be assessed by a professional, in this case, a care manager. If the professional deems the want to be a need then a need it is (Figure below). But this begs all sorts of questions of course. What criteria is the care manager applying (eligibility criteria)? Are they the same criteria as would be applied to another old person (equity)? Are they the same criteria as would be applied by other professional groups (professional priorities)? Is it still a need if the old person could employ a gardener (capacity to pay)? This is the arena within which the infamous debate about the 'social' versus bath takes place, where an old person may be assessed as needing a 'social' bath but not a 'medical' bath.

Figure : Recognising individual need

professional/expert view of need / individual perception of need	**Have got need**	**Do not have need**
Accept (seek help)	Think they are needy and they are	Think they are needy but are not
Deny (not seek help)	Are needy but will not accept it	
Not know (not seek help)	Are needy but do not know they are	Are not needy and do not think they are

For the individual the first step is their defining their own wants, usually couched in terms of needs, based on their medical symptoms, social, psychological and/or material conditions. As MacStravic (Determining Health Needs 1978) discusses, in practice need is first defined by the

consumer's decision to seek health services, then by the professionals decision to access or prescribe health services to a given patient, and then again by the consumer's decision to take professional advice, follow referrals or take prescriptions.

The decision to seek help, having acknowledged that there is some kind of personal deficit, is the next step. It seems reasonable to assume that the severity and / or the persistence of symptoms and / or illness will be a major influence upon whether people seek help and, in effect, turn their felt need into expressed need (see Figure below). Their decision is also likely to be shaped by what help they think may be available. This, of course, is where information about services is so important, but official information is ony part of the picture. Research suggests that people refer to informal sources of information at least as readily as they do to more authoritative sources. It is also true that knowledge about service options may be out of date, inaccurate, misleading and so on. At this very early stage in the process of seeking help the importance of construing wants in terms of what is known to be available as a remedy begins. It is not just the professionals, in other words, who are guilty of thinking in service driven terms.

Figure : Assigning priority to individual need

	Persistent features	**Not persistent features**
Severe features	High priority - seek help	High priority - seek help
Not severe features	High priority - seek help	Low or no priority - not seek help

Service based definition of need: the mixed economy

This approach to need definition relies upon assessments and surveys which relate to the number of places, beds, meals, and so on and is 'service driven' in that is calculates the needs of a population (whether that population is a GP practice population, or a regional health authority population or a national population) according to the existing service configuration.

This approach creates a different emphasis, as Frankel (1991) explains :

> *" where the concern is to determine an appropriate level of provision for a particular intervention, needs are those services that are*

necessary for the alleviation of that particular form of morbidity. The focus is therefore upon the services that are needed, rather than the neediness of the population."

The services which have in the past formed the template and benchmark for this kind of needs analysis have usually been publicly provided. The approach is therefore rooted in the tradition of public sector intervention.

It is difficult to overestimate the significance of service accessibility in the identification of need. What is missing from the literature is an examination of the place which recent thinking about the mixed economy of health and social care, in their broadest sense, occupies in the wants/needs debate. The mixed economy consists of five sectors of health and welfare.

Public sector
Le Grand and Robinson (1984) made clear in their study of privatisation that the state does not have a single role in relation to health and welfare. They suggested that state involvement took three main forms - direct provision, finance and regulation. A service provided mainly by the state may depend upon both public and private finance, whilst services provided by commercial enterprises, voluntary agencies and informal carers may be subsidised and regulated by the state but not directly provided by it.

Private for profit sector
There has been a dramatic growth in private sector provision for older people especially through the creation of residential and nursing homes, but also through domestic care agencies and private home nursing. Private medical care, usually underwritten by health insuranc policies, has also increased substantially in recent years.

Voluntary not for profit
This sector encompasses a vast range of activity. It includes large voluntary organistions staffed by salaried employees, self help groups, and advocacy groups some of which will have a local catchment area whilst others have a national remit. They vary in terms of their ethos, the work they do, the resources at their disposal, the amount of financial support they receive from the state, and the degree of public regulation to which they are subject.

Informal sector
Care provided through this sector is that which is mainly provided in peoples own homes by family, friends and neighbours. Willmott (1986) identified five categories of informal caring:

personal care: for example, washing, bathing, dressing, and feeding;
domestic care: for example, cooking, cleaning, and laundry;
auxiliary care: for example, child minding, shopping, and transport;
social support: for example, visiting and companionship;

surveillance: for example, keeping an eye on vulnerable people.

The size of the contribution made by this sector should not be underestimated. Every review carried out over the last twenty five years has emphasised the scale of informal care (Townsend 19 , Parker 19.., Henwood 199 , Wistow 19).

Occupational sector

This sector has not received the attention it deserves although there is a growing literature on it (Higgins 19 , Mann 19 , Challis and Rossetti 19). Entitlement to help is based upon employment, either by the person themselves or s a spouse or partner of the employed/retired person. The significance of occupational pension and health schemes is considerable.

Any older person who seeks help will already be satisfying a large part of their wants from a variety of sources. For example, a carer (the informal sector) may already be heavily involved in physical and emotional support. The older person may be purchasing medication to help with sleeplessness or with pain (private sector) and a housing association may already be providing accommodation (voluntary sector). The old person themself will be providing a large measure of self care. To the extent that these strands of 'provision' are effective the old person may be said not to be in need of housing or moral support, for example, or put more accurately may be said to have needs which are already being met. A Community Care assessment or a medical consultaton would be concerned to identify the wants or deficits which are not being met and which, through the medium of eligibility criteria or professional good practice, are deemed to be legitimate needs which should be met in some way or other. The 'some way or other' might imply use of the old person's financial resources to purchase help in the commercial or not for profit care sector. In other words, it might imply the private purchase of publicly provided services or the public purchase of privately provided help.

An individual with personal purchasing power may still have a need for publicly provided information, clinical expertise, and so on but they may not have a need for publicly purchased publicly provided services. They are not in need in the same way as someone for whom the only option is public provision. Need, in this sense, is contingent upon personal purchasing capacity and the state of the local health and social care for profit and not for profit markets. Two old people with similar physical characteristics who experience the same level of disability because of them thus experience different levels of publicly sanctioned need because of their different purchasing power. This is not an ideological point but one which flows from an appreciation of the crucial role which service accessibility plays in professional estimates of personal need.

Integrated definition of need

The identification of need is a process which transforms wants within the personal domain into publicly acknowledged entitlement to a treatment, service, or preventive remedy. This process has many stages which involve assessment by the individual, by potential or actual carers, and by public professionals. It is a transformation which entails an imaginative leap from the recognition of physical and/or emotional deficits to particular treatment or service solutions, and those solutions then shape another generation of wants and needs. The process is an iterative one and one which is personally and culturally constructed.

More specifically, the perspectives which have so far been identified which could be incorporated into a a more integrated approach to the assessment of need are:

> **person based** approaches by **individuals, their carers, or professionals** where the **unit** is an individual (case or care plans), a locality (GP practice or Social Service area), a population (national or regional), an age group (for example, people aged 75 and above), a medical or social condition (for example, people with dementia), an ethnic group (for example, Afro Caribbean elders), or other group (for example, older women living alone).

> **service based** approaches usually by **professionals and service planners** where the **unit** is a service (for example, continuing care beds or home care or hip replacements) in a locality, a region or nationally. Services are usually classified according to the **principal agency** responsible for their delivery - health, social, financial, accommodation - which in turn roughly correspond to the basic human needs of people living in a Western democracy.

This disentangling of the different strands of need identification and measurement suggests a matrix like the one set out below. Some examples of specific studies are given.

	Person Defined Need	***Service Defined Need***
Locality groups		
Age groups		Clayton's study of sheltered housing for elderly people (a); Farquhar and Bowling study of service use and the need for community services of three samples of older people living at home in East London and Mid Essex (b).
Other groups	Amelia Harris study of disability (c).	

(a) Clayton, S. *Assessment Of Needs For Sheltered Housing For Elderly People* in ***Social Need Revisited*** (1983)
(b) Farquhar and Bowling, *Elderly people's use of services ; a survey,* ***Nursing Standard*** 1993.

Describes the service use and the need for community services of three samples of older people living at home in East London and Mid Essex.

Baseline characteristics show that respondents in East London were more likely to live alone, be unmarried, to engage in fewer social activities and to have smaller social networks than those in Mid Essex. Respondents in east London were also more likely to report problems with their health and functional ability; and more likely to have experienced a major health event in the last 12 months than Essex respondents of the same age. East London respondents aged 85 and over were most likely to have been in contact with their GP over the past 12 months and to receive other health and social services.
The respondents were asked whether they would like to see, or to see more of, a range of health and social services. The most commonly requested was chiropody. If the respondents were asked about help needed or wanted with tasks of daily living, rather than professional services - different picture in that a higher percentage of respondents express a need. The conclusion is that a different pattern of need emerges if respondents are questioned about their need for help and preferences for its provision rather than being questioned about their need for specific professional services. Needs change with age, usually increasing, as health and functional ability decrease. Providing a service is therefore insufficient in itself; needs should be monitored over time. needs assessment should not be service driven - ie. focus on ability to carry out tasks of daily living and whether help/more help is required.

(c) Harris, A HMSO

The difference between person based and service based approaches should not be understated. It is true that in some instances they may amount only to looking through different ends of the same telescope. For example, where a person based approach incorporates a service element, perhaps where individual older people are asked about their preferences for types of treatment, a picture of the need for a service can be built up for a given locality by aggregating the individual responses of people living in that locality. This is part of the great potential offered by the routine assessment of people aged 75 and over. But in other instances the difference in practice as well as in theory is much more substantial than this. For one thing it is very likely that estimates of service need will be based upon historic activity data which imperfectly captures a pattern of use which has been shaped by professional decision making, gate keeping, targeting, and so on. They may bear little relation to what individuals think they need or would find acceptable.

In the transition from personal wants to public needs the capacity to pay is very important and has been touched on in the earlier dscussion but there are two other triggers which may propel people from the personal to more public arenas for the help they feel they need. Firstly, **expertise,** ie. knowledge and skill which an individual needs may not be available within their personal domain or the informal sector. For example, specialist medical intervention can only be found within the public sector and in a more limited way within the private sector of health care. Secondly, the remedy which an individual requires or feels would best suit them may not exist at all or may not exist in a form which is **congruent** with their definition of need.

In a context of tightly controlled public funding and greater targeting, policy makers and service planners have two main options in order to meet increasing demand for provision and services. They can either:

- increase the resources in the public domain to meet the needs of the population; or

- enable the private domain to cope with meeting individual needs.

There are a number of ways in which enhancement of the personal/private domain can be effected. For example, the requirement that 75% of STG be spent on services provided by the non public sectors encourages development. So too do financial incentives for individuals to adopt private pension schemes and private health insurance. Similarly an emphasis on health promotion and disease prevention is a way of placing the remedy outside the public domain. There has also been an increase in the number of 'alternative' and 'complementary' services and therapies, some of which are not available in the public sector. Reformulating people's needs has been a major thrust of the Community Care reforms and the substantial rise in the number of private agencies offering a range of domestic and personal care services is one example of the reformulation taking place. Whereas in the past people might have considered that the only way in which their needs

could be met was, for example, through residential or nursing home care, either paid for by the local authority or by private means; there are now a growing range of service options.

Need from a policy makers' and planners' perspective

This examination of need suggests a framework for policy makers and planners. This is not to say that other perspectives, most notably that of users and carers, are not relevant, indeed they are taken as crucial in what follows, but the starting point is that of undertaking needs assessment for the purpose of making or implementing policy.

Policy makers and planners are located at four main levels in the overall system of health and social care for older people - **national, regional, district and local** levels. The national level is, of course, central government in its various guises - the DoH, the NHSE, and the Housing Corporation for example; regional structures exist in both the NHS and the Social Services; Health Authorities and local authorities cover relatively small geographical districts, whilst Trusts, GP practices and Social Service Areas/Teams are the most local expressions of health and social care administration. Planners at every level estimate need in one form or another for a variety of purposes, but it would be a mistake to assume that there is a straightforward hierarchical relationship between the different levels. It is not simply the case that estimates produced by, for example, central government are rendered progressively more detailed and precise as the business of assesment moves from level to level. Estimates of need made by Trusts, may be used to refine estimates made at the Regional level, or estimates by Health Authorities may be used to inform planning at national level. The extent to which this actually happens may be open to debate but in theory at least we would expect the process of assessing need to be **'multi directional'** not simply 'top down'.

The policy process may be, crudely, thought of as being a process with various stages. The literature suggests that we can conceive of policy as entailing the formulation of objectives, the deployment of **inputs**, a **process** which transforms inputs into **outputs**, which in turn produce **outcomes**. In an ideal typical model the process is an iterative one which includes evaluation leading to policy reformulation or termination. There are many studies which demonstrate beyond doubt that the real world of policy is far more complex than this and that implementation is certainly not a sequential process. However, the basic components of this idealised model do alert us to the kinds of needs which a planner might seek to identify and quantify. For example, we might wish to assess the need for a change in the resources devoted to the health and social care of older people, ie. assess the need for a change in the volume of inputs; or, another example, we might wish to assess the deficit (need) or surplus for certain kinds of outputs (services) for older people. Each of the four policy stages are relevant at each of the four levels at which the analysis might be conducted, so that resource distribution

is relevant at the local level as well as at the national; the extent of the deficit in services is relevant at Regional as well as at district levels, and so on.

Whatever the level at which the assessment is being carried out and whatever the kind of need being examined, the basic materials for the assessment are likely to be similar. **Demographic data** will almost always be very important, of course, and so too will population estimates. Also important will be what might broadly be called **prevalence data**. This information is that which describes the frequency with which salient characteristics appear in the populations under consideration. Such characteristics may be ones with which epidemiologists are familiar, for example, morbidity of various kinds. But also relevant are studies of, for example, functional impairment, and, in this context, data which alow for estimates 'softer' characteristics like loneliness or isolation. The third major set of materials likely to be used is **activity data**, again defined broadly, which includes the volume of service available, its origin, and the intensity of use that is made of it.

This again is deceptively simple. The character of the three main sets of materials is constantly changing, or should be. Estimates from demographic data on older populations are likely to be more reliable than those for younger age bands simply because there is not the imponderable of birth rate, but there are nevertheless still some potentially very powerful factors which can catch the estimators off guard even for older populations. For example, in and out migration patterns before, at or after retirement. But perhaps the materials which are least certain are those which relate to prevalence. Earlier sections of this paper argued that changes in the way conditions can be treated affect our views of what constitutes need so that innovation in health and social care can alert us to characteristics of the population which were hitherto regarded as irrelevant or were simply not known. Not only that but the visibility of characteristics is affected by individuals' awareness of the relevance of symptoms or the availability of help. Assessing how many people in the population suffer from intense loneliness may not be possible if loneliness has not in the past been regarded as significant and may, in any case, be no easy matter to discover if the lonely people themselves are unwilling or unable to make themselves 'known' to the system in some way. The views of users and carers are of great significance here because they can change our information about the type of help required, the characteristics that give rise to the need for help, and the visibility of those needing it.

A focus on the policy process enables us to identify different kinds of need which will be of interest to policy makers and planners; more specifically it alerts us to need which arises from distributional featutures (ie. from input issues), from system operation (ie. process issues), from service features (ie. output), and from impact (ie. outcomes). It also allows for a clearer view of the kind of information required for assessing the nature and extent of need. This can be presented diagrammatically.

If we concentrate on assesment at a district or local level we can see that in practical terms the likely sources of data include the following:

- local **demographic data** and population estimates
- activity data on the extent and use of existing **public services**
- activity data on the extent and use of existing **non public services**
- the results of **community care assessments**
- the results of **over 75 assessments**
- special **surveys** of older people and their carers
- data on the application of **eligiblity criteria**
- **evaluations** of services and systems
- the products of joint or **collaborative initiatives**

Not all of these will be available in all locales but there is likely to be something of each in most places.

It is with this framework that the Community Care Plans from the London authorities are analysed.

Routes for identifying and assessing need

	Resource distribution route	System operation route	Service route	Impact route
Policy process	***input***	***process***	***output***	***outcome***
	eg. financial resources expended on older people	eg. hospital discharge	eg. continuing care beds	eg. independent older people
	eg. balance between public and personal finance	eg. community care assessment	eg. hospital at home provision	eg. fit older people
Possible sources of information	eg. purchasing authority budgets	eg. evaluation studies	eg. service stock data	eg. over 75 assessments
	eg. local authority financial returns	eg. user surveys	eg. activity data	eg. health promotion effectiveness studies
	need/unmet need	**need/unmet need**	**need/unmet need**	**need/unmet need**

Part 3

Social and Health Needs and Plans Reviewed

This review of social and health needs is based, principally, upon Community Care Plans (CCPs), but also uses material from NHS Trust reports, some reports from public health departments, GP practice plans, and some Health Authority commissioning and purchasing plans. CCPs are presented as being documents agreed by both Social Service Authorities and Health Authorities and it is clear that the significance of good working relationships between authorities is appreciated. However, the Plans do not deal in any depth with the medically focused health needs of older people. Several Plans do reproduce summaries of local health policies but, perhaps not surprisingly, these summaries are at a high level of generality. It is perhaps worth noting, in view of the theory which underpinned the introduction of the internal market, that Trust reports do not provide much evidence of their having undertaken independent needs assessment.

Definitions of 'need' and 'unmet need'

Most of the Plans give some explanation of the concept of 'need'. These explanations are of varying degrees of sophistication and elaboration. For example, one authority defines need as being simply "what someone requires", but in general the CCPs are focused on substantive needs without too many preliminaries about the theoretical issues entailed by the concept of need. For example, Hounslow's approach is rooted in the care of older people,

> " need : often used to describe help or care a person requires to live independently, e.g. mobility needs, accommodation needs, dietary needs.",

and unmet need is seen as being:

> "those Community Care 'needs' of an individual or customer group or section of the community that existing services fail to deal with satisfactorily. Unmet needs may be needs that are not addressed at all or for which services provided are insufficient or inappropriate or of poor quality "

Some definitions rely heavily on policy prescription, emphasising the impact route to need identification; for example, Enfield stresses independence, a major thrust of policy for older people for the last several decades,

> " need is a term covering the requirement of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life as defined by the particular care agency, authority, services users and carers. ",

whilst Hackney puts the desire to see 'needs led', rather than 'service driven', care, another policy derived objective, at the centre of its definition.

Other authorities take a broad approach and relate needs to wider social and economic characteristics, an approach which is close to the resource distribution route. Tower Hamlets CCP states that:

> " being an elder does not automatically mean one will need help to live independently in the community, many elders live independent and full lives without any intervention or assistance. Rather the key to establishing a true picture of need in the elderly population lies in the level of infirmity, and their economic and social situation. Research indicates that in areas where there are higher levels of deprivation and poverty, there are likely to be correspondingly higher levels of infirmity and social isolation. Thus in Tower Hamlets, an area which is considered one of the most deprived areas in the country, although there is a relatively small elderly population, the level of need is both considerable and complicated. "

Discussion of substantive needs and their relationship to other social and economic factors leads, in many of the Plans, to a discussion of the ways in which need can be assessed and confirms the earlier discussion of the intimate relationship between methods of assessment and the results of assessment. Enfield, for example, explains that,

> " needs can be assessed at two levels: at the level of the individual or at the level of a population within a defined geographical area. it can be approached from the bottom up or from the top down. The bottom up approach involves aggregating the needs of individuals to form an overall picture of care needs. This will be done primarily through the assessment process, but may also include local surveys and sharing other agencies' information on identified need. An understanding of need gained through consultation with service users and carers form another part of the bottom up approach. The top down approach involves using needs indicators or formulae derived from more widely based research and applying this to the population characteristics of individual localities. The two approaches are complementary. It is clearly not sufficient to rely on a top down approach from generalised formulae based on national statistics, as there may be many local variations that could not be adequately adjusted for . Neither is it sufficient to rely entirely on individual identified need, as much unmet need could be overlooked. In addition , medium and long term plans must take account of predicted future need as a result of demographic or other changes ."

The range of materal used in need assessment is very much like that outlined in the previous chapter. All of the CCPs outline the demography of their locality. The descriptions usually include the current population breakdown by age groups including those aged over 85 years, and a population projection for the year 2001. Many of the Plans also include other statistics such as the number of lone pensioner households, and changes in family size and employment of women with the implications for the availability of carers. The Bromley CCP is one which contains a *Borough Population Profile* which includes a population breakdown and projections, birth rates, mortality rates, limiting long term illness rates, housing tenure and amenities, lone parent households, people of retirement age living alone, carers, occupational class and employment figures, poverty and material deprivation, and crime figures.

Using the Census and the OPCS mid year estimates, the boroughs can compare their population with the other boroughs, for example Barking and Dagenham CCP states:

> " ...Barking and Dagenham still has the highest proportion of pensioner households in London and the highest proportion of lone pensioner households in outer London. Social perceptions of old age , medical progress and a relative improvement in economic status have changed the pattern and nature of need experienced by the elderly. More people are living to an older age and there is a corresponding need for more intensive and long term care. This means that the agencies responsible for providing community care have to pay special attention to the increase in the numbers of very elderly people. "

Demographic material and data on social and economic condition are not, however, the only sources used in estimating need. In Bromley prevalence rates derived from the 1988 OPCS survey of disability are also used in the *Assessment of Need* section to show the number of older people in the borough with some degree of disability, and those who have " high " or " very high " needs. Hackney, arguing the importance of Community Care Planning in achieving needs led services, highlighted:

- borough profile indicators of need in order to assess the likely demand for specific services;
- aggregation of care assessment and care planning information about individual service users, which identifies their specific needs and the resources commissioned to meet these, and
- details of service users', carers' and the public's needs and service delivery concerns collected through research and consultation.

In Waltham Forest the following sources were noted as being important in needs assessment:

- revised Census information - the Council's Policy Unit has updated the population data and indicators of social needs on a ward by ward basis;
- Citizens' Charter Performance Indicators - Dept of Environment monitors key needs and service delivery;
- Housing Investment Programme Submission - housing needs and resources;
- Annual Public Health Report;
- Locality Profiles and GP Annual Practice Plans.

The same Plan went on to identify information deficits and saw joint planning groups, inter alia, as being the places where improvements could be made by exploring the potential for achieving common needs data bases; improving the level of detail in relation to user groups and refugee communities; identifying a framework to assist better planning and co-ordination of primary healthcare and social care services; developing a model for monitoring / predicting demand for continuing health care support and social care, residential and nursing home places; determining the possibility of producing better estimates of the needs of people with dementia; and devising an improved model for collecting information on unmet need.

Hillingdon cites the register of people with disabilities as being a potentially useful source of data and goes on to note that:

> " the Health Agency has collected a considerable amount of information about the incidence of disability and ill health as part of its Annual Public Health Report. These two sources of information, when combined with the 1991 National Census information can provide the basis for planning to meet the needs of the future "

Enfield stresses the importance of drawing on data from a variety of sources, "from community meetings to the use of epidemiological data". Needs assessment work in this authority has also included older people's self reported health status and attitudes towards health, using interviews with older people.

Lambeth, Southwark and Lewisham Health Commission in *The Future of Primary Health Care in South East London* (May 1995), not of course a CCP, explains that the key factors in health needs assessment are as follows:

- *demography and epidemiology*: characteristics of the local population which affect health, such as age, ethnicity and social circumstances and the pattern of ill health
- *effectiveness*: evidence about which of the options available to improve health works best
- *comparative data*: contrasting health services available and the incidence of ill health or the use of services among the local population with similar populations elsewhere
- *preferences and priorities*: of local practitioners and residents

There is reference to **unmet need** in most of the CCPs. Enfield states that it will continue to examine the relationship between needs and resources, and will feed information on unmet need into the planning process. This information is to be collected at different points:

- all ineligible needs identified post-assessment, both for straightforward and comprehensive assessments;
- unmet needs identified during the review of care plans for all service users and/or carers with complex needs who were provided with services as part of care management; and
- at an early stage of non eligibility.

Tower Hamlets gives a long list of unmet need, a mixture of process and output needs:

- service accessible to all members of Tower Hamlets elders community;
- co-ordination between health and social services to ensure prompt assessment and "seamless" service delivery;
- range of personal care services;
- local nursing home provision;
- respite care;
- advocacy services;
- acute geriatric care services linked to accident and emergency;
- information and advice service for elders;
- hour warden cover for elders;
- practical tasks service for elders;
- services with flexible service hours;
- waiting time for assessments;
- aggregation of unmet need arising from individual need assessments.

The significance of information on unmet need was recognised In Waltham Forest CCP where it was recognised that the quality of the information could be improved and that the purchasing priorities needed to be more clearly linked to needs. More

specifically it was stated that the priorities for Joint Finance should be reviewed according to identified need.

But perhaps the clearest link between a mismatch in the volume of resources and the extent of need is seen in the comments made in the Plans about **targeting**. Need assessment is clearly seen as crucial by a number of authorities. For example, Kensington says that it was necessary to use "...limited resources where needs are greatest through more accurate needs assessment ". Lambeth's Plan says:

> " The new eligibility criteria attempts to more tightly define the characteristics and situation of adults who will be eligible for assessment. The new criteria acknowledge that, because of resource limitations, only those individuals in the highest priority of need will receive services. Those individuals deemed to be in lower priorities, yet who may be at some risk in the future , or unable to care for themselves for most of the time, will only receive services if the department's resources allow "

Tower Hamlets expresses similar sentiments,

> " Community care resources are very limited. A fair process is needed to ensure that those in most need receive services first, and that people with urgent needs have these needs met more quickly ",

and Waltham Forest spells out what this means for different agencies:

> " demand for services is likely to increase over the planning period but community care budgets will continue to be restricted. This means services will have to be rationed by concentrating on people assessed as being in the highest priority needs category; maximise the use of existing continuing care and community care resources within a framework of clear eligibility criteria; criteria may have to be tightened and existing users of domiciliary nursing and social care services re-assessed; ensure there is no duplication of effort and resources between community health services, Social Services and Family Health services. "

Similar points are made by Southwark,

> "Social Services have operated eligibility criteria since April 1993. These set target time scales for carrying out assessments for people with different levels of need and therefore help target services at those in greatest need. Faced with the budgetary pressures, the Council will use eligibility criteria as a means to ensure services remain targeted on those in greatest need ",

whilst Havering suggests that its rationing has been successful:

> " The pressures of a comparatively low budget and very high number of over 75's in Havering has meant services have had to be carefully target people in the greatest need. An analysis of SSI Key Indicators Information from a sample week in October 1994 comparing Havering's service to other Outer London Boroughs suggests this policy has been highly successful "

Resource Distribution Route

The planning and developing of services, as required by the NHS and Community Care Act, have been carried out against a background of continuing **changes in policy and legislation**. Many of these were noted in the CCPs. For example, creating a primary care led NHS with an emphasis upon the role of GPs; reviewing how people who need continuing health care will be supported [*NHS Responsibilities for Meeting Continuing Health care Needs* (HSG(958/LAC(95)5)]; working towards implementing the *Carers (Recognition and Services) Act* from the 1st April 1996, from which time local authorities have a duty to provide an assessment for a carer, where that carer provides, or intends to provide, a substantial amount of care on a regular basis; and implementing Care Planning for everyone assessed as suffering from serious mental illness under the Care Programme Approach by the end of March 1996. In the main these changes were noted rather than used as a basis for a reassessment of the way in which need should be identified and quantified.

Similarly, the *London Initiative Zone* (LIZ) whereby parts of London have been given extra funding by central government so that the provision of health care can be shifted from acute hospital services to primary health care as recommended in the Tomlinson report, was noted. So too is the *Disability Discrimination Act 1995* which will come into force over the next few years and which will give disabled people new rights in the areas of employment, getting goods and services, and buying or renting land or property. The *Community Care (Direct Payments) Bill* , going through Parliament at the time the Plans were prepared, which would allow local authorities to make payments to people who want them, and are able to manage them, to buy non public services for themselves, was also cited. Also referred to in the Plans was the Special Transitional Grant and the constraints placed upon its use by central government.

As well as national policies and guidelines, there have also been changes in local organisations which are specified in some of the Plans. For example, Havering cites the District Health Authority and the Family Health Services Authority merging into one commissioning purchasing authority; the increasing emphasis on a primary care led NHS with developments in GP Fundholding; and Total Fundholding with the implications that has for the roles and responsibilities of GPs and the Primary Health Care Teams, making it increasingly important to secure their full involvement in the development of the CCP; the Housing Authority undergoing compulsory competitive tendering.

There is little evidence that there has been detailed analysis of what new needs, of whatever variety, all these developments may give rise to. However, it is quite clear from all documentation that the **mixed economy of health and social care** is a working reality for all types of health and social agencies. A number of the CCPs stress the importance of managing the market of care (eg. Enfield, Sutton, Kensington and Chelsea), give an exposition on the types of contract (eg spot,

block), and some give details of the contracts which they have placed with external providers.

The CCPs paint a picture of authorities which are well aware of the significance of the mixed economy in matters of service provision, or to put it another way, the link between the resource distribution route and the service route to needs identification. Enfield, for example, says that it must,

> " ...develop and manage the social care market: in order to develop high quality community care services it is essential that there is a wide range of local providers (private, voluntary and public), able to meet the diverse needs of the local population. The Local Authority has taken the lead responsibility for developing the local social care market in order to achieve this. "

This SSD recognises the need to give guidance to providers (and potential providers) on the types and volume of services which are currently required and which might be required in the future. It says that it does this in a number of ways:

- by identifying unmet need by asking social service users for views on whether they were happy with the service they received;
- by identifying service shortfalls;
- by regular Independent Sector Consultation meetings;
- by setting up client focused working groups;
- by monitoring waiting lists;
- by reviewing all placements.

Bromley launched a new Council on Ageing in 1995 and this acts as a voluntary sector forum, it includes independent voluntary organisations, users , carers service commissioners and providers, for developing services for older people. Its purpose is to highlight areas of unmet need; propose new developments in existing services; facilitate the exchange of information on current service provision; and to discuss new developments. Lewisham has had a similar forum since 1990.

The approach which Kensington has adopted consists of stimulating and supporting the development of new services in the independent sector in line with identified need; undertaking more systematic monitoring and review of funded services to ensure value for money and the quality of services provided; and developing procedures for purchasing services both on a block contract basis and for specific individuals. As an aid to this process the authority has created a joint financed post in the voluntary sector to ensure that information about community care developments is widely communicated. A further post has been funded in the SSD to support the development of the mixed economy. Kensington reports that it will have contracted over £1.5 million for services provided by private companies which supply home care, transport and meals on wheels services. It is estimated that £8 million will be spent on purchasing residential and nursing care from private and voluntary sector homes.

In Lambeth, a Council-wide budget has been created for the voluntary sector of £6.5 million for 1996/97, replacing previous main programme grant provision. This is seen as a more strategic approach to grant funding designed to move away from historical funding patterns towards provision that reflects Council wide objectives.

There is also a Technical Assistance Fund established to encourage and support voluntary organisations.

Southwark 's CCP states that the principles agreed for the way that it purchases services in 1993 remain relevant during 1996/97, namely :

- to obtain value for money;
- to ensure providers are viable;
- to encourage competition but limit fragmentation caused by having too many small providers;
- to maintain a balance of quality providers in each service area;
- to ensure residential and day care services are provided locally;
- to enable users to have choice about the services they receive;
- to ensure providers can meet people's cultural, religious and other specific needs.

In Greenwich, work is continuing on a new accreditation scheme which will ensure that independent care agencies provide high quality care. Agencies have to show that they are reliable, competent, culturally sensitive, and respect users rights to dignity, choice and independence, equality and autonomy.

Assessing need from a service perspective, discussed in Chapter 2, is a very large feature of the CCPs, but what is also apparent is that service planning is firmly located within a policy context which insists upon a move from residential and institutional care to care within people's own homes. Every CCP devotes considerable space to spelling out the need for **community/primary care responses to need**. In some cases this means needs assessment which takes services as the starting point; for example, the Greenwich CCP says that:

> " a number of initiatives are looking at the needs of elderly people in Greenwich. These include reviews of : continuing care, survey of home care users, bathing review, and the needs of people living in residential care. The gaps identified include the need for high support sheltered housing and the need to improve much of the existing sheltered housing provision " .

Other Plans make explicit the connection between 'demand' and community care alternatives. Two extracts will give an idea of the scale of the shift, the first from Kensington,

> " during 1995 - 96 there have been marked changes in the demand for domiciliary care. Increasing numbers of older people are being supported in their own homes. Expenditure on domiciliary care in 1995-96 has increased by 28 % with a further 6% increase anticipated during 1996 -97. The levels of service provided to individuals has also significantly increased. There has been an increase of 15 % in the number of people receiving care at home and in need of more than five hours per week and an increase of 100 % in the number of people receiving live in or overnight care in their homes .",

and the second from Southwark,

> "There is a continuing increase in demand for home based community care packages as an alternative to care in a residential environment. This change in demand , coupled with the changing profile of the older population's needs, has led the Council to alter the number of residential and nursing home placements provided locally. Over recent years a reduction in the number of residential care home beds has broadly reflected the increase in home based

> services, while an increase in the number of nursing home placements has sought to respond to the needs of very dependent people who are unable to continue to live at home."

In Camden both the LA and the HA have agreed that there should be a strategic shift away from making use of continuing care beds towards community based support. This shift, according to the CCP, involves moving resources from hospital based continuing care beds, where there is currently under-use, to community provision . This shift of resources is expected to lead to a reduction of about 35 continuing care beds over 3-5 years across Camden and Islington. It has also been agreed that there should be clear eligibility criteria for all services.

The importance of **general practice** in the development of the primary care led NHS is unmistakeable. Although other models are discussed in some of the papers, it is, by and large, the local practice which is regarded as the focal point. Southwark cites the Primary Care Strategy and specifically notes the review of the way in which GPs are referring as a result of the over 75 health checks. Haringey is also working on these checks and is seeing the development of extended primary care. Kingston has appointed a care manager to five fundholding practices. Sutton notes a scheme of attachment of district nurses to GP practices; and in Lewisham there are community based diabetic clinics and patch intra venous teams. Newham has a GP Innercity Multifund which consists of 60 GPs in 28 practices which have become fundholding and which commission hospital and community health services for 125,000 people, ie. three fifths of the population of the Borough. Local teams of a multi professional nature have been developed.

Camden and Islington Community Health Services NHS Trust has as its Key Objective 10:

> "To integrate the Trust's Mental Health Services with Primary Care Services and Local Authority Services in South Camden and Islington."

The Annual Report and Accounts: Your Partner for Health (1996/96) notes the improvements in relationships with GPs (eg attached DNs) and with local authorities and have been supported by appointment of a primary care team builder. The Central Middlesex Hospital NHS Trust has increased outreach services to GPs. University College London Hospitals NHS Trust's Business Plan 1996/97- 1998/99 says:

> "The proper role of a specialist referral centre such as UCLH is to provide appropriate support to those delivering primary and secondary care.....It follows that we cannot develop our services and define our role in isolation from others. We already liaise closely with local purchasers, GPs and patient groups to ensure we understand and can respond to their needs..."

The Barnet Healthcare NHS Trust notes that GPs have 'remained loyal' and that the Trust will continue the expansion of outreach clinic sessions. The Trust's priorities include, in primary care, to establish a clinical team leader post to manage generic nursing teams on a GP locality basis. It also wishes PCHTs to "...establish needs

assessment and appropriate service delivery to practice populations; based on joint working....."

South Downs Health NHS Trust makes clear the concern which some community trusts may feel:

> "A particularly significant threat, potentially, would arise if regulations changes to allow GP fundholders to employ their own community nursing staff. It is essential, therefore, that we are able to define the added value that management by the Trust gives these services."

The Lambeth Healthcare NHS Trust, another community trust, wishes to have:

> "Further development of formal relationships with GP practices and Primary Health Care Teams. We wish to increase the number of formal "Service agreements" with GPs in Lambeth."

The variation in levels of fundholding is considerable; Tower Hamlets expects the first fundholders this year, whilst 80% of the population of Kingston and Richmond are patients of fundholding GPs.

There is considerable **geographical variation** in the size of the elderly population, the ethnic mix and the service distribution between and within local authorities, Health Authorities, Trusts and GP practices.

A report by Brent and Harrow Health Authority emphasises the differences in mortality and morbidity within its area. For example, using OPCS data, it presents the following table:

Standardised annual mortality rates per 100,000 for coronary heart disease (1992-94)

	Brent		Harrow	
	Men	Women	Men	Women
< 65	78	22	68	19
65-74	1011	406	916	350
75+	2999	2070	1828	1055

Source:OPCS

A report by the Kensington & Chelsea and Westminster Health Authority, for example, in April 1996 showed the variation within that Authority's area.

Service	Range (lowest - highest ward)
consultant cover	1: 4,896 - 1:20,782
CPN cover	1: 2,933 - 1: 6,858
day care provision (HA+LA)	1place per 173 - 1 place per 528 (over 65)
respite beds (HA+ LA)	1 place per 2,657 - 1 place per 13,033 (")
continuing care (HA)	1 place per 204 - 1 place per 593 (")

The report also noted that:

> "Social Services provision is also a key element in determining the range and depth of service provision within a locality and further work is necessary to determine the overall picture."

The variation in Social Services activity can be glimpsed through data on the volume of community care assessments carried out; for example Southwark says that it carried out 1,750 complex assessments during 1995/96 (roughly 13% of its population aged 75 and above), Bromley reports that it conducted about 2,500 per quarter, mostly of older people, during the same period (about 40% of its population aged 75 and above), and Hammersmith and Fulham made 624 complex assessments during a six month period in 1995/96. Such differences cannot be explained simply by reference to the size of the population of older people which each local authority has. It seems probable that the level of 'need' is determined by the size of the service stock and by the way in which systems operate in each location.

System operation route

Changing the balance of service resourcing directs attention to the processes which are necessary to make the aspirations a reality. It is because of this that the business of needs **assessment** is intimately related to how assessment is carried out. At the level of assessing individual need the processes described by Hillingdon are not unlike those described elsewhere:

> " Services are now accessed by needs led assessments carried out by local teams who purchase services from the Independent Sector or arrange services from the Social Services provider teams. This makes for more flexibility, and choice. Needs led assessments are also carried out by staff at local hospitals which makes the discharge of older people safer and more effective following treatment. The new provider teams are developing more flexible services which meet the needs of Users and Cares better."

Ten CCPs contain information about assessment. Islington notes that an evaluation of the assessment process suggests that there are differences between what the carers and users perceive as the needs; Kensington and Chelsea, and Newham are reorganising their systems; Hillingdon has a waiting list for 'needs led assessment'. Southwark found that its 1,750 complex assessments identified a need for 250 nursing home places and 100 residential places whilst in Hammersmith and Fulham 624 complex assessments (half year) resulted in 119 residential/ nursing home places being required, about 20% in both instances.

At a more strategic level the approach adopted by Lewisham is an example of the more ambitious where service planning and development is carried out by nine Service Planning Groups (SPGs) which are intended to have a widely representative membership including service users and carers, black and minority ethnic groups, voluntary agencies, health commissioners and providers and relevant Council Directorates. Some of the users have attended training in user participation in planning. The SPGs consult with service users in a variety of ways, including evening meetings, open days and meetings of voluntary organisations. The inter departmental approach is shared by many; for example, Housing and Social Services work together. The Housing Directorate aims, within the Housing Strategy, to provide an efficient housing service for people with special needs; to ensure

provision is as flexible as possible and can address changing needs, dependency levels and changing expectations of users; and to keep people in their own homes or near their existing support networks as much as possible.

All Plans give some detail about the ways in which they have sought to involve users and carers in need assessment. There are examples where the value of this shines through, as in Kensington for example,

> " needs which were identified as unmet by the current range of provision ranged from essential services such as better housing, heating and repairs through to aspects of daily living likely to improve an individuals overall quality of life (e.g. company and dancing). The broad ranging nature of the feedback received during these consultations highlights the need for more systematic needs assessment to be undertaken in the future ."

Similarly in Barking and Dagenham carers had identified a range of facilities they felt were needed:

- an improved 24 hour sitter in service including a service for carers who are ill or other emergencies
- an improved bathing service
- the need for regular and renewable aids to daily living
- a full time domiciliary respite care scheme
- the right to six weeks respite care like other workers
- respite care for people who are ill confused or who wander
- improved transport services
- a daily respite scheme

Some 'needs' identified by Hounslow, with comments from carers on draft CCP were:

> " would like to be given money to find someone myself to help with caring "
>
> " need for flexible and imaginative uses of respite care money and to ensure that people wanting respite care at home can have it "
>
> " respite care services should be sensitive to people's culture, language and religion "
>
> " use additional ways to publicise services and reach hidden carers, including information to community groups and in people's first language "

In Islington, a letter was sent to a random sample of community care service users and they were offered an interview to ask them about needs assessment, care management and satisfaction with the services they received. On the whole people were satisfied with both the process and the outcome of the needs assessment. Disatisfaction with the needs assessment focused on either a particular service not being available, the way the assessment was done, or a difference of opinion between the users or carer and the assessor about needs. The same authority had conducted a review of the nursing needs of residents of Islington's homes for older people. The review has been jointly funded by the Council and HA to examine possible options to meet the health care needs of residents in these homes.

Barking and Dagenham CCP discusses at some length the approach the authority has adopted and, by implication, some of the challenges which it presents. The authority is moving towards more active user and carer involvement and empowerment. The aim of increasing involvement is to ensure that the outcome of development is what users and carers want. In this CCP they define four levels of consultation and involvement which all have an appropriate role but each one of which will, the Plan suggests, achieve a different result:

- ***information only*** : a new service or change in practice is introduced without prior discussions with users and carers, who are then informed of the change.
- ***consultation only*** : users and carers are consulted and their views are taken into account when plans are made. This is consultation, but the level of inter action may be limited. Disillusion may arise if expectations are unduly raised.
- ***involvement in planning*** : at this level users and carers are able to take an active role in planning services. This may mean having a voice at planning meetings, helping to write service specifications and choosing providers.
- ***user and carer run services*** : the service is managed and run by users and carers. This may be an individual acting as his or her own care manager and buying services directly from providers; or alternatively, users and carers forming an organisation providing a service for themselves or others.

Basic consultation will continue where it is necessary to gain information or views from a large number of people. Barking and Dagenham, by 1994, recognised signs of " consultation fatigue ", which may have been caused, the Plan speculates, by rising expectations of users / carers and the inability of statutory agencies to meet all need. Basic consultation may not allow for an exchange of views, follow up questions, in depth exploration of an issue or to have the question put in a way that is understood. In consultation with older people and their carers, the emphasis should be on structured dialogue between all participants in community care for the elderly. In meetings with the independent sector, Council, providers and older people themselves, the following standards and aims were set:

- people should be aware of their rights in old age
- services should arrive before crises happen
- people should be served in their own communities
- people should have a full social life
- for older people to maintain control over their own lives
- for older people to have their basis needs met

Another example of a vigorous approach to the canvass of user and carer views is found in the Enfield CCP. In that authority, service user and carer participation is a performance indicator for the SSD's Key Result Area. The *Service User and Carers Participation Policy* has been in place since January 1994. Service users and carers participate in the design and review of their own care package and have more choice in services provided through a mixed economy of care. Quality circles are in operation in most Social Service Area Teams, which are attended by specific and generic users. Enfield CCP says that important attitudinal changes are in progress which are, in turn, influencing the general climate within which service needs are

assessed and delivered. Furthermore, it is argued, the partnership experience provides valuable opportunities for increasing knowledge, skills, understanding and expertise for everyone.

There was one example of consultation which went well beyond the service perspective. In Sutton, the Council has adopted its own *Local Agenda 21* , derived from the Earth Summit in Rio de Janeiro in 1992 where a comprehensive strategy was adopted which links local action to global problems. In Sutton, a Forum of community leaders has been established which aims to bring about lasting improvements to the social, economic and environmental fabric of the local communities. In consultation with six focus groups of randomly recruited local residents, people were asked " How can we safeguard our environment and the well being of local people now and in the future ?" The top priority was to *increase care and support for elderly people in their homes.* There is now a Forum for older people in the borough, which has the following aims:

- to promote the welfare and interests of seniors within the London Borough of Sutton
- to provide a platform where matters of concern to seniors can be raised and policies developed
- to act as an umbrella, non political organisation when making representations to and liaising with statutory bodies dealing with local affairs
- to promote policies as they affect seniors and generally put forward a positive view of them.

Stakeholder conferences found that the top three things most important to respondents were firstly, health; secondly, being able to get about; and thirdly, having someone to talk to. Four times as many people wanted to see more services provided in their own homes than in alternative settings. Following one of these conferences, the Joint Commissioning Group and the Joint Strategy Board agreed that the following five key themes should underpin the Strategy for older people.

1. Services should be provided in the most appropriate environment;
2. people with low to moderate, as well as high needs deserve some recognition;
3. emotional needs are as important as physical and mental needs;
4. services should have clear outcome criteria;
5. services provided by different agencies should be properly co-ordinated.

Interestingly, the results of consultation stressed that the Strategy should also recognise the important role played by older people in providing care, carrying out voluntary work and contributing to the life of the community, or to put it another way, the actual and potential role of older people themselves within the informal sector of care.

It might be expected that need assessment of the individual would be at its clearest in the context of community care assessment and management and the Plans do contain sections devoted to this subject. However, by and large, it is policy and procedural matters which dominate the discussion. For example, in Enfield assessment is seen as the process of identifying the needs of a person with a view to subsequently supplying support services. It is stressed that such an assessment should be 'needs led', ie. listening to the user and carer voice first, then getting the

views of GPs and other agencies, before making a judgement as to which services might be relevant. There is considerable detail on the steps to be taken:

Assessment Action Planning (before the care planning stage) includes:

- summarising the needs;
- establishing what the person's desired outcomes are whatever service is provided;
- using the summary of the needs, establish whether the person would be eligible to receive social services in accordance with the eligibility criteria. For those people within the ***high need band*** a service will be provided if the Department has a statutory responsibility. For persons within the ***high or medium need bands*** a service will be provided if resources allow. Where needs are within the ***low need band,*** service will usually not be provided. Certain needs may also be met by provision of services from the NHS and other agencies.

The need bands are based on the OPCS disability categories, so that:

High need - people who need assistance with personal care tasks every day. Relates to OPCS disability categories 9 - 10, which includes people with severe difficulties with personal care, mobility, intellectual functioning and continence

Moderate need - people who need assistance several times per week but less than every day. OPCS categories 4 - 8 which includes people with some difficulties in areas of mobility and intellectual functioning.

Low need - people who may need some preventative services e.g. people who have some disability but who don't need regular help. OPCD categories 1 - 3.

Care management and assessment in Lewisham is seen as a three stage approach - referral, core assessment, and comprehensive assessment. Assessment is, once again, needs led, "...with services tailor made to individual need "; Lewisham CCP states that " all assessments start from the user's or carer's definition of their needs and the outcomes they want to achieve"

There are, however, eligibility criteria to be satisfied before a needs assessment is carried out. In Hillingdon the current eligibility for an assessment is:

1. the current level of support is insufficient to meet the needs of the person, or is likely to be withdrawn or significantly changed in the near future;
2. a carer is requesting / needing assessment of their own situation;
3. the person is unable to perform significant personal tasks because of a serious physical, mental learning or sensory disability, or there is a likelihood of clinical deterioration in the near future;
4. the person is likely to require multi agency services on a regular basis;
5. there is a degree of stress, distress or risk unacceptable to the person, their carer or the wider community and/or
6. the person is emotionally or psychologically unable to cope in their daily living situation;
7. the person is physically, mentally or financially at risk from abuse or being abused and/ or
8. the person or carer is a danger to her/ himself or others;
9. the person or their carer is of the view that the applicant is no longer able to cope independently in their current accommodation for whatever reason.

A similarly economical approach to assessment is seen in some other Boroughs. In Camden there is a Selective Needs Assessment Team (SNA) which carries out assessments when needs are likely to be met through the provision of a single

Community Care service, e.g. home care, meals service, day care, or a combination of these services. The team was initially established as a pilot and is staffed by a multi agency team of seven assessors from Home Care, Age Concern, Camden CAB and a health advisor for elderly people for Camden and Islington Health Services Trust. Multi disciplinary Assessment and Care Management Teams (Health and Social Services) have been established in local health centres, which provide a quick and responsive assessment and care management service for older people with complex needs.

Joint working and commissioning between health, social service, and other agencies presents opportunities for each to share information. This may be seen as the first step on the way to a fully developed approach to joint commissioning. The assessment of need is fundamental to the process of joint commissioning and to that extent it might be expected that collaboration, networking, and so on, provides fertile ground for developing a coherent and systematic approach to need. The CCPs present a picture of a landscape within which there is plenty of evidence that the mechanics of joint working are in place and some signs that the spirit of collaboration is also alive and well. What follows are some examples of the kinds of approaches which are being adopted. It is less clear from the CCPs that all this activity has produced very much consistency in the ways in which need is thought about and quantified.

The Kensington CCP sees one of the future challenges as being "...to reduce the problems of the health / social care divide by extending joint commissioning ". The authority as a number of projects intended to meet the challenge. The Social Services and the Health Authority have produced a *Joint Strategy* and are currently considering, in conjunction with the Health Trusts, the establishment of joint health and social services community mental health teams and the integration of the Care Programme Approach and Care Management. There is also a joint planning structure which provides the formal mechanism for inter agency working. The Joint Planning Teams have a membership drawn from Social Services, the Health Authority, Housing Needs Group and representatives from the voluntary sector. Individual Joint Planning teams are increasingly working towards integrated joint commissioning.

Joint Commissioning is being developed between Social Services and the Health Authority in order to be able to deliver joint packages of care to physically frail older people in their own homes, and respite care. The Primary Care Support Force is working with the Borough to develop GP involvement in the delivery of services. The *Strategy for Housing People with Special Needs* is working on linking the Housing Needs Assessment and Community Care Needs Assessment processes, including shared information and clearer referral systems between the two departments. Joint working with Health is also cited as being of importance in the *Strategy for Older People* , particularly in relation to continuing care, hospital discharge, and the development of joint training. Hospital and Locality Implementation teams have been set up to discuss and identify necessary developments in local services.

In Sutton, the strategic direction of the Health Authorities is towards a primary care led NHS where the specific aim is to locate decisions about purchasing and the

provision of health care as close to patients as possible. This means involving all GPs in decisions about priorities and commissioning. Changes are being made in commissioning responsibilities which anticipate a significant shift away from the commissioning of health services on a whole population basis towards meeting the needs of specific GP fundholders. In addition work is continuing to improve team working in primary care, and with the local authorities to improve access to services for all patients. An integrated approach to practice development is being adopted, within which each GP practice will be encouraged to agree its own Development Plan addressing the health needs of its population, services currently provided, identified gaps in services, together with GPs' plans for improving the service offered to patients.

Hillingdon has joint projects with Housing, Health and Social Services, for example collaborative commissioning and the Supported Housing Group. There is joint training for Community Care, based on the principle that much of the training should be across all services, inter agency and multi disciplinary in order to foster understanding of different roles and functions including joint purchasing and joint providing. There are a number of collaborative commissioning projects groups which work on particular issues and service developments, including services to older people with a learning disability, review and improvement of services to people with continuing health care needs, and developing a longer term strategy for collaborative commissioning between Health and Social Services based on shared values.

In Islington, joint working and commissioning with is seen as being key in the production of cost effective and user sensitive services. Joint agreements have been reached with health service provides and purchasers to develop a joint operational policy to cover home care and nursing needs at home. These include dependency criteria which can be applied across the health and social care needs field. They are designed to clarify separate responsibilities for health and social care but to facilitate the co-ordination and integration of services where care needs overlap.

In Waltham Forest there have been a small number of meetings between primary care and social care staff, and with GPs, to work together to identify possible sources of additional funding to promote good practice at a local level. Developing Primary Care - an initiative to promote joint working between the HA and the Trust - has led to the creation of primary healthcare clusters, ie. 28 primary healthcare teams with nursing services aligned to practice populations. This model has been tested in three pilot sites, and a multi agency training programme will be introduced to support new ways of working and to underpin links with local authority services.

In Newham the plan for the next three years is to add to *the Joint Continuing Care Strategy* a plan for Health, including GPs and Social Services, to decide together what home care and community nursing needs should be met and how provision can be made through joint commissioning.

Enfield has Primary Care Development Plan schemes which benefit older people through the provision of day activities; pharmaceutical training for home carers and

residential home staff; the provision of a carers' bus for information, advice and support; and a pilot scheme for a bathing service.

The Barking and Dagenham CCP stresses the importance of public accountability and firm financial management. The partnership agencies have not sought to tackle complex and risky methods of joint commissioning when similar benefits can, in the authority's view, be achieved by easier means. Joint commissioning is seen as a means to an end, where the benefits being sought are the delivery of a seamless service; a greater emphasis on needs led planning; a reduction in the opportunities to disown or pass on responsibilities and costs; obtaining a better picture of need; securing a more effective pattern of services at better value for money; and making services more responsive to change.

Joint finance in Greenwich has been used to support a number of innovative schemes such as the Vietnamese Mental Health Project and the Greenwich Information Network. GP and community health services are being developed through the allocation of £22 million over the next five years. New services are being organised in four localities to cover the whole of the borough in which closer links have been established between GPs, other practice staff and care managers.

In Havering, joint planning involves Joint Officer Teams for different customer groups. The Joint Officer Team for Older People is responsible for the strategic planning of services. The Team includes Social Services staff, Health staff, the FHSA, the Community NHS Trust, Housing and other Council departments, and local voluntary organisations. The cross boundary issue selected for the Team's work programme is collaboration with GPs. Current work for 1996/97 includes the development of an Advocacy Project; reviewing the effectiveness of joint working in, for example, the Home from Hospital team, bathing services, rehabilitation services, and continuing care arrangements.

The implementation of **hospital discharge policies** remains high on all agendas. Virtually all CCPs make some mention of the policies and the extent to which they are being effective. Almost all have identified areas where further work needs to be done; for older people with mental health problems (eg. Hillingdon), or as a result of reorganisation (eg. Lambeth). The Kingston Hospital Trust has appointed a discharge facilitator.

Central Middlesex Hospital NHS Trust set up a bridging team in November 1995 to care for older people when they return home from hospital; the team sees an average of 27 new clients a month.

A great deal of effort and resource is to be devoted to **upgrading provision or changing its character**. At least nine authorities are carrying out improvements in residential care in order to conform to the inspection requirements. In one case (Islington) a residential home is being turned into a nursing home, and Redbridge is upgrading its sheltered housing.

Camden and Islington Community Health Services NHS Trust opened a new ward at St Pancras Hospital for older people with mental health problems.

Service route

Support and information for carers

Virtually all agencies highlighted the importance of carers. Several CCPs cited the GHS and derived LA specific statistics from it. Southwark, for example, estimates that 15% of people aged 16 and above are carers, with 6% being carers of their parents. Some 2,200 people aged 45 to 64 in the Borough are thought to be caring for at least one other person. A survey conducted by the National Carers Association found that 65% of carers thought their own health was being adversely affected by their caring responsibilities. A local survey in Southwark, conducted in 1995, suggested that 53% of carers in the LA had themselves got an illness or disability of some kind.

The needs of carers for support was seen by many agencies as requiring a substantial response from both health and social care organisations. For example, Richmond CCP suggests a six pronged approach:

1. to improve the availability of information on services and other resources by means of publicity, by developing outlets for information, and by providing personal information services;
2. to improve the communication between carers and health and social agencies by giving better information about individual prognosis and likely future needs;
3. to improve the responsiveness and range of services to meet need, to include a range of flexible practical help, enabling them to have a break, including the carers needs in the assessment of user needs, and by providing bereavement counselling;
4. to include better information about carers in planning services;
5. to empower carers;
6. and to set up specific posts to achieve this.

Some LAs have established carer fora (eg. Redbridge), or carers networks (eg. Kensington and Chelsea), or a helpline (eg. Brent), or emergency services (eg. Hillingdon), or a carers' bus to distribute information and advice (eg. Enfield). Some of these kinds of initiatives have a particular focus; Bexley has information for carers about home care; Bromley has focused its attention on advice about people with dementia.

Although there is probably more emphasis on the carer's role in the CCPs than in other documentation, there are clear signs that health agencies are alert to the issues. For example, the Health Shop is an initiative set up by the Lambeth, Southwark and Lewisham Health Commission in September 1994. Its purpose was

to provide information on how to improve the quality of health care. It is not just concerned with services for older people but does offer its service to them and their carers. In the first year of its operation it responded to over 20,000 enquiries. 89% of the enquiries were by telephone. GP practice plans also give evidence of an appreciation of the significance of carers.

Information and advocacy for users

The authorities see a clear need for better and targeted information for users. Those LAs which have developed charters for service are heavily committed to improvements. Many have produced special leaflets, some of a general nature (for example, the roles of the various agencies) and some with a more specific remit (eg. explanation of eligibility criteria for continuing care).

Advocacy is also highlighted as a need by some authorities. For example:

> "Age Concern Enfield will set up an advocacy and befriending scheme for older people. This will be set up as a pilot project to train volunteers to act as advocates for older people in different situations, including in comprehensive community care assessments." (Enfield CCP)

The approach adopted by Havering is not untypical of many other LA initiatives:

> "The consultation programme this year has included a one day workshop with customers and carers. This was to develop the community care charter and plan as well as give and receive information to help draw up the continuing care arrangements. The report of the workshop has been passed to the joint officer teams to take into account when developing their priorities and work programmes. We will continue to try and involve users and carers as early a stage as possible in planning services...."

Accessibility of services

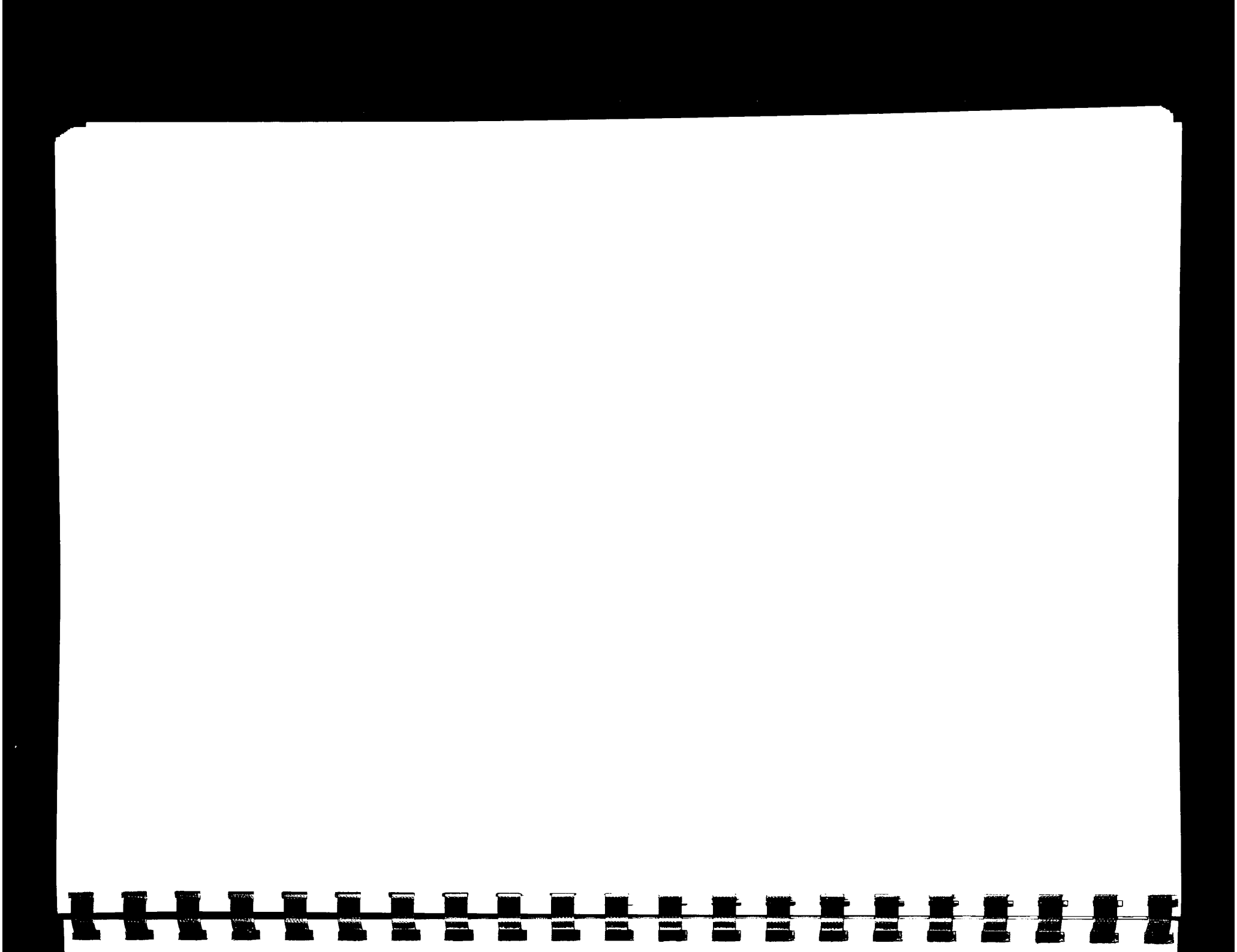
Six LAs specifically refer to making services more accessible as one of the needs which older people have. Accessibility is a rather vague term which embraces physical proximity as well as eligibility criteria. Sutton, for example, has as part of its joint strategy for 1996-9 that:

> "There is a need to address the ways in which older people gain access to services, and to improve and clarify existing processes. In particular, the Strategy includes a commitment to develop: improved and streamlined 'multi disciplinary' assessments; clear eligibility criteria for existing services; reduced waiting lists; 'targeting' of services to where they are most needed."

One general practice says in its development plan that its first aim is:

> "Focusing upon the needs, perceived and real, of the patients served by the Practice and ensuring that services to meet those needs are accessible and acceptable to all."

It intends to achieve this by being involved in local needs assessment, surveying patients, focus groups, a Patient Panel, and a comprehensive complaints procedure.



Furthermore, it proposes to introduce one open access clinic for older people which will be voluntary sector led and which will be multi disciplinary and multi agency "...(eg. nurse, chiropody, dietetics, physiotherapy, social services, alternative therapies etc.) to ensure a holistic approach." (Rushey Green Group Practice, Service Development Plan).

One health commission which used surveys of patients during the development of its strategy reports that accessibility of services was a major concern (LSLHC).

'Out of hours' help

There is a general recognition that older people have needs which have to be met outside standard office hours. Sixteen CCPs specifically mentioned this. For example, in Enfield it is proposed that there should be a night sitting service; in Kingston that day care hours should be extended; in Barking and Dagenham that there should be an emergency night service; and in many LAs that home help hours should be extended. Hillingdon noted the need for community pharmacy services to have longer hours.

The RTR Healthcare Trust has extended its 20 hour domiciliary nursing service by two hours.

Practical domestic help

The significance of domestic help is, of course, well appreciated - 20 CCPs make specific reference to the development of these services. Some authorities are particularly concerned to make the service sensitive to cultural norms and traditions (eg. Camden, Hammersmith and Fulham). In at least three authorities a voluntary accreditation/registration scheme for domestic care agencies has been introduced (Islington, Greenwich, Newham). Havering is developing a Staying Put scheme; Bexley plans 350 extra hours each week of domestic help, serving in total about 500 more people in the community.

Rehabilitation

Looking after people once they have returned from hospital, or some other form of intensive treatment, is seen as a high priority by about ten LAs. Hounslow CCP says that about 500 people per year have a stroke and is planning to improve services to deal with the consequences. Haringey is introducing a multi disciplinary stroke team; Sutton is mounting a joint rehabilitation/ assessment project. At least three authorities are introducing pharmaceutical training for users and carers.

Six Plans note the need for occupational therapy, and Haringey says that its waiting list for OT is 1,057 people. Several also argue the need for more chiropody, with Lewisham about to pilot a scheme whereby people can get direct access through ten GP practices. Kensington is to introduce a 'one route' approach to getting equipment and aids and Barking and Dagenham found that this was precisely the kind of service many of the carers they surveyed wanted.

The RTR Healthcare Trust is developing multi disciplinary rehabilitation at home. Barnet Healthcare NHS Trust identifies its major changes for next three years as including reprovisioning of community services, elderly rehabilitation, development of community mental health teams, and a new mental health inpatient service. Its Business Plan for 1996/7 states:

> "Increased levels of inpatient elderly rehabilitation activity has resulted in pressure on the services to support this workload. Analysis of district nurse activity data in the year has also highlighted the increased dependency level of patients discharged from the acute sector to home, and the resulting pressure on district nursing staff."

Stroke audit showed half of those surveyed were well enough to return home following discharge planning.

Day care

Day care needs were identified in a handful of Plans. In three cases the particular need was seen as being to make day care sensitive to various ethnic groups. Bexley wished to improve day care for older people with mental health problems, and Haringey for elders with especially high physical and mental health needs.

Transport

About nine CCPs identified transport as a significant issue for older people and their carers. It was carers who pinpointed the difficulties in Barking and Dagenham. Merton notes that it supports the London Committee on Accessible Transport (LCAT). None of the CCPs contained specific proposals for change or development.

Sheltered housing

The importance of sheltered housing can be seen in 15 CCPs. Several authorities note the need for ethnic groups (eg. Southwark, Newham) and for high need groups of older people (eg. Greenwich, Haringey). A number of local authorities are proposing reviews of sheltered housing and in particular the role of the warden (eg. Hillingdon, Hammersmith and Fulham). Many Plans make explicit the relationship with housing associations.

Residential and nursing home care

All CCPs devote some space to a discussion of the need for nursing and residential care. In some instances the concern is to encourage provision which is culturally sensitive (eg. Hammersmith and Fulham), in others to promote care which caters for social, nursing and medical needs (eg. Kensington and Chelsea). Bexley estimates that it needs ten more places in nursing home and 35 in residential care, as well as another nine NHS continuing care beds; Hounslow feels that places are not keeping up with need; and at least two authorities have identified a need for hospice care (Kingston, Kensington and Chelsea).

The RTR Health care Trust is developing a nursing home complex. Camden and Islington Community Health Services NHS Trust's Corporate Business Plan 1996/97 has a section on 'Continuing Health Care Needs', in which Key Objective 11 is:

> "To align the in patient bed base and contracted levels of activity by reprofiling.",

and in particular, to have older people's beds run at average occupancy of 90%, and to relocate two wards.

Respite care

Several types of respite care are needed: respite at home (Hammersmith and Fulham, Barking and Dagenham); day respite away from home (Barking and Dagenham); and residential/nursing home respite. Southwark says it needs 20 respite beds for older people with mental health problems, and Camden also highlights this group. A number of authorities are going to undertake reviews (eg. Kingston).

Surrey Heartlands NHS Trust opened a new unit in March 1997 with 40 beds in five 'house groups' of eight to provide respite care and continuing care for elderly people with mental health problems.

Mental health

About two thirds of the CCPs identify mental health services as a major challenge. Camden estimates, on the basis of OPCS data, that it will have to provide for 1,200 people with dementia and 3,140 with depression; Bromley estimates 3,600 people with dementia, 600 - 1,600 with severe functional psychosis, and 5,200 - 11,000 people with neurosis or personality disorders. The response is varied. Some agencies, as was noted above, favour more information for carers and older people themselves; others wish to develop resource centres which include respite care (eg. Barking and Dagenham); Havering is promoting 'holistic', multi disciplinary care; Camden is proposing the creation of Community Mental Health Care Teams and a residential unit. Newham also favours a community team approach.

Riverside Mental Health Trust has set up a Community Support and Rehabilitation Service (CSRS) which is, it claims, "....the first fully integrated health and social services initiative nationally." It goes on:

> " Definitions of what is a social problem and what is a health problem are often artificial and refer more to organisational structures than to the needs of our patients. We're excited that, as in the case of Hopkinson House, we now have the chance to develop a holistic service in response to the needs of respondents." Gill Newsome, Service Director, CSRS

There is a Home Treatment Team as an alternative to admission or for early discharge. However, the Trust does acknowledge that there can be difficulties:

> "Social Services....This is a fundamental partnership of vital importance and, over the years, a strong relationship based on understanding and respect has developed. During the last year, however, particular tensions have become evident: difficulties in finding alternative arrangements for patients who no longer need acute hospital beds; and the need to integrate the Care programme Approach with Care Management. We are working hard on both issues."

Kensington & Chelsea and Westminster Health Authority's paper 'Next Steps Towards a Joint Strategy for Older People with Mental Health Problems' argues that:

> "Compartmentalisation of health and social needs is neither possible nor desirable. This is particularly true of older people with a mental health problem who often have complex needs due to the combination of physical and mental health problems."

The paper notes that:

> "...the ageing of the ethnic communities as the number of non white over 65s is estimated to increase by 50% over the next 10 years. This has implications for the accessibility and appropriateness of services and the known patterns of under- and over-representation of users from ethnic backgrounds in the various parts of both the current adult and elderly services."

From national prevalence data, adjusted for KCW, the Authority calculates the numbers of older people with mental health problems as set out below.

Disorder	Estimated No. 1996	Estimated No. 2000
Dementia		
- Males	1,161	1,214
- Females	2,465	2,452
Total	**3,626**	**3,666**
33% with moderate or severe dementia	1,209	1,222
Schizophrenia	499 (estimate for 1995)	1,347
Severe depression	1,347 (" ")	1,313
Total	**1,846**	**1,751**

However, the prevalence data validity is questionable, says the report, because the Public Health Department point prevalence study in 1995 suggested higher levels of severe and enduring mental illness in the adult population, and this might carry forward to elderly. The effects of some long term conditions, like substance abuse, is unknown.

The same report compares existing provision with estimates derived from Stevens and Rafety (eds),

Facility	Number required	Number provided in KCW
Acute/assessment beds - functional illness - dementia	 27 45	68 Flexible use - no fixed split of provision
Continuing Care (depending on other local provision)	90 -135	120
Day places per day - functional illness - dementia	 22 - 37 90 - 112	 29 NHS 44 NHS (Further 62 LA)

The gap between the figures in the two tables suggests, says the paper, that people are being cared for somehow at home.

More pressure, or need, may come from:
- reassessments of people in non NHS provision;
- pressure on LA budgets;
- dislocation of social/care networks;
- assessments of carers needs.

A multi disciplinary team is best placed to assess needs; the integration of care management and care programme approach is required. Furthermore, the report says:

> "Respite to support informal carers is vital. Nevertheless, anecdotal evidence suggests that current respite provision is under utilised. More information is needed."

Eight CCPs note the development of policies to combat **abuse of older people**. Greenwich is appointing a specialist worker and Camden has undertaken to investigate alleged mistreatment within a specified time.

Impact route

The framework developed in the first part of this paper would suggest that policy guidance on **health promotion and the prevention of ill health** would generate a distinct class of needs. The CCPs confirm the impression that very little attention is being directed at this area; many of the Plans acknowledge the significance of health promotion but it is clearly not a high priority.

At least six LAs, however, are promoting self care programmes for older people. Haringey is emphasising ways of preventing cardiovascular disease; Brent, Bromley, Kensington and Chelsea, and Sutton are concentrating on safety at home. Havering is continuing with, and developing, over 75 health checks. The CCP for

Richmond cites the plans of the Richmond Twickenham and Roehampton Healthcare NHS Trust in which the development of a Look After Yourself programme is being undertaken in line with Health of the Nation targets.

Barking and Dagenham have as one of their guiding principles that " people should not have to be in a crisis with all the distress that entails, before seeking help. The SSD in partnership with the community must respond quickly to need " and Kensington acknowledges the connection between prevention and priority need:

> " Whilst services continue to be concentrated on those most in need, broadly based preventative services will continue to play a role in supporting people in the community. The balance between these is likely to change as the level of need grows ."

Southwark CCP referring to the HA's *Primary Care Strategy* states that while recognising the importance of targeting resources at preventing or minimising need through early intervention, current resources limit the extent of new work in this area. However, the implications of the strategy will be discussed with Social Services . Both Health and Social Services are reviewing the way GPs make referrals to Social Services as a result of health checks for people aged over 75.

Islington's CCP, in the introduction, states that:

> " we recognise the need for preventative services, to stop people getting to a stage where they need higher level care services, but we cannot fund preventative services at the expense of vital community care services. Our first priority is to provide care for those with the greatest needs. We will do all we can to provide and lobby for preventative services, in partnership with users, carers, and the independent sector, but we will not shy from tough decisions. "

However, there are some initiatives underway. In Southwark, there are two schemes in primary care for carers. They consist of a project manager and two full time workers employed to advise and support GPs in meeting the needs of carers. The HA is currently looking at ways to introduce routine health checks for carers either through the primary health care teams (GPs) or community nursing services (district nurses).

In general, however, this area of policy was not a route which was being used extensively to identify and assess need.

Summary

There is a great deal of development taking place in London both in terms of systems and services. Joint working between Health and Social Services is now commonplace, and the shift towards community based approaches is well on the way. Concern about upgrading existing service stock is widespread and the challenges posed by mental health problems in old age are well appreciated. Needs assessment, however, is still in its infancy with a number of authorities having

identified it as a priority for the coming year, and where assessment has been undertaken it is almost always of a service based kind.

The next chapter presents some conclusions based on this review and assesses the usefulness of a more systematic approach to the formulation and application of the concept of health/social need by policy makers and planners.

Conclusions

Using An Integrated Approach

The CCPs do not reflect all the planning which takes place in SSDs. The Plans are a mixture of statements about past achievements, future intent, the soundness of stewardship, and they have a strong flavour of a public relations exercise. It would, therefore, be improper to suggest that any particular authority's planning is as good, or as bad, as its Plan might suggest. More specifically, it might seem overly optimistic to try to obtain a clear view through the Plans of the ways in which need is thought about, identified and quantified. In any case it is apparent from even the most cursory reading of the CCPs that there is great variation in their style and content.

However, patchy and variable as they may be, these Plans are the only source of information, common to all authorities across London and with the blessing of both health and social services, about proposals for meeting the care needs of older people. Individual authorities may have prepared more authoritative papers which discuss different approaches to need, but in order to get a picture for the whole of London the Plans are the only source one can draw upon. In short, the collectivity of CCPs may not constitute the most sophisticated account of planning intentions but it is the only one which has the potential of comprehensiveness.

The definitions of need range from the complex to the simplistic. This variation is not explained solely by the fact that different authorities may have had different types of audience in mind, although they certainly did. It is clear from the texts that some authorities did not treat need as self evident whilst others did. The dominance of service based approaches is apparent. Although there is a good deal in the Plans about the ways in which users and carers are being involved in planning, the descriptions suggest a preoccupation with processes and an emphasis on services. There are substantial sections devoted to care management but very little use seems to have been made of these assessments in building a picture of what individual older people and their carers want. Reference is made to over 75's assessments too but again there is little to suggest that the results of these are being used to inform planning.

Perhaps the most significant omission is the absence of translation of health oriented information into plans. For example, there are almost no instances of the use of estimates of hip operations to predict the numbers of old people who may require help at home. Or, another example, almost no use of estimates of the incidence of dementia to determine the level and type of assistance which may be required. Furthermore, evidence of health promotion strategies is not used to create joint approaches to improving self care.

In summary, **the difficulties** suggested by the analysis of Plans are:

- the application of a systematic approach within individual Plans to identifying and quantifying need;
- the adoption of a systematic approach across all London authorities;
- the translation of data about general social conditions into specific proposals;
- the use of routinely collected information for planning purposes;
- breaking out of the present service configuration to allow scope for alternatives;
- appreciating the linkage between data produced by different authorities.

Differences within and between authorities

Trying to ensure that all authorities in London adopt a similar approach to the identification and assessment of need would be a formidable task, but it is less hard to imagine persuading authorities to be rather more systematic in their approaches than they may have been in the past. The framework presented in Part 2 of this paper could provide a basis. Policy makers and planners require information from all routes - input, process, output, and outcome - and generated by a wide range of enquiries ranging from the Census to very local user surveys.

Of particular importance is the inclusion of non public provision within the ambit of the data collectors. Establishing need is difficult enough but establishing unmet need is impossible, within the context of the mixed economy, without a clear view of the remedies available within the private, voluntary, independent and, of course, informal sectors. The significance of the role which carers play is apparent in the Plans but the connection between the role and unmet need is less clear in them.

Research

There are, however, gaps in the information/knowledge base which can only be filled by more research. The general relationship between, for example, poor housing and respiratory ill health is well known but it will probably never be possible to be very precise in estimating impact, there are too many

variables, but it may be possible to be more precise than we can be at present and if it is, then that should be of considerable use to planners. The connection between general social or medical conditions on the one hand, and need or unmet need on the other, is one which could and should be unravelled.

Service alternatives

Experience from joint commissioning pilot schemes suggests that new ideas for new services do not just 'fall out' of needs assessment, whether the assessment is of an individual or of a population. There is evidence in the Plans of innovative thinking and service development but there is also a good deal of evidence to support the view that breaking away from the conventional wisdom about services is a lot more difficult than exhortation to be 'needs led rather than service driven'. Listening to users and carers does seem to facilitate the process and there are three very obvious ways in which that can be done; through care management, over 75 assessments, and specific surveys or canvass of user and carer opinion.

Assessing need and unmet need will never be a simple matter but the framework outlined in this paper may help to clear the way for a more systematic and collaborative approach, within a context of a mixed market of health and social care.

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Appendix: Canvass of Health and Social Service Documents

A letter was written to the Director of Social Services in each of the London Boroughs. The letter stated that:

> " we have been asked by the London Commission to provide a framework for considering the health and social care needs of older people in London and the ways in which these needs are assessed. This work is based on the identification of the needs of older people in London based upon the views of the principal agencies, other academic and professional bodies. We are working on this project with the Centre for Policy on Ageing and the London Research Centre.
>
> We are proposing to produce a summary of the quantitative material contained in the various documents; and to produce an account of the needs identifies by the various stakeholders and how this fits in with a framework for the categorisation of need. We are endeavouring to collect as much of the relevant material as possible for this work, and would be very interested to see a copy of the Community Care Plan for your Authority. We would be grateful for your co-operation with this, and look forward to receiving the Community Care Plan at your earliest possible convenience "

The following Social Services Departments were contacted:

1. Barking and Dagenham
2. Barnet
3. Bexley
4. Brent
5. Bromley
6. Camden
7. Corporation of London
8. Croydon
9. Ealing
10. Enfield
11. Greenwich
12. Hackney
13. Hammersmith and Fulham
14. Haringey
15. Harrow
16. Havering
17. Hillingdon
18. Hounslow
19. Islington
20. Kensington and Chelsea
21. Kingston Upon Thames
22. Lambeth
23. Lewisham
24. Merton
25. Newham
26. Redbridge
27. Richmond Upon Thames
28. Southwark
29. Sutton
30. Tower Hamlets
31. Waltham Forest

Documentation was received from all but three authorities.

We had also requested any other relevant information and were sent other information from some of the boroughs such as Joint Community Care Charters, Community Care Strategies, and Joint Commissioning Newsletters.

After reading the CCPs, other relevant information referenced in the CCPs was requested and it was as a result of this that we were sent documents from Lambeth, Southwark and Lewisham Health Commission on the " Future of Primary Health Care in South East London " and other documents on joint commissioning for health care and mental health services in South East London.

The Community Care Plans were analysed using the following headings:

- definitions of need and any needs assessment;
- demography;
- services;
- users and carers;
- policy injunctions;
- the mixed economy;
- prevention / promotion;
- joint working and commissioning.

All NHS Trusts covering the London area were contacted and information on older people asked for. The documents we were sent as a result are listed in the Bibliography.

We also wrote to all GP practices in the chosen localities and received three plans; several practices wrote to explain that they did not have relevant information or were too pressed to be ale to supply it.