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We welcome comments about the content of the Bulletin and would appreciate notification of problems with the electronic version.

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## About this Bulletin

The PSSRU Bulletin is a guide to the work of the Personal Social Services Research Unit, presenting articles on some of our major research projects and providing pointers to the work for which there is no space to present results.

As well as the main articles listed in the contents section, this issue also includes on the inside back spread a brief listing of most current projects and, on the preceding pages, details of recent PSSRU books, monographs and discussion papers, together with an order form.

For further information, the PSSRU librarian or other staff (see the list on page 47) will be glad to help. The PSSRU has a World Wide Web site (<http://www.ukc.ac.uk/PSSRU/>) which gives up to date details on publications, projects, staff and seminars.

We value your views on our work and would be grateful if you could take a few minutes to complete and return the readers' questionnaire in this the centre of this issue. If this copy was wrongly addressed, please let us know.

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### STOP PRESS

Since this issue went to press, the results of the latest research assessment by the Higher Education Research Council have been announced. All three of our host institutions were rated highly in the subject group (social policy) to which PSSRU work is attributed. The University of Kent and the LSE remain in category 5, the highest, while at the University of Manchester the rating was 4. Only five institutions achieved category 5. The LSE, which has the largest number of academics in social policy, was given the only grade 5\* in the subject.

## Introduction

### Bleddyn Davies

Exciting times present vast opportunities, though what we first see are always the challenges. Like everyone else, we are trying to rise to the challenges by seizing the opportunities.

Recent changes in DH R&D funding policy reflect underlying influences on changes in research needs. They have given the opportunities to make a radical response. The most visible aspect of the PSSRU response is the establishment of two new branches. The logic underlying their establishment, where they are, what are their aims, what kind of organisation the PSSRU is becoming, reflects our perceptions of these underlying factors. Less visible is the structure of our programme for the five years to come. A word about each.

#### The multi-site PSSRU

We are honoured that the establishment of PSSRU branches is in two distinguished institutions, which in our area are ranked in the highest rating awarded by the Higher Education Funding Council, *'outstanding by international criteria'*.

One new branch is in the Department of Social Policy at the London School of Economics. This is undoubtedly the most distinguished department of its type in the world. Though its status was changed when Richard Titmuss became the head, it has a history stretching back to the days when Clement Attlee was a lecturer and beyond. The School has an unmatched reputation for depth and breadth in British social science, and a long history of formidable policy impact. We shall gain immeasurably from planned collaborations with such people as Howard Glennerster and Julian Le Grand, the constant intellectual challenge from colleagues and visitors from this most self-consciously international of British centres of excellence, from its extraordinary networks, and from its position in the centre of the capital. Martin Knapp and I are half-time professors there, with Martin being site Director.

The second new branch is in the School of Psychiatry and Behavioural Sciences at the University of Manchester. This is a department which has strong mutual interests. Professor Peter Huxley, who is now a part-time professor in the PSSRU, is the country's foremost authority on care management in mental health. The Manchester branch is adding completely new and extremely exciting work from independent funding to streams

of work on care management funded as part of the DH 'noncompetitive' programme, springing from the collaboration between Peter Huxley and Professor David Challis, PSSRU's site Director. It is also creating new projects on other important areas, involving people from all of the PSSRU sites: some of these projects are briefly listed later in this Bulletin. Manchester trains the largest number of doctors of any European medical school and it shares the leading role in British psychiatry with London University's Institute of Psychiatry, the home of the Centre for the Economics of Mental Health, with which we also have many shared people and projects.

The Faculty of Social Sciences at the University Kent at Canterbury remains the host for the biggest branch and the common facilities: the dissemination and publications office, the Sir Roy Griffiths Library of Community Care, the computer support section and the executive officer. Dr Ann Netten has been promoted to a second assistant directorship at this site.

The model is of truly integrated multi-site working. This can be seen from the lists of projects and appointments. Most projects are being conducted from more than one site. Every professor works in at least two institutions. The noncompetitive grant is to the PSSRU as a whole, and its routing to host institutions follows from the strategic allocation to programmes. There is a Unit-wide committee structure, Unit-wide seminars and other events, Unit-wide publications office and library, Unit-wide Director prioritising programmes reflecting a Unit-wide strategy group, and so on.

There are some obvious reasons for going multi-site, and for the nature of the organisation created.

The PSSRU has always worked in all parts of the UK. It was important to improve our capacity for doing work outside peninsular Kent for reasons other than having to travel to London before starting most of our journeys. We needed a network of locations giving entrée into the policy networks, as well as sites well situated for field collections.

Technological advances and the changing balance of needs and resources require us to work still more at the interface of health and community care. We need more links with clinicians and health agencies. We need to absorb some insights from professions related to health, though without losing our

distinctive production of welfare focus. A base in a medical school will contribute.

Advance in the social sciences is rapid and occurring on many fronts, with potentially important contributions to the Unit's development. The PSSRU needs the exposure to these if it is to serve the policy community to the best effect. This exposure is easier in the institutions with the widest and deepest coverage of social science, and a heavy emphasis on advanced work.

Already, the establishment of the new sites is allowing PSSRU to do more work and work in new fields. Partnerships with people and groups from the new host institutions are emerging. There is greater excitement and energy throughout the Unit.

### **The Programme**

The new structures are intended to further the PSSRU's long-standing mission: research and analysis on equity and efficiency issues in community care and related areas. The new opportunities are already enabling us to introduce new interpretations and to work in new areas. It is striking how the contracts for which researchers are invited to bid are in effect asking for the application of the production of welfare approach — exciting and gratifying after many years in which the questions, methods, and approach to policy was seen by so many in the policy world as alien.

The broadening and deepening is occurring as well in the areas in which we have made our past contributions. The inside pages illustrate continuities in streams in which the demand for research is more recognised than ever. An example is care management. The projects are still contributing to new thinking of a kind more advanced in the PSSRU than anywhere else in the world and to fundamental logic and frameworks. But in the programmes *Mapping Care Management* and *Evaluating Community Care for Elderly People* (ECCEP), more of the effort is on describing current implementation of the approach and the development of argument about how to improve it. Also there will be the flowering of PSSRU care management argument in more Unit projects for people with mental health problems. ECCEP is a classic production of welfare (POW) study. The continuity around the POW theme has allowed ECCEP to be the after stage of a strict before-after study; the same questions, the same areas separated by a decade, comparable evidence but more of it, updated to take into account scholarly advance and changes in policy and practice issues. Again, the PSSRU was publishing argument about new

financing mechanisms for community and long-term care during the years before the Griffiths Report, and the Financing Project is collating knowledge about new mechanisms elsewhere, developing arguments about mechanisms for the UK, and is building models which will allow the policy world to understand their implications.

The inside pages illustrate the change in the balance in response to changing research needs of the policy world and the spread of POW to new areas: the remarkable growth of POW and related studies in mental health; the way in which the work on the mixed economy of welfare contributes to and draws on the range of PSSRU interests; and the development of work on the interfaces between community care and health.

### **Opportunities bring challenges and risks**

So the message is up-beat. But, particularly in the immediate aftermath of the announcement of the new DH research funding policy, many were more conscious of challenges and risks than of opportunities. More funding will be of short duration. The University of Kent is setting a good example in providing open contracts to some experienced Unit researchers. Some excellent researchers who have made a great contribution to the long-run programme, and who have a substantial part of their careers ahead of them, have either to adapt their working styles to seize opportunities for external funding or move elsewhere. The new noncompetitive grant cannot cover all those paid for in the past, or fund new projects and the Unit's new middle managers. But really good researchers in our field are extremely scarce, and the field cannot afford to lose them.

Again, for experienced researchers in the middle of the Unit, there is more focus on, and greater incentive to fit into, the perceived research needs of policy-makers, rather than to work away at a stream of argument in the expectation that how they think today, the world will with luck think tomorrow — or next year, or, anyhow, in five years' time. The first reaction is to say: that is as it should be. But the second reaction is to remember how many important contributions were completely contracultural for many years before they became the foundations of reform. Finding them requires different mechanisms and the application of different criteria. Perhaps that is an argument for variety in the sources of funding and pluralism in the criteria for its allocation.

# EVALUATING COMMUNITY CARE REFORMS

## Evaluating Community Care for Elderly People: who gets how much of what service

Bleddyn Davies, José Fernández and Raymond Warburton

### The study

The focus of the ECCEP project is equity and efficiency in post-reform community care: who gets how much of what community service at what cost, and with what effect on whom (inset 1).

#### Inset 1 Aims of ECCEP

##### 1 Quantitative description and estimation — across contrasting service areas — of:

which elderly service users ...  
living in what kinds of circumstances ...  
with what kinds of support networks ...  
are helped by how much  
of what type of help ...  
from what source ...  
at what cost ...  
at what impact on whom.

##### 2 'How' explanation

The processes which link proximate causes to the patterns.

##### 3 'Why' explanation

The reasons why the causal factors differ between local systems

ECCEP is in effect the second stage of a before-after study. It is making a similar data collection to that made in the PSSRU domiciliary care project of 1984-89, whose argument was pulled together in *Resources, Needs and Outcomes in Community-Based Care* (Davies, Bebbington, Charnley and colleagues, 1990). The ECCEP research is being conducted in the same twelve small areas of ten local authorities in England and Wales. Both stages have been based on interviews with users and their principal informal caregivers, workers, and managers of agencies, and on information about the use of resources through time. Like the first stage, the second stage has interviews at first assessment and six months later — with the possibility in ECCEP of a third set of interviews 18 months later. Both were designed to describe the needs, resources, outcomes, and the relations between them — including marginal costs of outcomes, the marginal productivities of service inputs, the costs of achieving target outcomes, the consequences for outcomes of different inputs levels and mixes, and the like. Both programmes describe how the structures and processes lead to the patterns, and throw light on why these pattern-determining factors vary between authorities.

Like the first stage, the design of ECCEP is longitudinal. Cases were eligible for the project only if their package of services was, in the opinion of care managers, likely to last for more than two months.

ECCEP's first round of interviews with users, caregivers and their workers took place in late 1995 and 1996 and the second round took place six months later. Samples of people admitted direct to residential care as well as of groups allocated community services allow the investigation of the patterns of need which now discriminate between people allocated community services and residential care.

The data also cover a wide range of descriptions of authority policies, priorities, and arrangements. The team is currently analysing the first-round information. The aim is to provide the description of the wide range of information collected before converging on focused analyses of particular policy issues.

### Some first results

**Package costs by interval need and social support.** The thorough comparison of post-reform patterns with those a decade earlier will be undertaken later. However, inset 2 provides preliminary evidence for a basic comparison of package costs. Like the variables analysed in the remaining insets, the data refer to the time of the first user, assumed to take place shortly after the end of the Set-Up period at the beginning of the Continuing Care period of users' care-managed careers (Davies and Chesterman, forthcoming 1997). The pattern of variation has three features suggesting greater concentration of resources on those with greater disabilities and on those with family caregivers. But there is not such a clear pattern of association with being supported by an informal caregiver making at least weekly inputs. A similar analysis of the number of hours of home care to those receiving it also shows a clear positive association of median hours with interval need.



There have clearly been changes in patterns. They reflect the degree to which departments' managers and workers have seized on some features of the new philosophy and attempted to act on them. Discussions with three groups of people in each of ten authorities (senior managers, middle managers, and field personnel) asked each of the 138 participants to rate their priorities in their implementation of the changes. With respect to goals overall during 1992-94, most of the participants in all of the authorities claimed that the top priority had been to give users a real chance to stay at home with good care. For field workers, it remains the most important goal for the period 1995-97. Their second highest priority was to enhance user empowerment. These opinions were compatible with those of new users and their principal informal caregivers. Interviewed immediately after the implementation of the first full care plan, 80 per cent of users and 88 per cent of the principal informal caregivers felt that they had had a say in the care planning; 93 per cent of users and 71 per cent of caregivers stated that they thought that the care managers had understood them and 51 per cent of users stated without qualification that the care managers had offered them choice, with another 19 per cent stating that they were offered choice in some respects. So the new patterns — shown in inset 2 — reflect the determination of authorities to make good use of the policy opportunity.

***Care at home or in a home?*** An important aim of the reforms at national and local levels has been to provide more users with a chance to live supported in the community rather than enter a care home. So it is important to know what discriminates between those for whom one mode of care is provided rather than the other.

Inset 3 summarises some of the results of a preliminary analysis comparing our samples of community service recipients and direct admissions to homes.

The table presents estimates for *hypothetical cases*. These have been specified to illustrate (i) the range of predicted values of the dependent variable, and (ii) sensitivity to each dimension of need. The method of illustrating the range was as follows. Cases are defined so as to contrast with respect to having admission-reducing or admission-raising values of the indicators within each need group. The value for each predictor in a need group was chosen so as to reinforce the direction of the effect on the dependent variable associated with the values chosen for the other predictors in that group. The values were chosen not to be extreme, being set at the third or seventh decile for a continuous variable.

The definition for the first case in the table sets values of the important predictor variables from all of the need groups such as to reduce the predicted value of the dependent variable. The values for all values for the second case are set so as to increase the probability of remaining in the community. The remaining cases illustrate the effects of variation in the dimensions of need indicated by each variable group. The cases postulated have predictor values which differ from the first case in only one variable group in whether they would raise or lower the predicted value of the dependent variable. Again, values for a predictor were chosen to reflect moderately high or low values. Case specifications are implied more clearly in the commentary on the results.

The results suggest that

- The models work well: at first sight, better than those fitted for data collected a decade ago for people who had previously received home care (Davies and Baines, 1994). To the degree that needs-related circumstances predict admission better, there may have been an increase in equity and efficiency, as long as the patterns can be justified in terms of the final outcomes achieved.
- The well-established association with whether the user lives alone is demonstrated again. More interesting is the previously unestablished relationship between the quantity of caring inputs by users and the choice of care mode. Still more interesting is the influence of the care manager's view that the carers' approach to caring lacks a healthy balancing of the interests of users and caregivers (Twigg and Atkin, 1994).
- The greater influence of cognitive impairment with behavioural disturbance again fits well with the results of research conducted prior to the reforms.

***Predicted utilisation of services.*** Inset 4 describes the probabilities of some important services being in a package, and the quantity in that package, for hypothetical cases with different need-related circumstances. The analysis was designed to illustrate the

## Inset 2 Costs to the SSD and CHS by interval need and informal support

The *dependent variables* are the gross costs of the packages provided by the SSD and by the SSD and community health services. They are analysed by 'interval need' and whether the user has a principal informal caregiver, defined by the care manager's description of someone who was providing care of specified types weekly or more often. By 'critical interval need' is meant a handicap of a kind which causes a need for human assistance several times a day and unpredictably. By 'short interval need' is meant a need for human assistance at a predictable time but at least once a day. By 'long interval needs' is meant a need for human assistance at a predictable time less frequently than once a day. (The interval need definitions are as applied in *Matching Resources to Needs in Community Care*.)

### Gross weekly costs of community services by interval need and whether supported by a principal informal caregiver

|                        | Whether supported  |                    | Mean   | Standard deviation | Median | 1st decile | 9th decile | Maximum | Number |
|------------------------|--------------------|--------------------|--------|--------------------|--------|------------|------------|---------|--------|
| Independent            | Supported          | SS cost            | 85.97  | 78.10              | 72.33  | 33.00      | 275.01     | 275.01  | 8      |
|                        |                    | Health and SS cost | 98.06  | 73.63              | 78.58  | 38.60      | 275.01     | 257.01  | 8      |
|                        | Unsupported        | SS cost            | 111.20 | 37.03              | 121.44 | 75.10      | 157.21     | 157.21  | 4      |
|                        |                    | Health and SS cost | 107.25 | 87.31              | 97.13  | 2.08       | 239.21     | 239.21  | 5      |
| Long interval need     | Supported          | SS cost            | 42.88  | 39.44              | 30.50  | 8.42       | 105.49     | 126.38  | 34     |
|                        |                    | Health and SS cost | 51.39  | 45.15              | 33.00  | 8.42       | 124.85     | 147.63  | 34     |
|                        | Unsupported        | SS cost            | 19.42  | 18.70              | 13.46  | 1.90       | 41.24      | 76.67   | 20     |
|                        |                    | Health and SS cost | 42.34  | 73.01              | 17.59  | 8.42       | 77.84      | 330.78  | 20     |
| Short interval need    | Supported          | SS cost            | 80.19  | 92.10              | 58.94  | 9.45       | 148.84     | 788.42  | 94     |
|                        |                    | Health and SS cost | 92.01  | 95.24              | 75.10  | 16.84      | 178.34     | 788.42  | 94     |
|                        | Unsupported        | SS cost            | 70.11  | 49.53              | 54.69  | 21.05      | 153.09     | 221.68  | 35     |
|                        |                    | Health and SS cost | 101.44 | 80.29              | 82.87  | 25.24      | 182.44     | 401.05  | 35     |
| Critical interval need | Supported          | SS cost            | 122.38 | 104.12             | 95.51  | 24.03      | 273.60     | 599.16  | 154    |
|                        |                    | Health and SS cost | 158.28 | 126.86             | 124.21 | 36.00      | 321.64     | 811.66  | 154    |
|                        | Unsupported        | SS cost            | 138.78 | 149.68             | 117.99 | 25.26      | 218.57     | 840.00  | 33     |
|                        |                    | Health and SS cost | 162.14 | 188.69             | 137.95 | 25.26      | 254.57     | 1092.00 | 34     |
| All                    | SS cost            |                    | 95.19  | 99.44              | 70.87  | 9.45       | 199.58     | 840.00  | 383    |
|                        | Health and SS cost |                    | 119.58 | 120.62             | 90.49  | 16.84      | 247.59     | 1092.00 | 385    |

Among other things the table illustrates three features which are compatible with more concentration of resources on those of greater disability.

- The large number of informally-supported users of critical interval need, compared with the number of informally-supported persons of short interval need; the larger number of supported than unsupported persons of short interval need; and the relatively small number with long interval need, a higher proportion of whom are unsupported. At first sight, the pattern seems different from that reported for 1985 in table 3.14 of *Resources Needs and Outcomes*. There then seemed to be more unsupported than supported persons in these two need groups; more with short than critical interval needs; and more with long interval needs.
- The clear gradient by interval need among median package costs, irrespective of whether supported; and the steeper gradient of the costs of the CHS and SSD packages in total than of the SSD package alone. The gradients by interval need had anomalies in 1985, though the gradients were then steeper for the combined costs than also.
- The ratio of median costs for the critical interval groups to the equivalents for the long interval groups was much higher in 1995, particularly for the unsupported users. In 1995, the ratios for the supported were 3.13 and 3.17 compared with 1.10 and 1.92 a decade earlier, and for the unsupported, the ratios were 9.04 and 7.84 compared with 2.78 and 3.79.

range of predicted packages, and the sensitivity of the allocation response to variation in different kinds of needs-related circumstances.

The results show that

- Variations in physical handicap and health are the strongest influences on the probabilities and quantities for home care and home-delivered meals, but variations for day and respite care are more influenced by such factors as cognitive impairment and caregiver stress. There are clear patterns in the responsiveness to needs-related circumstances, even for the services whose utilisation differs most between areas.
- Variations in needs-related circumstances are associated with large differences. Again, comparisons with results described in *Resources, Needs and Outcomes* and

### Inset 3 Influences on who is allocated home care and who residential care

The *outcome* is the probability of care at home with a community-based package (rather than admission to care home). The *data* are from the long version of the interviews with workers performing and coordinating the core care management tasks up to the implementation of the first post-assessment care plan of indefinite duration, shortly after the end of the set-up period. They relate to 110 of the 489 users in the ECCEP sample. The *method* of analysis used is logistic regression analysis. The modelling strategy reflected two strands of argument. One was the importance of teasing out the relative impact of needs-related circumstances from such supply factors as care management arrangements, local policy priorities, and supply constraints which the care managers suggested had affected the care plans for the case. The second strand was to explore the central mediating role of the care manager, and the degree to which need and supply factors worked through care managers' perceptions and are mediated by care management arrangements, rather than directly on the outcomes. The table presents estimates for *hypothetical cases*, specified in the manner described in the text.

The predicted probabilities are based on equations containing variables for each broad group. The definition of case 1 illustrates which variables proved important. Case 1 is defined as: great physical handicap (high square of ADL score); behavioural difficulties associated with cognitive impairment; an informal caregiver but with low support inputs (hours of help with caregiving, hours of help with personal care), caregiver relationships with reliant user, and care manager considers caregiver failing to balance own and users needs; lives alone; managers view that low policy priority and achievement to care in home and prevention (low mean priority rating to needs-led assessments, low evaluation of authority's achievement to giving real chance for more users to stay at home or to regain independence, and evaluation that low support for caregivers).

The *influential needs-related circumstances* on probabilities are physical handicap, behavioural disturbance associated with cognitive impairment; the presence of an informal caregiver and whether the caregiving inputs are low; user-caregiver relationships; and the policy priorities and the view of their personnel of their authority's priorities and achievements.

The expected probabilities are shown in the table.

- The contrast between the first two cases illustrate how strongly the selection of care mode is related to need-related circumstances. The choice of care mode is correctly predicted by the model for 87 per cent of cases.
- The results show the great influence of the informal support network.
- Behavioural disturbance has greater effect than a high level of physical handicap, though the effect of the latter on modal choice becomes greater the higher is the level of the handicap.

|                   |                    | Like case 1 except ... |                            |                       |                          |                              |                   |
|-------------------|--------------------|------------------------|----------------------------|-----------------------|--------------------------|------------------------------|-------------------|
| Low probabilities | High probabilities | Low physical handicap  | No behavioural disturbance | High informal support | Principal informal carer | Good carer-user relationship | Lives with others |
| Case 1 %          | Case 2 %           | Case 3 %               | Case 4 %                   | Case 5 %              | Case 6 %                 | Case 7 %                     | Case 8 %          |
| 18.6              | 100                | 42.1                   | 58.2                       | 30.5                  | 91.0                     | 88.1                         | 78.3              |

Whereas the community sample seems to be representative of the population we sought, our analyses suggest that the residential sample under-represented the most dependent cases. However, it is likely to contain a disproportionately high number of users for whom there would be a choice between care at home and in homes.

other publications from the Domiciliary Care Project suggest that the pattern is compatible with greater responsiveness to variations in needs than a decade ago.

We have already asked other questions. For instance, we have undertaken preliminary analyses of the degree to which the patterns of who gets how much of what reflects needs rather than supply factors. The results so far suggest (i) little impact by the cruder supply constraints which care managers agreed affected what people obtained, (ii) greater impact of variations between areas in care management arrangements and practice, but (iii) much greater influence of needs-related circumstances. How the care manager plays the role is key: the care manager does not always see what the user and caregivers perceive, and often does not recognise conditions, most importantly those which are often remediable and should be alleviated or cured under any reasonable criteria of humanity and cost-effectiveness recognisable by other care professionals. (Depression is an example, as Bannerjee and MacDonald (1996) have recently reminded us.) This mis- and under-recognition of need may be a major weakness of our community care system, limiting as it does the potential for seizing investment opportunities of all kinds.

These snippets do not suggest the range of what can be discussed from the evidence provided by the ECCEP programme. Watch this and other spaces during the coming months and years!



#### Inset 4 The influence of need dimensions on initial care packages

The following tables describe the estimated probabilities that each of several important services form part of the care package of hypothetical users, and the quantities of services which the hypothetical users are predicted to utilise.

**Method** For each service, statistical models were estimated. They predicted from needs-related circumstances (i) probabilities of receiving the service, and (ii) average number of units of service received by recipients. Needs-related circumstances were grouped into the following domains: user physical disability and health; user cognitive impairment and associated behavioural disturbances; user morale and other mental health problems including depression; informal caregivers circumstances, informal support and relationships. So each group of predictors was explored for all dependent variables, but the group of predictors emerging differed between dependent variables. Mediating variables which to some degree reflect unmeasured need and the level of provision of services performing some of the same tasks were also included if they affected the associations with need indicators. Logistic regression models were fitted for probabilities, and ordinary least squares regression models were fitted for the continuous variables. The sample was re-weighted to compensate for differences in sample and population characteristics. Hypothetical cases have been specified to illustrate (i) the range of predicted probabilities and quantities; and (ii) sensitivity to each dimension of need as described in the text, and applied in inset 3.

Data are from interviews with the users, principal informal caregivers and workers responsible for the performance of the core care management tasks interviews post-assessment at the time of implementation of the first indefinite care plan.

| Probabilities (per cent)                         |      | Units consumed <sup>a</sup>                        |      |
|--|------|--|------|
| <b>Home care</b>                                 |      |  |      |
| 1. Low probabilities                             | 8.3  | 1. Low cost  | 0.8  |
| 2. High probabilities                            | 97.7 | 2. High cost                                       | 13.3 |
| 3. Case 1 but high disability                    | 55.4 | 3. Case 1 but high physical disability             | 9.8  |
| 4. Case 1 but cognitively impaired               | 37.0 | 4. Case 1 but cognitively impaired                 | 3.2  |
| 5. Case 1 but low informal support               | 21.0 | 5. Case 1 but weak informal support                | 1.9  |
| 6. Case 1 but user female                        | 14.0 |  |      |
| <b>Home-delivered meals</b>                      |      |  |      |
| 1. Low probabilities                             | 15.0 | 1. Low cost  | 3.4  |
| 2. High probabilities                            | 59.2 | 2. High cost                                       | 6.0  |
| 3. Case 1 but short interval needs               | 30.3 | 3. Case 1 but low day care                         | 3.8  |
| 4. Case 1 but low user morale                    | 24.0 | 4. Case 1 but caregiver elderly                    | 4.4  |
| 5. Case 1 but low informal support & lives alone | 24.9 | 5. Case 1 but has cancer                           | 6.0  |
| <b>Day care</b>                                  |      |  |      |
| 1. Low probabilities                             | 8.7  | 1. Low cost  | 1.6  |
| 2. High probabilities                            | 68.1 | 2. High cost                                       | 2.3  |
| 3. Case 1 but lives alone                        | 13.4 | 3. Case 1 but high physical disability             | 1.8  |
| 4. Case 1 but low morale                         | 21.7 | 4. Case 1 but carer stress & bad user relationship | 1.8  |
| 5. Case 1 but cognitively impaired               | 19.1 | 5. Case 1 but user cognitively impaired            | 2.1  |
| 6. Case 1 but carer stressed                     | 15.2 |  |      |
| <b>Respite care</b>                              |      |  |      |
| 1. Low probabilities                             | 4.0  | 1. Low cost  | 12.5 |
| 2. High probabilities                            | 81.4 | 2. High cost                                       | 46.6 |
| 3. Case 1 but high disability & has cancer       | 7.9  | 3. Case 1 but high disability and has cancer       | 23.8 |
| 4. Case 1 but cognitively impaired               | 13.4 | 4. Case 1 but cognitively impaired                 | 19.5 |
| 5. Case 1 but depressed                          | 18.5 | 5. Case 1 but depressed & anxious                  | 13.8 |
| 6. Case 1 but carer stressed                     | 9.5  | 6. Case 1 but carer aged & bad user relationship   | 26.1 |

#### Note

a The units are: for home care, hours per week; for meals, number per week; for day care, sessions attended; for respite care, days of respite from referral to interview.

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# Alternatives to Long-Term Hospital Care for Elderly People in London

Andrew Bebbington and Robin Darton

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## Introduction

The purpose of this project was to investigate the extent to which limitations on the availability of community-based substitutes for long-term inpatient care necessitate higher than average spending on health services in order to maintain an equitable level of provision for elderly people living in London. It also considered what long-run options exist for compensating for the lack of residential sector facilities in London.

Levels of service provided to people over 75 in London show that there is a slightly above average provision of NHS beds and domiciliary services such as district nurses and home helps. However, this is offset by much lower than average levels of provision in the residential sector. This is due mainly to the lack of independent sector residential and nursing homes. There has been a general decline in NHS beds and local authority residential care, but compensating growth in the independent sector has taken place mainly outside London.

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## Methods

The project investigated the opportunities for substitution between hospital and community services by two means. First, the balance between services across 178 district health authorities in 1992/93 (the latest year for which data were available) was examined using information from a wide range of sources, including the 1991 Census and related data sets, as well as Department of Health statistics. Second, the views of participants about the ability of residential and domiciliary services to substitute for inpatient services, and problems in making the transition from one to the other, were sought from interviews with six health authority purchasers responsible for purchasing services for long-term care of elderly people in six DHAs, including three in London and three elsewhere, and contact with directors of three independent residential and nursing home chains.

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## The shortfall in London's services

Average rates of provision per capita (aged 75+) outside London were applied to London itself, after making allowance for needs factors such as the number of elderly people with limiting long-standing illness, living alone, and the cost implications of the overall shortfall of services in London were computed. This indicated that there would need to be an additional recurrent expenditure in the public sector of £290m (at 1992/93 prices) to sustain London's services for elderly people at the same level as the average for the rest of England.

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## Substitution

### *The balance of services*

Limited evidence for both substitution and complementarity effects was found from analyses comparing the balance of services in different areas and changes in the balance of services through time. The implication from this is that these services are not in practice substituted or, more likely, variations between DHAs in the balance of services do not reflect an efficient and equitable response to variations in local needs and prices. Thus, it is not possible to say to what extent the higher expenditure on inpatient services for people over 75 in London is directly caused by the shortage of residential services. However, it is implausible that this higher level of expenditure could possibly substitute for the shortage of nursing and residential homes.

### *Views of purchasers*

The potential for substitution between long-stay NHS beds and services being provided by the independent sector was acknowledged. However, the main proactive work by the authorities to encourage substitution had been used for specific initiatives, particularly for elderly people with mental infirmity. Fewer corresponding arrangements had been made in geriatric care, although two metropolitan authorities outside London had made specific arrangements to fund patients requiring continuing care in nursing

homes. In dealing with the independent sector, respondents preferred the flexibility offered by spot contracting, although this implied less commitment to the long-term use of independent provision. In practice they were more concerned to emphasise rehabilitation, and to improve day care and domiciliary provision to enable elderly people to remain at home or return home after rehabilitation, although it was admitted that the development of such community-based services was patchy.

### ***Views of providers***

The independent sector providers considered that the major factor responsible for the low levels of provision in London was the scarcity of land and relatively high land prices. Existing properties were not suitable for conversion to the standards required, and payment of VAT on conversions was an immediate disincentive. The recruitment of staff was particularly difficult in Inner London. Although levels of reimbursement to homes in London compared with elsewhere have improved following the 1993 community care changes, greater incentives from health and local authorities for developments by the independent sector were desired by independent providers.

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### **What are the alternatives to residential care?**

Three options were examined. First, development of the independent sector. There were few encouraging signs that this is happening on a sufficient scale. It would take 30 years at present rates for provision in London to reach that currently provided in the rest of England. Second, develop alternatives in the community. The purchasers saw great opportunity here, with community nursing an undeveloped area, but so far not much has happened.

The third option is, de facto, what is happening. This is the movement out of London of large numbers of elderly people in search of support, particularly residential care. London is unique in this, and the rate is accelerating. While it may represent an efficient response to the problem of high costs and supply constraints within London, it is not clear that this is in the best interests of elderly people. There are some signs of growth in a residue of very needy people in London who appear to be getting inadequate support of any kind.

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### **Acknowledgements**

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# Performance Indicators for Community-Based Social Care

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David Challis and Raymond Warburton

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## Introduction

The PSSRU has developed a framework of local performance indicators for community-based social care, with an emphasis on care management activities. The framework currently applies to services for older people and people with mental health problems.

## Social services indicators

In terms of indicator development in social services, real momentum was achieved in 1982 when the Audit Commission was formed and embarked on a series of special studies from which audit guides were created for routine use. These guides comprised lists of performance indicators which auditors could use in their work. (Audit Commission, 1986) The Audit Commission also produced Local Authority Profiles in which performance indicators for a range of local services were presented, and comparisons were made between the authority in question and similar authorities. The emphasis of the Audit Commission was on value for money in public services, and economy, efficiency and effectiveness.

The Department of Health began to take a strong interest in performance indicators in the early 1980s. A limited set of health performance indicators was developed. Later in the decade a working party chaired by Korner expanded the number of performance indicators and improved methods of feedback. (Department of Health, 1988)

Within the Department of Health, the Social Services Inspectorate (SSI) worked alongside colleagues in the Statistics Division to merge activity data routinely collected by the Department of Health with social services financial data collected by the Department of Environment and social services cost and activity data collected by CIPFA. SSI produced an analytical framework for its key indicators, which it hoped would ensure the proper and considered use of the indicators. (Warburton, 1988).

In terms of the scope and types of indicator that CIPFA, the Audit Commission and the Department of Health produced in the 1980s, they were usually limited to service inputs, costs and outputs. However, these national bodies recognised that the scope of their indicators needed to be broadened to take account of service outcomes, quality, equality, and processes.

Many managers and professionals working in health and local authorities criticised the indicators produced by these national bodies. The major criticisms were that indicators only focused on what could be easily quantified and rarely looked at outcomes, and were either too crude or too simply financial. In addition, not all indicators had obvious links to key policy goals. It was also said that indicator values were sometimes too readily and wrongly equated with good or bad practice, and average values of indicators were often perceived as a norm. Of key concern to managers was that indicators produced by national bodies were often published years after the period to which they referred.

## Developments

In attempt to remedy some of these problems, the Social Services Research Group published their ideas for performance measurement in a series of monographs, covering different user groups in turn. Their great contribution was to introduce both qualitative and local dimensions to the definition, generation and use of indicators. The first SSRG monograph included an analytical framework for the development and interpretation of performance measures for local service units, as well as examples of performance measures for older people and people with a 'mental handicap'. Within this model SSRG produced a range of local indicators — some of which should be routinely collected as part of management information systems, some of which should be part of once-off collections, and others which provided qualitative information to occasionally support the routinised information. Each indicator was related to a policy or objective. (Barnes and Miller, 1988)

In recent years much has happened in social and health services to deflect attention away from performance indicators. From 1989 onwards health authorities and social services authorities have been rightly pre-occupied with the implementation of the two

White Papers 'Working for Patients' and 'Caring for People' However, attention is now shifting back to how all these changes can be monitored and interpreted at both local and national levels.

Quality has come to the forefront in recent years as well. SSI have taken a lead on standards and inspection methods for different forms of provision such as home care (SSI, 1990). Contracts for community care have been used by many local authorities to revisit the standards of care required in residential care homes and nursing homes, and in many instances to raise them.

The Government's policy of charters for public services in which agencies inform their users what to expect if they come for help, and monitor these commitments has introduced a new perspective to performance indicators. For local government the Audit Commission, at the request of the Government, produced a framework for performance measures. Recently the Department of Health has produced a framework for local community care charters and standards. (Department of Health, 1994)

### ***Academic contributions***

Academic institutions have also addressed efficiency arguments in the social services. The PSSRU set up a number of projects to explore various aspects of efficiency in the care management and service delivery of community care. (Davies and Challis, 1986; Davies et al, 1990). Donabedian developed a useful framework for analysing quality in health care which is based upon the extent to which the process of care contributes to valued outcomes. The criteria used to judge quality are derived from three domains — structure, process and outcome. (Donabedian, 1982).

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## **PIAF**

The PSSRU's work on performance indicators attempts to bring together the logic from past and recent academic, administrative, professional and financial approaches into a performance measurement framework that can be used locally. The PSSRU approach updates and revises existing performance indicators and related frameworks in the light of the community care reforms. In this respect, national collections with some notable exceptions are lagging behind. (By way of an exception see : Department of Health, 1995) The PSSRU framework is called 'PIAF' — the Performance Indicator Analytical Framework.

PIAF distinguishes four broad types of performance indicator. These are described below.

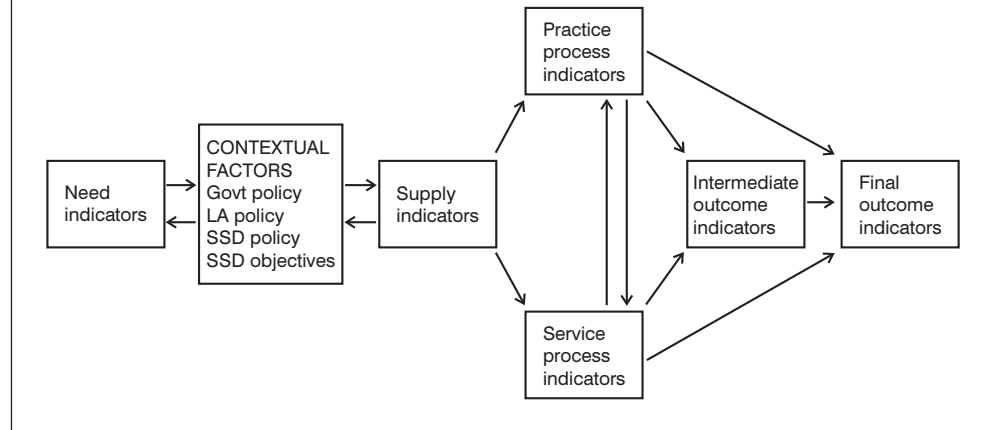
- **Outcome indicators** describe the effects upon the user or carer which are valued in their own right. They can also describe achievement or service impact.
- **Process indicators** describe the ways in which people are assessed for services and how services are provided. *Practice process indicators* cover all the stages of care management from case finding to closure. *Service process indicators* cover deployment of staff, service patterns, service usage, and cost of packages of care.
- **Need indicators** refer to numbers and types of potential and actual users and carers, and the help they want or need.
- **Supply indicators** refer to expenditure, facilities, staffing in all sectors of provision, service charges, and unit costs. Supply indicators can be used to map, manage and manipulate the market.

The different types of indicators interact with each other, and should be interpreted according to figure 1. The chart may be seen as a causal process where local demand or need factors impinge upon or are influenced by both national and local policies and context, which in turn influence the supply of services available in the locality. The two sets of process indicators refer to how that supply is translated into forms of practice and styles of service provision. In turn, these will work through into effects experienced by users and carers to generate outcomes.

The indicators have been broken down into those which are 'core' — so important that they need to be produced and analysed routinely at all levels of management and practice; those which are non-core, provided supporting evidence and elaboration; and those requiring special studies. Core indicators can be produced monthly or quarterly. Non-core indicators can be produced quarterly, six monthly or less frequently. Special



**Figure 1 Performance indicators analytic framework**



studies can be conducted six-monthly or annually. From special studies, it might be possible to identify ways to routinise information that proves to be very useful and worth producing on a regular basis.

In setting up performance indicator systems, it should be borne in mind that the use of indicators should be part of the process of good management at all levels. There should be transparent systems for the addressing issues arising from indicators and the taking of remedial action. Performance indicators should be part of a broader review and evaluation process. Performance indicators should be based on information which is complete, valid, reliable and which if needs be can be routinely and readily collected. When analysed, performance indicators need to be set in the context of both agency history, policies, and funding, but also the policies and practices of other agencies.

## Comparisons

One of the main purposes of developing performance indicators is so that comparisons can be made. But what should be compared with what? Within a local authority, the work of one worker can be compared with other workers, types of worker can be compared, teams such as social work or home care teams can be compared, units such as day centres or care homes can be compared, and so on. Comparisons can also be made across authorities. In making comparisons there are two key things. First, compare like with like. Second, do not automatically assume that differences reflect something wrong.

Comparisons can also be made between a standard that is hoped for and actual practice. Finally, comparisons can be made between expected frequency patterns with observed frequency patterns.

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# Mapping and Evaluation of Care Management Arrangements for Older People and Those with Mental Health Problems

David Challis, Peter Huxley, Richard von Abendorff, Robin Darton, Jane Hughes, Ann Netten and Karen Traske

Assessment and care management were identified in the White Paper of 1989, *Caring for People* as the 'cornerstones' of good community care. The PSSRU has a long history of research in the development and evaluation of care management services (Challis et al 1993). The study of Mapping and Evaluation of Care Management arrangements for two major client groups is designed specifically to build on this work.

Since 1993, and indeed earlier in the form of a range of pilot implementations, local authorities have been developing a range of forms of care management arrangements. In the early period following the implementation of the NHS and Community Care Act the Department of Health mounted two special studies on Assessment and Care Management (DH, 1993, 1994). It was evident from these studies that there was marked variability in both the form and type of assessment and also the ways in which care management was being implemented. The SSI review of assessment processes suggested that there had been an enormous investment in the development of assessment processes within local authorities. There were a large number of different assessment proformas which were very varied with a predominant focus on community based services. There were problems about the length and the complexity of documentation, the purpose of the assessment tools themselves, the ways in which needs and problems were categorised, and the lack of a linkage from the process of problem identification to response formulation and therefore care planning. The early developments in care management similarly reflected the considerable organisational change being undertaken. Early evidence on care management suggested that the focus had been more on establishing organisational structures than pursuit of the more strategic goals of community care, the unclear relationship between care management as an organisational process compared with more intensive models of care management, a narrow and rather rigid perception of the separation of purchaser and provider roles at the practice level, and a great focus of staff activity around the assessment process with a relative neglect of reviews of individuals and their care plans. (DH, 1993, 1994).

The focus of the new study is to provide an evaluation of the different forms, types and models of care management which have emerged for the two major client groups, the elderly and the mentally ill. This study is being undertaken at the present time since it is only now that a degree of stability in organisational forms and arrangements is beginning to emerge that makes this study appropriate and timely. The work is designed to delineate the characteristics of variation found in care management arrangements, to identify the distinctive characteristics of models of care management, and to discriminate between the different models of care management in terms of their structures, processes and outcomes, so as to identify differences in their relative costs and benefits. This work would be undertaken in three phases. The first phase will involve mapping the developing pattern of care management. The mapping of care management will provide a broad national picture of the forms of care management emerging covering both care management systems in general as well as the more focused forms of intensive case management for highly vulnerable groups. It is designed to provide a baseline picture of the organisational forms developing in response to the new arrangements. A number of questions will be tackled in this first phase including:

- What are the variety of forms of care management which are in operation?
- How do care management arrangements differ and appear similar across different client groups?
- How do care management arrangements vary according to such factors as service systems, rurality and external relations of the agency?

The second phase will involve delineating the models identified in phase one. Detailed information will be collected on the different models on such factors as case loads, staff mix and similar activities. The questions that will be tackled there within the second phase include:

- How do staff in different care management models distribute their time?
- What is the case mix of different care management models?
- What is the balance of team care management compared with individual worker care management?
- How do different care management approaches use and relate to different providers?

The third phase involves the comparative evaluation of the different models which have been delineated previously. This will involve monitoring the receipt of service and experience of clients receiving the different service systems. Among the research questions that are covered will be:-

- What are the different outcomes for different models of care management?
- What is the balance of cost and outcomes for similar cases in different forms of care management?
- For which types of case is which form of care management more or less effective?

This three phase programme is thus designed to provide a baseline picture of the development of care management in the early period of stability following the implementation of the NHS and Community Care Act. It will move from description of broad care management arrangements to delineation of the crucial features of care management models through the evaluation of some of those salient model to identify their relative costs and benefits for different types of client. It is hoped that this PSSRU research, based at the Kent and Manchester sites, will provide important insights as to the relative merits of different approaches to providing coordinated care. It will be closely linked with the Department of Health funded study of the relationship between the care programme approach and care management for people with mental health problems so that the range of responses defined to provide more coordinated care with continuity of support can be more fully understood.

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## ADVERTISEMENT

### Care Plan Magazine Links with PSSRU

Since December 1995 the PSSRU has provided a series of papers on care management and related topics for the magazine *Care Plan*.

*Care Plan* has become firmly established as the leading magazine for health and social services staff involved in care management and individual care planning. Published quarterly in association with Anglia Polytechnic University, the 40-page magazine offers readers authoritative and detailed features, comment, reports and research summaries, on issues relevant to all major service user groups. Bridging the gap

between health and social services, the magazine is also committed to fostering collaboration and joint working between agencies. Most of all, it is dedicated to helping ensure that the needs and wishes of service users and carers remain at the centre of care management in practice.

*Care Plan* costs £28 per annum for subscriptions paid through authorities and organisations and £18 for individuals. Cheques to Positive Publications, 84 Dowanhill Road, London SE6 1SY. Tel: 0181 698 5716.

# Comparative Community Care Project

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Bleddyn Davies and John Chesterman

This project aims to both to extend the framework of concepts and argument, and the empirical knowledge, about the matching of care management arrangements to policy priorities, user needs-related circumstances, and the characteristics of areas and care systems. Ideas are cheap and plentiful. Ideas whose importance are rigorously tested against evidence are much scarcer. Tested ideas provide a surer foundation for developing care management policies and arrangements, and for designing artefacts to support them, such as information systems.

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## Literature analysis

One form the project takes is the review of literature for other countries whose systems we have studied and observed closely enough to see the literature in context. PSSRU studies of community services and care management have always attempted to illuminate British issues with a thorough analysis of experience from overseas.

The PSSRU volume *Care Management, Equity and Efficiency: the International Experience*, which originated in a paper for the OECD, is about the economics of care management. It describes the place of the care management approach in reform and development logics in various countries. It describes how its application is expected to improve equity and efficiency, the variety of care management arrangements, and the nature and outcomes of the leading care management experiments throughout the world.

Because care management is developing quickly in an increasing number of countries, a sequel is planned, to present more material useful for managers and practitioners than the OECD-based first edition.

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## Secondary analysis of evaluation data

We reanalysed the American long-term channeling project, described as ‘the noblest experiment of them all’. Our results suggested a completely new perspective on the project’s outcomes. We could throw new light on the world’s most extensively analysed project because our modelling was based on a clear theoretical argument about how care management worked, not simply an empirical evaluation of the outcomes.

Most of the analysis is of the dataset for the Kent Community Care Project [KCCP] and its PSSRU-evaluated replications and descendants because this will for some time remain the biggest and best British data which is based on the kind of care management intended by policy makers. (The implementation of the new ideas in standard practice is as yet uneven and lacks in depth evaluation data.)

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## Examples of argument

*Targeting criteria and gain/cost ratios.* Targeting which is stringent with respect to incapacity to perform acts of daily living is unlikely to achieve the most welfare gain from the social services budget. The PSSRU book *Resources, Needs and Outcomes in Community-Based Care* showed that the relationships between clients’ needs-related circumstances and the impacts of service inputs on outcomes were too complex for that. However, no one has provided a comprehensible framework of evidence-based knowledge which would help authorities to make their eligibility and targeting guidelines contribute better to getting most welfare from their budgets.

The ratios of gains to costs are not highly sensitive to the weights attached to individual dimensions of gain, suggesting that the analysis is in this respect robust. The ratios are higher for those of lower levels of disability, indicating that restricting service to those of the greatest disability is likely to be an inefficient use of resources. The best targeting strategy, we suggested, might be to combine automatic eligibility based on a stringent test of physical functioning with unsatisfactory informal care inputs, with a quota of resources which would be at the discretion of field teams to apply on the basis of expected gain/cost ratios. The gain/cost ratios are to some degree predictable from information which could be recorded at initial assessment, so providing a basis for some guideline information for practitioners, managers, and those who define targeting policy.

### ***Will similar care management arrangements achieve similar costs of outcomes?***

One of the beliefs reflected in the community care reforms is that ‘better management’ can result in similar inputs resulting in more predictable benefits. That is, there would be more similar relations between costs and outcomes given needs-related circumstances. Some argued that there could be continuous improvement, and so falling costs given outcomes. In contrast, sociologists of organisations have traditionally been sceptical about the attainable degree of predictability in the relations between resources and outcomes.

The KCCP model aimed to create the incentives and other preconditions for progressively improving cost and other outcomes. The experiments were aimed to produce both within-and between-project learning, WPL and BPL. In fact, ‘negative learning’ was always possible — for instance, the budgets or budget limits for each case could be set at levels which are too high or too low for the caseload as a result of invalid inferences from earlier experience in a project.

Policy-makers have advocated the implementation of budget-holding care management, shown by earlier PSSRU work to have favourable outcomes. It is therefore important to evaluate the degree to which the implementation of the KCCP model would produce similar or improved outcomes.

The results showed:

- there were predictable relations between resources, needs and outcomes, and so technological determinacy.
- there was WPL within the Kent Community Care Project itself, but little sign of WPL in the other projects.
- BPL was not significant.

So organisational theorists may have been unduly pessimistic: there was a higher degree of technological determinacy than would be expected. However, the incentives did not lead universally to sufficient WPL or BPL to affect the basic relations between resources, needs and outcomes. The results illustrate that it is dangerous to infer that innovations significantly affect equity and efficiency from process studies which do not also estimate the relations between resources, needs and outcomes.

### ***The separation of care management costs of outcomes from other service costs of outcomes***

The conventional argument developed in the United States is that care management (cm) improves efficiency indirectly by reducing the costs of other inputs required to produce outcomes by an amount which will at least offset cm costs. Many argued that direct effects would also be important in the care management of people with mental health problems, but the direct effects were not stressed in the rationale of most care management programmes for elderly people. The KCCP, in contrast, was postulated on the argument that it should produce both direct and indirect effects.

Results from the analysis of British and American data suggest that the gains might depend more on the direct effects on outcomes of the care management inputs, less on the indirect effects emphasised in the traditional argument. There is some evidence from the PSSRU ECCEP programme that the same may be the case in post-reform community care in the UK (Davies, Warburton and Fernández, 1995). That could in part be because the balancing of care management and other inputs, and the way care management tasks are performed, are not tailored sufficiently to user circumstances. How care management tasks should be undertaken for what subgroups was extensively discussed in the light of international experience in *Resources, Needs and Outcomes*.

The analysis meets a criticism made by Americans of their care management research: that the evaluations are not of care management itself but of overall programmes including features unrelated to the care management.



### ***The longitudinal perspective on care-managed service: the distinction between set-up period (SUP) and continuing care (COCA) costs***

The community care revolution is partly about thinking more proactively, more longitudinally, more in terms of the evaluation of care inputs as investments. Consonant with this, the care management approach is a long-term not acute or short-term intervention model.

The longitudinal analysis of a care-managed career distinguishes four periods, of which two are the set-up and continuing care periods. There are important results.

The duration of SUP time and costs varied greatly between individuals, and also between programmes. The weekly costs of care management were much higher during the SUP than COCA periods. A high proportion of SUP costs are the overheads necessary for matching resources to needs over a longer period. The COCA periods are generally of much longer duration. So SUP costs are partly an 'investment', a front-ended resource use intended to have an effect whose benefits are expected over much of the remaining care-managed career. The evaluation of what level is worth while depends on the length of the period over which the benefits are expected; i.e. the length of the COCA period. The benefits in relation to the costs over the care-managed career will generally be greater the longer is the COCA period. Statistical modelling of the relations between costs, need-related circumstances and outcomes shows the costs of outcomes to be predictable to a substantial degree. The results suggest the circumstances of cases for which the overall costs of outcomes are sensitive to variations in the length of the COCA period.

One implication is that need-related circumstances affecting the likely length of the COCA period should be taken into account in deciding on the levels of SUP 'investments'. A second implication is that it is likely that research could establish plausible relations between needs-related circumstances, costs of outcomes, and COCA time. These could be useful background for practice policies and guidance.

For more on this, see our forthcoming book *Budget-Holding Care Management in Two Routine Programmes*, and papers extending the analysis to other data bases.

### ***Volatility and change during the COCA period***

Securing quick and effective responses to volatility and change in needs-related circumstances is an important thread of the argument for care management as a long-term rather than short-term or acute model. Our analysis yielded interesting results which illuminate the nature of budget-holding care management.

- For only a minority of cases in any of the three programmes investigated was there little or no change in either care management costs or package costs. So volatility and change was indeed a general pattern.
- For most, the pattern is unidirectional change, a constant proportional rate of growth model being significant at at least the 10 per cent level.
- Both volatility and steady utilisation were common.
- The distribution of time profiles was surprisingly similar between programmes.

Among those for whom the constant rate of change model fitted well, the rate of change was often high. The high rates of decline were found for care management, not for other home care costs, for which there was a steady upward drift in home care costs from the first month of the COCA period.

Caseloads per care manager changed much less. Therefore, care managers were shifting resources quickly between users in response to trends in their needs; taking their own time and some services away from some (usually those who started the COCA period with high costs) to give some more others, much more to some cases. This is precisely the pattern expected if the caseload consists of those for whom there is a high risk of complex change requiring a long-term care management model.

There are important implications. There are indeed cases, probably many cases, for whom the need is a long-term care management model. There is a risk that resources will be used inefficiently or that some persons' needs will be ineffectively met by a short-term model which concentrates authority and responsibility for assessment and

initial care planning but which does not have adequate care management arrangements subsequently. The ECCEP project will describe contemporary care management arrangements.

Arrangements to secure the effective performance of the core tasks of care management for elderly clients in general has been an important theme of several programme streams at the PSSRU, particularly the writing about the individual PSSRU experiments and the stream on resources, needs and outcomes in community services. Arguments from each have had their impact, though we suspect that managers may sometimes have applied inferences from the one to situations for whom the analysis of the other is more relevant. The comparative project illustrates how useful it is to use minuscule resources to collate or reuse data at low cost, but against more relaxed deadlines than are appropriate for work on the new datasets for which the world has paid in the expectation of fast reporting.

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## Learning materials on mental health

Two sets of training modules have recently been produced by Manchester University in conjunction with the Department of Health. They are now available at a cost of £20 per set plus post & packing.

### Learning materials on mental health — an introduction

These learning materials are designed for front-line workers without extensive training in mental health, who work with people experiencing mental health problems. They will be useful to mental health support workers, residential and day care workers and to social workers whose training has not included a substantial mental health component. The materials provide up-to-date information on various aspects of mental health and can be used on a self learning or group learning basis.

### Learning materials on mental health — risk assessment

These are designed to inform the full range of mental health professionals involved in mental health risk assessment and risk management of the latest knowledge and best practice in the field. The materials focus mainly on the risk of violence, but suicide and self neglect are also covered. They are in modular form and designed to be used flexibly on a self learning or group learning basis. Learners may want to concentrate on a particular module, or to work through the entire set.

Further information is available from Dianne Price, Department of Psychiatry and Behavioural Sciences, 12th Floor, Mathematics Building, University of Manchester, Oxford Road, Manchester, M13 9PL. Telephone: 0161 275 5221, fax: 0161 275 3924.

# The Scale and Funding of Voluntary Provision: Care for Elderly People in Context

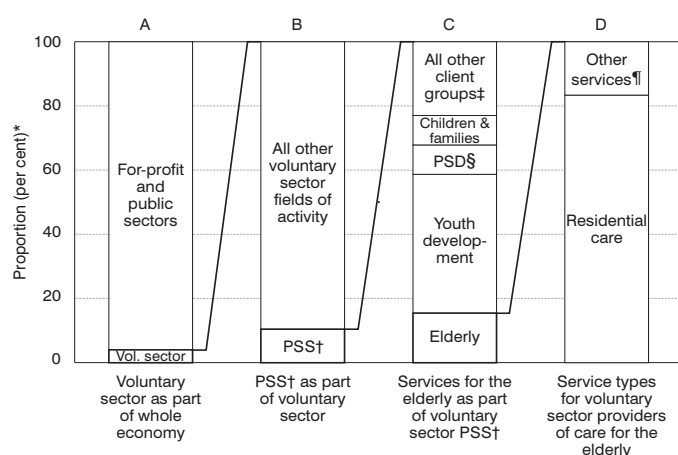
Jeremy Kendall

Between 1990 and 1995, the PSSRU conducted the UK leg of the most ambitious cross-national comparison of the voluntary sector ever undertaken. The project involved the comprehensive mapping of the scope and scale of the voluntary sector for the first time, charting its contribution to the economy as a whole, as well as providing a detailed analysis of its financial base. It also examined the sector's historical development, its legal treatment, and the nature of the policy environment in which it operates.<sup>1</sup>

One broad intention of this study was to measure the voluntary sector's economic contribution to the 'conventional' macro economy (without systematically imputing values to non-financial resources), to identify the range of services in which voluntary organisations are involved, and to explore how the sector is funded. The study therefore provides useful background information about the overall significance of the sector, and the types of activities in which it is involved.

Figure 1, moving from left to right, starts by revealing the scale of overall voluntary sector activities in the context of the economy as a whole. Full-time equivalent paid employment in voluntary organisations (broadly defined) in 1990 was 4 per cent of the whole-economy total, and the sector's total operating revenue stood at £29.5 billion. Just over £3 billion of this total accrued to voluntary sector organisations providing personal social services, widely defined. The figure shows that voluntary providers are contributing across all of the major client groups. We highlight here the types of services provided to elderly people, the largest single client group as measured in terms of overall public expenditure on personal social services.<sup>2</sup> It should be noted that 'multiple services' includes activities across the other service types which could not be separately distinguished under the other discrete categories shown, and that elderly people also benefit from social services provided by multiple client group organisations. In addition, in constructing these estimates, we relied in part on voluntary organisations' own annual reports and accounts, and often these did not allow service categories to be identified as clearly as we would have liked. Nevertheless, our data do provide a useful starting point in what has traditionally been an area characterised by an extreme lack of information.

**Figure 1 Voluntary sector services for the elderly in context**



## Notes

\* Column A refers to proportion of full-time equivalent paid employment in UK economy accounted for by voluntary organisations; columns B to D refer to shares of total income.

† Personal social services: ICNPO subgroup 4100 only.

‡ Services for people with learning difficulties, women's groups, carers' groups, pre-school playgroups, and multiple client group services.

§ Services for people with physical and sensory difficulties.

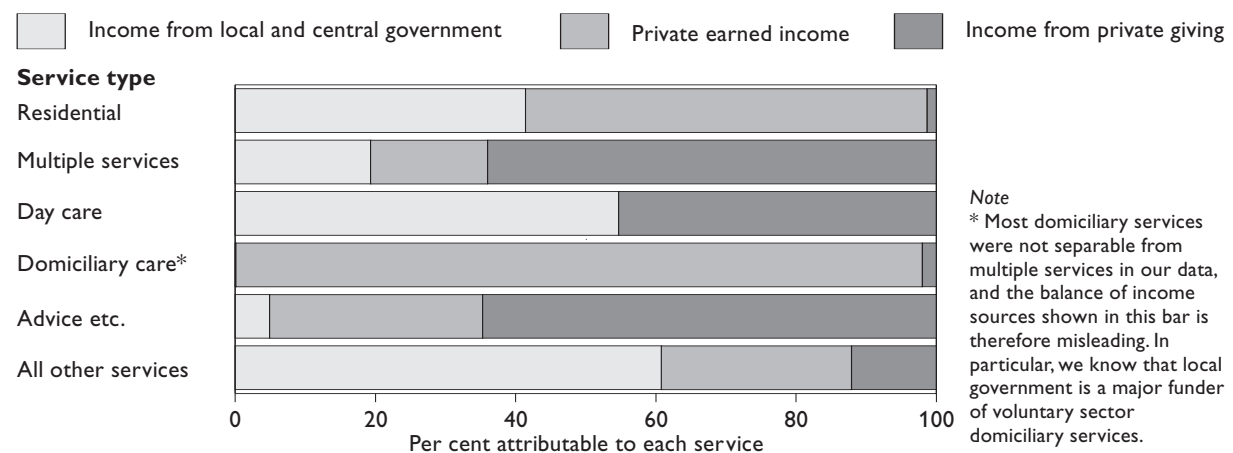
¶ Multiple services, day care, domiciliary care, advice, other services.

It is clear that in 1990, as far as care for elderly people was concerned, residential care still dominated the sector's activities financially, with payments for this service type accounting for over four-fifths (83.5 per cent) of total operating revenue (across all public and private sources). However, one of the features that has traditionally distinguished the voluntary sector's contribution from that of the private sector in this field is that it has operated alongside local authorities as a significant provider of non-residential care — and received significant financial support from local authorities to do so.<sup>3</sup> Furthermore, while the scale of these activities is relatively small in comparison with residential provision as measured by *monetary* income, it should be recognised that a different balance would certainly emerge if reliable data on non-financial resources were available. Volunteering is relatively rare in residential care settings (across all provider sectors; Ernst and Whinney, 1986), and the significant amount of volunteering that is known to be undertaken in

support of the elderly is concentrated outside old people's homes in the community (Lynn and Davis Smith, 1991; Knapp et al., 1996).

Figure 2 illustrates the extent to which these voluntary providers were reliant on public sector support in 1990. The importance of public funding to providers of many forms of non-residential care is shown clearly in the figure, which also shows the significance of private *giving* (including individual and federated fundraising, trust and corporate support) in a number of non-residential forms of provision. Residential care was also reliant on public funding — in this case from both local and central government (most significantly, income support). But private *earned* income was the major source of non-statutory funding for this type of care. This primarily reflected the continued significance of private fees paid by individual users to voluntary sector providers in residential care settings.

**Figure 2 Voluntary sector services for the elderly: income sources of service types**



A version of this article appears in Netten, A. and Dennett, J. (1996) *Unit Costs of Health and Social Care 1996*, PSSRU, Canterbury.

## Notes

1. The full results of all aspects of the UK leg of the project are in Kendall and Knapp (1996); summaries of the statistical mapping, and policy issues facing the sector, can be found in Kendall and Knapp, 1995a and 1995b. Early summaries of the overall international findings are Salamon and Anheier, 1995 and Salamon and Anheier, 1996.
2. Services for the elderly accounted for 44 per cent of all net current public expenditure on personal social services in 1990/91. See Department of Health, OPCS and HM Treasury (1993) *Department of Health and Office of Population Censuses and Surveys Departmental Report*, Cm 2212, HMSO, London, cited in Knapp and Wistow, 1993.
3. Kendall and Knapp, 1996, chapter 7. In 1990/91, voluntary organisations were receiving three times as much local authority expenditure as private sector organisations in support of non-residential care activities (see Wistow et al, 1994, chapter 3). This ratio will of course have changed significantly with the rapid expansion of private sector domiciliary care services under contract with local authorities since 1993.

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## OLDER PEOPLE IN CARE HOMES

Interest in the field of residential care is long established in the PSSRU. Work in this area is currently particularly active, with a number of different projects ongoing or planned which have residential care of elderly people as an important focus. These are for a variety of purposes in the first instance including:

- feeding in to the development of Standard Spending Assessment Formulae
- investigation of the relationship between costs and dependency
- examination of the functioning and regulation of markets in social care
- as an important option when tracking needs resources and outcomes over time of newly assessed individuals
- investigating quality of care and quality of life of residents

The projects (some of which are summarised below) include joint ventures with other institutions and draw together individuals with a variety of backgrounds, disciplines and interests. An informal interest group has been formed which brings together people within the Unit who are actively involved in this area to share ideas, problems and developments. By organising internal and external seminars and symposia it is intended to increase the comparability, enrich the analysis and broaden the applicability of ongoing work and identify important directions for future research.

### Survey of Residential and Nursing Home Care

Andrew Bebbington, Pamela Brown, Robin Darton and Ann Netten

The PSSRU is conducting a three part survey of residential and nursing home care, with fieldwork being undertaken by Research Services Ltd.

The three elements of the study are:

An *Admissions study* to identify elderly people who will have a significant financial impact on local authority resources committed to residential care. This includes those people:

- for whom the decision has been made that they are to be admitted to residential care;
- who have been admitted on an emergency basis and need to be at least financially assessed by the local authority;
- who are already in residential care who are being assessed because they no longer have the resources to pay for residential care;
- who are moving from one home to another with important cost implications.

Data has been collected about the characteristics of 2500 people admitted over a three month period during autumn 1995 to residential and nursing homes in eighteen local authorities. The study will be reporting back during 1996.

A *longitudinal study* will follow up these admissions over a four year period. This will provide information about:

- how long people stay in residential care and mortality;
- destination outcomes;
- changes in dependency over time.

The 2500 residents are to be followed up six months, eighteen months, 30 months and 42 months after admission.

A *cross-sectional study* will identify:

- the characteristics of the resident population currently in residential care;
- the characteristics of homes, including some assessment of quality of care;
- the characteristics of short stay emergency, NHS and privately funded admissions to homes.

The study is due to go into the field during autumn 1996. The principal objectives of the study are to feed in to the development of the SSA formulae and to explore the relationship between costs and dependency. By linking the study with other ongoing and previous work it is hoped to maximise comparability and provide a valuable picture of the current use of residential and nursing home care.



# **Quality of Life and Quality of Care in Residential Homes**

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**Peter Huxley, David Challis, Caroline Mozley and Justine Schneider**

The PSSRU has contributed to two studies to investigate quality of life in residential care for elderly people as part of the Centrally Funded NHS R&D in Mental Health administered by Northern and Yorkshire Region.

The first study, led by Professor Anthony Mann at the Institute of Psychiatry, is an in depth study of 280 residents in sixteen homes. An important hypothesis underlying the study is that high quality of care will result in observably lower levels of depression as well as fewer unmet health and social care needs. The sample of homes included homes that participated in the Caring in Homes Initiative. The study employed a wide range of instrumentation and includes an economic component. A report is now available.

The second study, led by Peter Huxley at the School of Psychiatry and Behavioural Sciences at Manchester University, is in the very early stages. The aim is to estimate the quality of life and quality of care and cost in relation to the psychiatric and physical morbidity in different residential settings and to explore the implication of these findings for informing purchasing strategy. This is a prospective study of 600 new admissions assessing people soon after admission, at six months a year. The project will also use a wide range of instrumentation and will build on the results of the previous study when identifying the key elements of quality of care and quality of life.

## **Life Expectancy in Care Homes for Older People**

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**Alisoun Milne and Raymond Warburton**

The Social Services Inspectorate has commissioned PSSRU to carry out a small piece of research to investigate the survival rate of older people admitted to permanent placements in residential care homes or nursing homes. The commission stems from the widely voiced concern that too many older people are not surviving (for very long) the move from the community to a care home.

In order to carry out this work PSSRU has collected data from a shire county, a metropolitan district, an inner and an outer London borough. Staff of these four authorities have completed simple forms on all older people admitted to permanent placements between 1 April 1995 and 30 June 1995, requiring financial support from the public purse. The form asks for basic information about the admission and the situation as at 31 March 1996, specifically finding out if users have died, moved placement or back into the community.

The information from the forms is currently being analysed. Preliminary results indicate that during the nine to 12 months period that is being studied over a third of the users died. The average length of stay for those who died was 4.5 months. It seems that the actual move into a care home, and subsequent moves in the year — most from residential care beds to nursing beds — are not factors associated with death. In addition, very few people admitted to care homes were discharged back to the community within the year.

The four authorities differ in their placement patterns, which appear to depend on supply factors such as the number of local authority residential care beds, historical relationships with providers, as well as 'need' within the elderly population.

# Towards a National System for Continuing Assessment in Care Homes

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David Challis, Iain Carpenter and Karen Traske

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## Assessment as a policy issue

Policies on services for older people are converging across many countries, with a shift in the balance of care towards community-based support, and less reliance overall on institutional care. This has led to more careful targeting of admissions to residential and nursing homes. Assessment consequently plays a critical role. The goal of long-term care for elderly people is to maintain as high a quality of life as possible in the presence of chronic physical, cognitive and social disabilities, which commonly deteriorate over time. Older people's lives are also frequently punctuated with episodes of acute problems which may be medical, cognitive, behavioural or social. Hence, assessment is important not only at the point of entry to continuing care, but on regular occasions thereafter.

This study, funded by the Joseph Rowntree Foundation, examined the role of assessment and ways of moving towards a common system for residents in care homes, which could assess individual care needs, assist in constructing care plans and provide appropriate information to permit costing the level of care provided (Challis, Carpenter and Traske, 1996). Such an assessment process could offer a common basis for agreeing levels of care across organisations and localities, be acceptable to both health and social services staff, be focused upon the personal needs of the resident and be readily incorporated into a computer software package.

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## Assessment systems in practice

Assessment has been used for identifying eligibility for services, clarifying the needs, problems and preferences of individuals and their carers, particularly at key points such as deciding whether someone should move into residential care, and for reviewing needs over time.

Previous studies found that assessment prior to admission to institutional care can identify problems which can then sometimes be resolved, making admission unnecessary; it can also reduce deaths and highlight the needs of carers. However, despite their desirability, true multidisciplinary approaches to assessment are relatively rare. Furthermore, few studies have examined the use of assessment and reassessment following admission to long-term care.

### *Assessment documentation*

As part of the study, a detailed evaluation of assessments from 50 local authorities found they varied greatly in the extent to which information was structured, although many covered to some extent most of the areas considered important. However, there appeared to be a lack of integration of health and social services assessment information in the documents used. Only 24 per cent of forms were used jointly by health and social services, the remainder by social services departments only. The review revealed a wide variation in content and quality of information and no clear linkage between identifying problems and formulating a proper response.

Very few documents were designed for assessing or reviewing the needs of elderly people once they were living in residential or nursing homes and there was a very variable coverage of care needs, depression/anxiety, problems of cognitive impairment and behavioural patterns. 'Activities of Daily Living' assessment is reasonably consistent in content but not always structured.

There are a number of standardised assessment systems which are relevant to the care of elderly people. Most of these have been designed for use in a research setting, often with a focus on particular areas, such as activities of daily living, cognitive function, or quality of life. There are few integrated standardised assessments useable in everyday practice, which address all these topics.

### *The broader role of assessment*

Assessment information has uses beyond those of individual care planning. Although assessment needs to begin at the level of the individual, this information may be subsequently aggregated to give indicators of needs for care and the quality of processes and outcomes relative to costs for a whole home.

Assessment of quality in residential settings currently focuses to a large extent on standards measuring regime, staff quality and casemix using aggregated home level information. There is very little individual care plan or resident focus to quality assurance, using resident assessment information.

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#### **Towards a standard assessment system**

There is clearly a need for assessment information to be useable for a range of different purposes and at different levels of aggregation. The requirement for the UK would seem to be a single system which can be used for at least six different tasks: individual care planning, management, supervision, assessing the implications of individuals' mixed needs within one 'casemix', cost and quality assurance. The study looked at a number of different systems currently in use and concludes that the US Minimum Data Set/Resident Assessment Instrument (referred to as the MDS/RAI) has the greatest potential for use in the United Kingdom.

The MDS/RAI was developed at the end of the 1980s in response to concerns about quality of care in US nursing homes. The aim was to produce a system with a core of items necessary for comprehensive assessment, providing a structured framework that could be used to inform care planning. It was designed in such a way that it could be regularly updated and that data from assessments could be used for monitoring quality of care and costs of care both at the level of the individual and at the level of the institution.

#### *The structure of the MDS/RAI*

The MDS/RAI is composed of a minimum dataset (MDS) and assessment protocols. It covers a wide range of subjects, including detailed assessment of physical function, mood, cognitive function and psychosocial factors. Identified problems trigger assessment protocols which guide the assessor through best practice towards developing a care plan. The protocols do not stipulate the content of the care plan but rather prompt the assessor to address which areas should be considered. In this way, care plans remain tailored to individual needs.

#### *The MDS/RAI in use*

The MDS/RAI includes the variables required for a system that predicts resource requirements at the level of the individual which can then be aggregated to the level of the institution. Its validity and reliability has been demonstrated in a number of countries, including UK hospital settings, and it should meet the needs of nursing home and residential care settings.

Quality indicators have been systematically developed from the MDS and have been shown to be useful as measures of quality at either resident or institution level. The items have been validated for use specifically in measuring physical and cognitive function and quality of life.

Because of the detailed structure and extent of the MDS/RAI, it has been used in teaching in the care of elderly people, where it has been found to improve the expectation of job satisfaction of care staff and made significant changes to their views of elderly people, breaking down some of the barriers of ageism.

#### *The effects of implementation*

Use of the MDS/RAI in the United States has led to evidence of improvement in a number of areas. Studies suggest that there were significant reductions in the prevalence of pressure sores, use of restraints and catheters, improvements in quality of life and reduction in the rate of transfer from long-term to acute care settings, with no increase in mortality. The accuracy and completeness of nursing records also improved.

### *The MDS/RAI and computer systems*

The Instrument has been designed for use with computers. There are several software applications available in the US which have a range of functions from simply collecting data to providing figures and assessment protocols as well as casemix and quality indicators. A package developed in Europe is available which would require further modification and development prior to implementation and evaluation in the UK.

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#### **Conclusion**

It seems the MDS/RAI offers a tool which could address the needs identified for a standardised national assessment system for use in care homes and fill the gaps highlighted in the literature and from the study of current assessment documents. It could meet the needs of elderly people, formal and informal carers, and providers and purchasers of long-term care.

A two-stage pilot study is being undertaken, also funded by the Joseph Rowntree Foundation: first, an examination of the feasibility and acceptability of this approach in UK care homes, so as to modify the documentation in the light of local circumstances, and second, a full controlled trial, examining the costs and benefits of this approach to assessment in care homes, for individual residents, homes, managers and purchasers, compared with the alternative of current practice.

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#### **Reference**

Challis, D., Carpenter, I. and Traske, K. (1996) *Assessment in Continuing Care Homes: Towards a National Standard Instrument*, PSSRU, University of Kent at Canterbury (see page 45 for details).

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### **Provider Motivations**

**Jeremy Kendall, Julien Forder and Martin Knapp**

If commissioners are to be in a position to manage social care markets, they must understand and be able to predict the likely behaviour of both current and potential new providers to changes in commissioning arrangements and regulation. An essential precondition for this is an understanding of the motivations, values and beliefs of providers. However, motivations are not directly observable, and therefore a means of linking motivations with more easily discerned characteristics — such as sector and home size — would aid the commissioners' task. Research by the Mixed Economy team has explored some of these linkages.

The evidence on motivations, taken together with the evidence on purchasers' over-simplistic perceptions of provider motivations implies that significant gaps exist in understanding between purchasers and providers. A number of the latter — especially small private homes — appear markedly less commercial in their expressed motivations than many purchasers tend to believe. Some owners even described themselves as 'not business-like' or 'not really in a business', and professional goals which were related to user welfare, as well as norms of duty and responsibility, all emerged as highly relevant.

A minority of providers did *appear* highly aware and commercially 'switched on', but most displayed rather unsophisticated market behaviour. Homes which did exhibit the most noticeable market awareness and commercial orientation tended to be from the private sector, relatively large, part of a multi-home organisation, of intermediate age, and purchased rather than inherited. We found that for almost all facets of behaviour considered there was a significant relationship between the likelihood of such behaviour being commercially orientated and the extent of local competition. One of the clearest findings, however, was the enormously wide range of provider behaviour related to the considerable variety of home characteristics.

In order to shape the developing market sensitively, local authorities need to develop a richer understanding not only of the relationships between homes and market characteristics, but also of the diverse patterns of motivations and behaviours. They need at least to acknowledge the complexity of this market and the dangers of proceeding on the basis of ill-informed stereotypes of providers.

Further information is given in the recent book *Social Care Markets: Progress and Prospects* (see page 45 for details).

## Centre for the Economics of Mental Health

The CEMH at the Institute of Psychiatry — part of the University of London — was established in 1993. Four PSSRU staff — Martin Knapp (Director), Jeni Beecham (Assistant Director and Lecturer in Mental Health Economics), Angela Hallam and Justine Schneider — work part-time at the Centre, which also has five full-time staff.

With its central focus on mental health economics, CEMH is internationally unique. Together with the well-established mental health programme team at PSSRU, staff at CEMH are well-placed to make a range of contributions from economics and other disciplines, as well as applying economic evaluative techniques to the topic of mental health.

Researchers at CEMH and PSSRU are particularly interested in:

- cost measurement
- economic evaluation
- the mixed economy of mental health care
- contingent valuation
- cross-cultural quality of life
- links between costs, needs and outcomes
- models of choice under uncertainty
- mental health policy
- international comparisons
- employment schemes
- case management

The current range of mental health topics researched at CEMH and/or PSSRU include:

- drug therapies and compliance
- child and adolescent mental health care

- old-age psychiatry
- psychotherapy
- care management
- nursing care
- residential care
- addiction services
- community mental health care
- chronic fatigue syndrome

CEMH and PSSRU run joint seminars and courses and jointly publish the *Mental Health Research Review*. Recently, an edited book, *The Economic Evaluation of Mental Health care*, was published by Arena as part of the PSSRU series.

For more information, contact the Centre Secretary, Daphne Hargreaves, on 0171 955 6238 (fax: 0171 710 7600; email: cemh@iop.bpmf.ac.uk).

## Bi-National Direct Contracting Workshop

On May 9-10 1996 several members of the PSSRU and colleagues from Britain attended a joint workshop on contracting in mental health at the Center for Research on the Organisation and Financing of Care for the Severely Mentally Ill at Rutgers University, New Jersey. The initiative for the conference was taken by Agnes Rupp of the National Institute of Health in Washington, D.C., and other US research funders also attended. American participants came from the universities of Berkeley, Harvard, Yale, Boston, Minnesota, Los Angeles and Rutgers, as well as from Princeton Healthcare Group and Connecticut Department of Mental Health.

US and UK perspectives were presented on current policy and practice, models of contracting, performance evaluation, GP fund holders, Health Maintenance Organisations (HMOs), and evidence of cost-effectiveness from both countries. The complexities of managed care, and sophisticated American studies of contracting, for which the UK has no equivalent, made it difficult to make direct

comparisons, but common themes emerged. These included: the role of consumers, the interface between health and social care needs, the dimension of trust between patient and provider, the use of targets and incentives, equity, access and selection of patients, and the potential of medical audit.

In a small, intensive seminar such as this much can be achieved. Unlike larger conferences, it permits in-depth discussion from a common vantage-point. It leaves behind academic point-scoring and strives towards genuine understanding. And a multidisciplinary group helps to ensure that research questions generated in such a setting are valid and of broad policy interest. We hope to repeat the exercise in Britain, but in the meantime we shall be reflecting on the similarities and differences in mental health purchasing on either side of the Atlantic.

*Justine Schneider*



# Psychiatric Reprovision in North London

Angela Hallam

Since 1986, the PSSRU has been undertaking a cost-effectiveness evaluation of the closure programme of two large psychiatric hospitals in North London. We have described and costed the individual service packages received in the community by former long-stay patients from Friern and Claybury hospitals both one and (more recently) five years after moving to their community placements.

Friern hospital closed in March 1993 and we are now in a position to report the cost of reproviding services for the full long-stay population. Across the whole sample (751 service packages) the mean weekly total cost of community-based care is £628 (at 1995-96 price levels). The former inpatients moved to a variety of settings, some living completely independently, some in foster placements or group homes, while others have been accommodated in units which provide 24-hour waking cover by nurses. The last group to leave the hospital was, inevitably, the most dependent, and facilities were built or refurbished in alternative hospital (or hospital-like) settings to provide for these people.

The size and comprehensiveness of the dataset have enabled us to examine characteristics assessed by the clinical research team before clients left hospital and compare these with the subsequent costs of supporting them in the community. Thus we have identified factors which might allow us partially to predict the cost of care. We have also found correlations between costs, needs and outcomes which can inform future practice and policy. We published our findings at an earlier stage of the evaluation, and have recently repeated the analyses for the whole former long-stay population. A full report of our results to date was made to North Thames Regional Health Authority in late 1995 and a programme of dissemination is being undertaken. Research will continue with the support of a grant from the Department of Health.

## Mental Health Research Review No.3

The third issue of the Mental Health Research Review appeared in April 1996. The Review is a joint production by the PSSRU and the Centre for the Economics of Mental Health (CEMH), describing mental health research currently underway at one or both sites, and aims to present research objectives, methods and findings in a concise and readable form. It also serves as a reference point for the concepts and tools frequently employed in the PSSRU and CEMH in the economic evaluation of mental health services and treatments.

The articles published in the third Review reflect the nature of recently completed and ongoing research at the PSSRU and CEMH in the economic evaluation of policy in the mental health field. The scope of topics covered should be of general interest to government and health and social care decision makers, as well as practitioners and other academics interested in the application of economic analysis to mental health policy.

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*Specialist work schemes: some baseline data and costs*

Shane Kavanagh

*Northern Ireland Care in the Community*

**Copies can be obtained from**

**Daphne Hargreaves at CEMH (0171 919 3198)**

# Northern Ireland Care in the Community

Shane Kavanagh

## Introduction

In line with the other constituent parts of the UK, the Department of Health and Social Services (DHSS) in Northern Ireland has a long-standing objective to develop community-based care services for people with mental health problems or learning difficulties. This policy was given further impetus in 1986 when the Regional Strategy for 1987-1992 set the specific target of reducing the number of long-stay hospital inpatients by 20 per cent by 1992 (DHSS, 1986). In 1989 the DHSS commissioned the Health and Health Care Research Unit at Queens University, the PSSRU and Research and Development in Psychiatry to evaluate the success of this policy and to identify issues pertinent to further deinstitutionalisation.

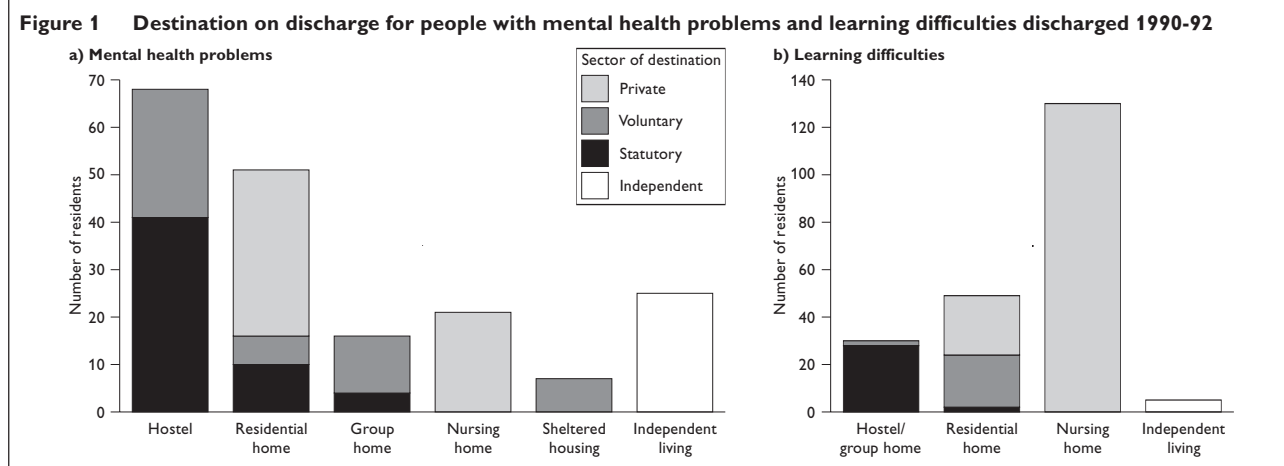
## Methods

The ongoing implementation of the policy across Northern Ireland, the changing nature of provision in the hospitals, and the varied developing forms of community arrangements precluded the use of an experimental design with clearly defined control and experimental groups. Faced with this constraint, the study compared the quality of life of people in hospital and their subsequent quality of life — at six months, twelve and twenty-four months — following discharge to a variety of community settings. (This summary compares the assessments in hospital and twelve months after discharge.) Assessments were made along the following dimensions: morale and life satisfaction, ability to perform activities of daily living, behaviour and social integration. Data on personal circumstances, quality of the care environment, receipt of health and social care services, accommodation charges and income were also collected.

## Results

Between April 1990 and June 1992, 188 people with mental health problems and 214 people with learning difficulties were discharged from long-stay hospitals in Northern Ireland. The vast majority of people in both groups moved to highly supported accommodation in the community (figure 1). Only 13 per cent of people with mental health problems and 2 per cent of people with learning disabilities were discharged to independent living arrangements. A variety of different types of supported accommodation from a variety of providers — voluntary, private and statutory — was utilised by both groups. Supported accommodation for people with mental health problems was evenly distributed between the sectors whereas 75 per cent of people with learning difficulties were discharged to private sector accommodation (mostly nursing homes). Twelve months after discharge over 90 per cent of people with mental health problems and 80 per cent of people with learning difficulties were still resident in the community.

How did these people fare following their discharge to community arrangements? The assessments one year after discharge to the community showed little change in daily living skills for either group (with the exception of a small decline in self-care skills for people with mental health problems). Similarly, there were no significant changes in behavioural problems for either group. Greater integration and improvements in social



networks are often posited as one of the motivations behind community care but there was little evidence that this had been achieved. Both groups reported little difference in the number of friends within their place of residence and the vast majority of people (70 per cent) in both groups reported that they had no friends outside their place of residence either in hospital or twelve months later in the community. People with mental health problems showed little change in their morale and life satisfaction with the exception of scores on the depression inventory which showed a slight improvement. It was often difficult to obtain similar assessments for people with learning difficulties but those people for whom assessments were completed showed little change with the exception of the depression inventory which again showed a small improvement. Despite the apparent lack of change in the various quality of life assessments, the majority of people in both groups reported increased satisfaction with their home environment and indicated that — unlike those in hospital — they preferred to remain in their current place of residence (table 1).

**Table 1 Comparison of selected measures of outcome for former long-stay patients discharged 1990-92**

|  | People with mental health problems<br>(mean score) |              | People with learning difficulties<br>(mean score) |              |
|--|--|--------------|---|--------------|
|  | In hospital  | At 12 months | In hospital                                       | At 12 months |
| Daily living skills score <sup>a</sup>                     | 16.13  | 15.85        | 11.71   | 11.43        |
| Behavioural problems score <sup>b</sup>                    | 1.35   | 1.44         | 1.75  | 1.80         |
| Number of close friends in place of residence              | 1.30   | 1.05         | 1.14  | 1.46         |
| Number of close friends outside place of residence         | 0.45   | 0.57         | 0.41  | 0.24         |
| Depression score <sup>c</sup>                              | 24.38  | 25.12        | 26.22   | 28.95        |
| Satisfaction with home environment <sup>d</sup>            | 10.67  | 11.55        | 10.34   | 12.15        |
| Percentage of residents who would prefer to live elsewhere | 59   | 32           | 74  | 15           |

a Includes self-care skills, community skills, social skills and responsible behaviour and ranges from 5 (lower skills level) to 20 (higher skills).

b Includes anti-social or odd behaviour, dangerous behaviour, psychological impairments etc., and ranges from 0 (better) to 4 (worse).

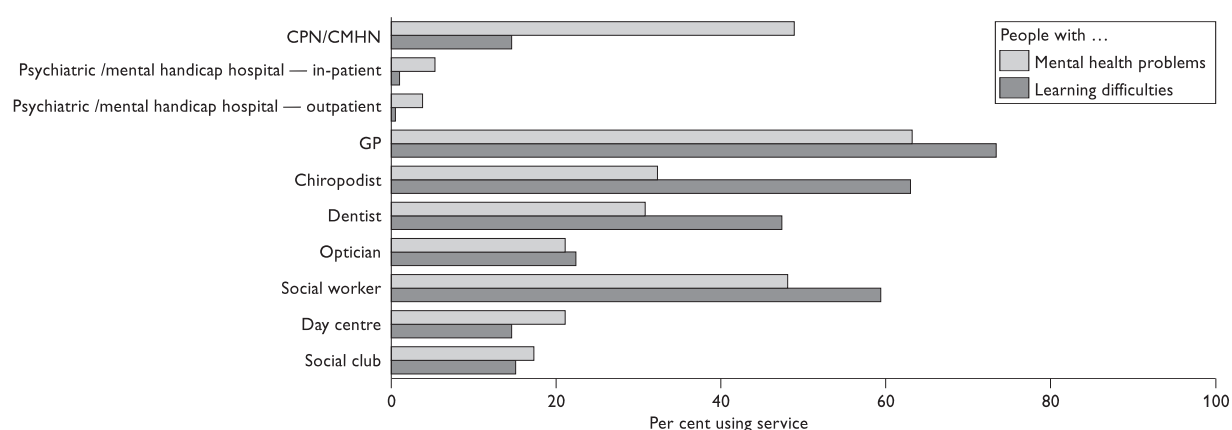
c From the Depression Inventory, ranging from 0 (more depressed) to 36 (less depressed).

d Higher scores indicate greater satisfaction.

People from both groups used a wide variety of services (figure 2). Extensive use was made of general practitioners, chiropodists, dentists and opticians, indicating that the physical aspects of care for these groups should not be overlooked. Social workers also saw a significant proportion of both groups. However, whereas almost 50 per cent of people with mental health problems saw a community psychiatric nurse (CPN), a much smaller proportion of people with learning difficulties saw either a CPN or a community mental handicap nurse. This result may in part reflect the fact that this form of nursing support was provided internally within private sector nursing homes.

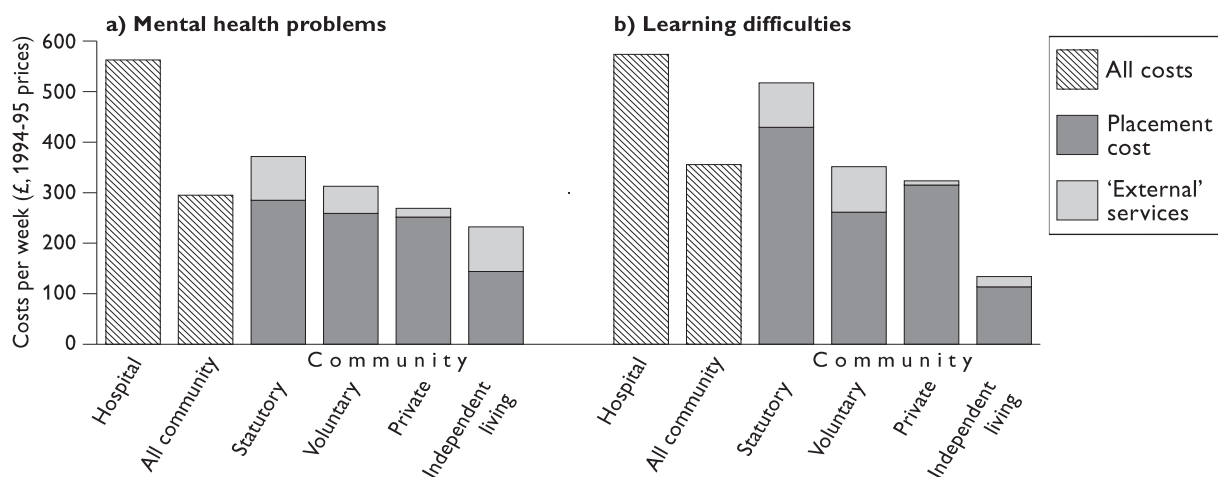
Costs were — on average — significantly lower in the community than in hospital (figure 3). However, this conceals considerable variation in community care costs where a number of people in both groups incurred costs in excess of their hospital costs. Considerable variations in placement levels were found between the different care settings.

**Figure 2 Service receipt one year after leaving hospital<sup>a</sup>**



a excludes people who were readmitted to hospital

**Figure 3 Comparison of hospital and community costs**



Public sector facilities were the most costly while independent living was the least costly. The costs of services external to the care facility also varied considerably. In general, people in statutory and voluntary facilities tended to incur higher costs for external services compared to private facilities. The costs of services for people with mental health problems living independently were in excess of those living in supported accommodation. Costs were generally greater for people with learning difficulties compared to those with mental health problems. Funding patterns were also altered, with the Benefits Agency assuming a much greater proportion of the costs.

## Conclusion

Overall, the finding that quality of life was at least no worse than in hospital and was achieved at a lower cost suggests that the policy of community care for former long-stay patients has been successful. However, relocation in itself is not a panacea for the care of people whose needs for care are complex, multi-faceted, and difficult to define and articulate. The level of dependency of many people remains high and there appears to be little integration into the wider community. Careful attention by purchasers is necessary to ensure that their purchasing decisions do not create 'mini institutions' in the community. Furthermore, our research found only weak associations between needs and resources suggesting that service packages could be more responsive. The use of various types of accommodation with differing inputs from many external service providers places the onus firmly on purchasers to ensure that the contracting and monitoring process delivers the appropriate level of care.

## Acknowledgements

This research was conducted by Jack Astin, Jennifer Beecham, Andrew Fenyo, Shane Kavanagh, Martin Knapp, (PSSRU) Michael Donnelly, Sinead McGilloway, Nick Mays and Sarah Perry (Health and Health Care Research Unit, Queens University). The research was funded by the Northern Ireland Department of Health and Social Services. The views expressed in this paper reflect the views of the authors, not those of the DHSS.

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# DEMAND, SUPPLY AND FINANCE

## Long-Term Care Demand, Supply and Finance

Bleddyn Davies and Raphael Wittenberg

The mechanisms for financing community and long-term care have at last become the focus of well-publicised national debate. About time, some may say. For fifteen years the PSSRU has been collating information about financing models developed in other countries and arguing that community reform here would be incomplete without the development of financing mechanisms (Davies and Challis, 1986).

### The supply focus of British reforms

Sir Roy Griffiths devoted a page of his report (Griffiths, 1988) to discussing such development. He advocated, among other suggestions, that the PSSRU concept, a British social maintenance organisation, should be developed and evaluated experimentally. The initial priority for reform was, however, almost entirely given to tackling the structures and philosophies which most directly influenced supply. In this, British reform differed from the reform attempts of most other countries, which relied more on financing mechanisms.

It would have been profoundly at odds with British history for the development of new financing mechanisms to have had higher priority. It has higher priority elsewhere partly because in other countries central and local government have less direct control on the real economy of the supply of care. Such control has allowed British health and community care policy to be more successful in achieving greater supply efficiency — more gain per pound of public expenditure. For this reason, the PSSRU are now arguing that the effects of financing mechanisms on the real economy of care will matter much more than in reforms elsewhere. (Davies, 1996).

### The new focus on financing mechanisms

A range of factors have encouraged debate of financing arrangements. These include the projected continued growth in the numbers of very elderly people, uncertainty about future levels of family care, the interface between health and social care and the different funding and charging regimes associated with them, and the need to balance competing pressures on resources. The key financing policy debate concerns the appropriate balance between private funding from savings or insurance benefits and public funding from general taxation or social insurance.

The debate is being pursued in a variety of ways. The House of Commons Health Committee is currently conducting an inquiry on the financing of long term care. The Joseph Rowntree Foundation is also currently considering options for financing continuing care for elderly people. Both inquiries are expected to report shortly.

The Government has responded to public concern on the financing of long term care by relaxing the assets element of the means test for local authority supported residential care and by issuing a consultation paper on partnership schemes (Chancellor of the Exchequer et al, 1996). The paper invites comments on proposals to increase the assets limits for people purchasing private long term care insurance or annuity products under a partnership arrangement and to allow greater flexibility in pension schemes to assist long term care finance. The former proposal, a form of partnership between private and public finance, is based on schemes operating in four US states.

### The potential contribution of modelling

To inform this debate it would be most valuable to have reliable projections of two key variables. The first is the likely level of demand for long term care services under different scenarios about changes in life and health expectancy and in socioeconomic variables. The second is the costs associated with meeting the expected demand for care and the distribution of these costs under different policies and funding mechanisms.



Projections have been made for this country by at least three agencies. The Institute of Actuaries (Nuttall et al., 1993) has made projections of the likely numbers of disabled people and of the costs of caring for them on varying assumptions about changes in age-specific mortality and morbidity rates. London Economics and the Institute for Public Policy Research (Richards et al., 1996) have made projections of future patterns of demand and supply of long-term care and associated costs. The DH has also made broad projections of expenditure on long term care on a range of assumptions.

More detailed modelling has been undertaken in the USA. The Brookings Institution and Lewin-VHI Inc. have developed a Long-Term Care Financing Model using microsimulation techniques. This model projects the size, financial position, disability status, and nursing home and home care use and expenditures of elderly people through the year 2020. Expenditures are further extrapolated on a broader basis to year 2050. The model has been used to simulate the effects of changes in the system for financing long-term care in the USA (Wiener et al., 1994).

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### **The financing project**

The DH has agreed a study of long term care demand and finance in this country as part of the PSSRU's long run programme at the London School of Economics. The study will build on existing work and enable more detailed projections to be made taking account of a wide range of variables. The overall aims of the project are to make projections of likely demand for long term care for elderly people to around the year 2030 under different scenarios and to assess the likely impact of different policies and approaches to funding long term care for elderly people on the balance of expenditure between sectors. This will involve formulating a model.

The projections will cover:

- estimated numbers of elderly people with different levels of dependency by age group, gender, and household type
- estimated levels of long term care demanded under current patterns of services or variants that display greater cost-effectiveness
- estimated expenditure by funding source (households, social services, health service etc.) under the current funding mechanisms or specified variants

The project will involve four strands of work. The first is an investigation of likely trends in some of the key influences on demand for long term care services. These would inevitably include such controversial and difficult issues as future patterns of family care and future dependency levels of elderly people. This strand is a necessary preliminary for making projections of future demand for long term care by elderly people. It is essential to identify the key factors that influence demand for these services and to consider how they may change over the period covered by the projection. An important part of the project will be to look at the literature on factors influencing demand for long term care and how these factors may change.

The second strand will involve the construction of a cell-based model that will have capacity to make projections from an early date. This will involve consideration of subgroups of the elderly population, by age, health state and other variables, and their average utilisation of long term care services.

The model will consist of a number of modules. Each module will use data available at the time of its development. The initial architecture will reflect the types of data available. New data may enable the architecture to be improved and modules to be up-dated or replaced.

The third strand will be to make projections, using the cell-based model, of demand for long term care services and associated costs. The projections will be made under a range of scenarios concerning variables such as changes in the real costs of care or in age-specific dependency levels. The aim will be to investigate the sensitivity of projections to key assumptions and to try to produce a realistic range of projections.

The fourth strand will be to investigate the feasibility of constructing a dynamic microsimulation model. The microsimulation model would be based on individuals rather than subgroups. It would, therefore, be valuable for considering distributional issues, between individuals in different circumstances and over the elderly life-cycle. This seems necessary for detailed planning and for detailed consideration of the effects of

different regimes for funding long term care. The construction of such a model will be a longer term development.

A key aspect of the project, and objective of the modelling, is to investigate the implications of alternative scenarios, including alternative financing mechanisms. Scenarios will differ in two respects. One set of analyses will be concerned with investigating the sensitivity of projections to variables, parameters and assumptions in the model. Another set will be concerned with investigating the effects of different policies, including alternative financing mechanisms.

Specifying the architecture of the model will require Alexandrine handling of some the knottiest problems. What is the set of mathematical specifications which will best capture the interdependence between the availability of finance for care and the long run supply of informal care? And what quantitative parameters will best describe these relationships? Such questions go beyond what social science has established, and, in some cases, beyond what it can be expected to establish with any precision. So one important task is to show the consequences of alternative scenarios, each based on architectures and parameters which are credible to the experts in the relevant field. In this way, we shall explore to which factors and relationships between factors the projections are sensitive. That will in turn help to define research needs, covering theoretical issues, data collections and foci for analysis.

The project will also explore the effects of different financing arrangements, this being a key aspect of the work. Mechanisms that could be investigated include those put forward in the Government's recent consultation paper, other mechanisms and combinations of mechanisms. To do this well will stretch our scholarship. We will do it better if the scenarios are based on understanding the experience of other countries — the kind of analysis of financing mechanisms in which PSSRU has been one of the few British voices in the past.

The study has recently commenced. The aim is to be able to produce projections for policy-makers from an early date. The intention is, therefore, to develop a simple model initially and build on that. There seems potential to develop and improve the model over a substantial period.

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## Needs Based Planning

**Andrew Bebbington and Karen Turvey**

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### Introduction

The needs based planning project was developed in response to the new community care policy and to the guidance provided by the Department of Health. There are two parts to the project. The first part comprises a series of demonstration projects whereby models of population needs assessment are being developed in local authorities and the second is a review of various local authority approaches to needs based planning. The focus of the project is on the needs of the elderly and younger physically disabled care groups.

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### The policy context

There has always been a requirement on local authorities to allocate resources in relation to an assessment of the needs of the community. However, local government re-

source allocation had generally been carried out incrementally whereby spending is adjusted year by year, with occasional shifts resulting from local political concerns or in response to some short-term problem, or as a result of spending constraints. On the whole, local authorities have only occasionally attempted to examine spending in relation to patterns of need at local authority level. Needs analysis has usually had little impact on policy or strategic planning.

The NHS and Community Care Act of 1991 has brought about many changes. By separating purchasing from the traditional provider role, the new community care policy has brought about a fundamental change in the planning role of health and local authorities. The policy implies changed assumptions about what constitutes need and requires an improved understanding of local needs. The policy has not only placed a duty on local authorities to assess the needs of the population in support of their Community Care Plans, but has also brought about changes which have by their nature encouraged many local authorities to undertake a more detailed needs assessment. Many local authorities are faced with finite budgets and seemingly infinite demand. For many of them, the key issue is one of geographical equity in resource allocation.

Through individual needs assessments, greater consumer choice and increasingly innovative packages of care provided in the community, the new policy has brought about a situation in which there is a greater variety of demand as well as greater variety in supply, and so increasing the complexity of service allocations. Local authorities have been grappling with these issues and attempting to create models of need assessment which reflect both policy and local considerations and concerns.

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#### **Population needs assessment**

Population needs assessment has been defined as 'the process of estimating, projecting and categorising the needs of a local population'. There are many ways of predicting numbers in need. One method is to carry out a survey of needs, however, this is often time consuming and expensive. Another method is to use existing national or regional surveys after adjusting them to reflect the composition of local populations from the Census and similar sources. Population needs assessment can be an aid to planning services and allocating resources or help in determining budgets for smaller localities. However, locality purchasing must be sensitive to local needs and may produce a different pattern of services from that described by population needs assessment.

Individual needs assessment is a process by which professionals assess an individual in order to determine what services best meet that individual's need, taking into account their needs related circumstances. The two processes of population needs assessment and individual needs assessment are complementary. In reality it appears that the synthesis of these two sources of information gathered from the top-down and from the bottom-up, is a major stumbling block to local authority population needs assessment. This is due to a combination of several factors. First, the information obtained through individual needs assessment is generally not stored in a way which can be easily accessed or aggregated for planning purposes. The local data available as yet is mostly qualitative and anecdotal. Although this type of information does have a place in population needs assessment, it is only of limited use as it is unable to be translated to specific service and resource requirements. Secondly, local authorities have not yet developed methods to integrate individual needs assessment data with national data.

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#### **The PSSRU model**

The needs based planning project addressed these issues by developing a methodology (in collaboration with Surrey SSD) which incorporates local needs assessment data with national data into locally representative estimates of need. The PSSRU work builds on the DHSS 'Balance of Care Model' by adapting it to reflect specific local authority needs, priorities and constraints. A computer based planning model was developed which can be used by local authorities as a basis for estimating need, demand for services and resource distribution.

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#### **Further details**

References and further information are available in PSSRU Discussion Paper 1206/2, *Needs Based Planning for Community Care*, by Andrew Bebbington and Karen Turvey, with Karin Janzon (see page 42 for ordering details).

# Commissioning Choice and Independence

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Julien Forder

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## Objectives

A major programme of research jointly undertaken by the London School of Economics branch of the Personal Social Services Research Unit and the Community Care Division of the Nuffield Institute for Health, University of Leeds, continues to examine the mixed economy of care. The over-arching aim of the new phase of work, under the title *Commissioning Choice and Independence* is to describe, monitor and evaluate the developing mixed economy of social care in England.

The research programme comprises four inter-related activities:

- Description of the broad development of a mixed economy of social care, including the development of the purchasing and providing functions.
- Description and evaluation of the organisation and structure of local authority commissioning functions with particular regard to the perceptions and beliefs of local authorities, their policy positions, and their purchasing and commissioning arrangements.
- Description and evaluation of the organisation and structure of supply, including analysis of the incentives and motivating forces which affect providers in the various sectors, their behavioural processes, and the consequent implications for the mixed economy of care.
- Description and evaluation of the development and regulation of social care, including forms of relationship between purchasers and providers, the respective distributions of control and the framework of incentives that exist in different regulatory settings.

The details of the new DH-funded programme, due to commence in mid 1996, are still under discussion. In this article the focus is the research conducted since 1990, and particularly in the last three years.

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## Methodology

The first of the four component aims — the mapping of the broad mixed economy — was mainly addressed in the first phase of the research programme, conducted between 1990 and 1992. This work provided a detailed account of the intentions and actions of a representative sample of 25 English Social Services authorities in relation to their initial implementation of the community care legislation in general, and their promotion of a mixed economy in particular.

The second phase of the research involved a return to those same authorities for a second mapping of the mixed economy in early 1993. The findings from the 1990-92 work provided us with a broad baseline for the study of more recent changes in policy and practice. Initially, an in-depth study of the purchasing function was undertaken. This sub study evaluated data that was collected from a number of sources, chiefly, telephone interviews with principal officers in our 25 social services departments, face-to-face interviews with Directors and Chairs (or their nominees), and other documentary sources. Also undertaken in this phase was an evaluation of providers of residential and domiciliary care for elderly people in a sub sample of eight local authorities. Data were collected from a postal questionnaire completed by a sample of provider organisations and subsequent face-to-face interviews with key representatives.

Throughout the research programme a balance has been maintained between description and evaluation. Although the former is analytic in the sense that a descriptive account is constructed within a particular frame of reference, the focus is not causal explanation; it seeks to gain a comprehensive picture of a particular context, but does not infer from this an abstract model with which to form generalisable predictions. With this approach we developed an understanding and thematic mapping of:

- the perceptions and beliefs of purchasers in regard to social care markets;
- the behaviour and actions of purchasers, mainly in terms of purchasing and commissioning arrangements and also their collection of information about providers; and
- the motivations and behaviour of providers.

With our evaluative approach we sought to assess the organisation of social care with reference to a set of public policy goals (including choice, independence, cost-effectiveness and innovation) and also a set of more fundamental social, political and economic goals. There were two elements to this. First, we begin by tackling the question of the attainment of public policy goals directly, by eliciting the views of key stakeholders (as we have indicated above, these were predominantly Directors and Assistant Directors of social services and also Chairs of social services committees). In doing so, we were adopting an internal perspective. Second, we took an external perspective in that we applied a theoretical framework that has core presuppositions that are not fundamentally context specific i.e. not specific to social care. In particular, we employed an amalgam of transactions cost economics and mainstream microeconomic theory. This theory was tailored for our purposes according to our observations of the organisation and structure of social care and the motivations and perceptions of key stakeholders. It was used primarily to assess alternative forms of governance or regulation of social care.

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## Findings

Only a small number of our key findings can be included in this article (but see further reading). These relate in particular to the understandings and attitudes of local authority purchasers. Although the number of authorities that could be described as 'market enthusiasts' remained a minority in our sample, by far the largest number of authorities could be categorised as 'market pragmatists'. A crude anti-commercialism in social care was being replaced by a more cautious recognition of the potential benefits and opportunities, as well as the problems, of using markets. Two-thirds of our sample of authorities saw overall advantages in developing markets, although almost all were cognisant of an 'implementation gap', perceiving social care as different from the usual goods and services traded in markets.

Turning to local authority behavioural processes, we found that many authorities had become systematic in their mapping of provision. However, in all but a very small minority these were far from complete, often lacking information vital to successful market orientated purchasing. Some local authorities were beginning to appreciate that their purchasing power could be deployed strategically to achieve their policy objectives. There was some interest in the idea of developing local 'trade-and-industry' policies to counter both the market structural problems and the informational imperfections we found.

At the early stage of development of social care markets, authorities were understandably cautious, and sought to maintain a 'steady state'. Indeed, the commissioning and purchasing arrangements they were operating at the time were perhaps too close to the 'hierarchical bureaucracy' model and thus could be argued to generate excessive transactions costs. Having found this, it was somewhat ironic that the rhetoric and expressed understandings of local authority personnel, charged with the responsibility of strategic market management, was orientated considerably closer to the pure market model. Whilst there is of course a substantial implementation gap, this orientation probably goes too far towards a *laissez faire* market model, and again would generate excessive transactions costs. We argued that the optimal lies somewhere between these endpoints, but that finding it is an elusive task at best.

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## Further reading

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A series of *Mixed Economy of Care* Bulletins is available. Please contact Maureen Weir at the PSSRU (tel. 0171 955 6183).



### Unit Costs of Health and Social Care 1996

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Ann Netten and Jane Dennett

The most recent volume of a series of reports (formerly *Unit Costs of Community Care*) on unit costs of health and community care services became available in June 1996. Each report draws on a variety of sources (primarily regular statistics, research reports and ongoing research) to bring together the most up-to-date information about unit costs. Information is broken down into as much detail as possible and sources identified for a wide variety of services. The objective is to allow users of the report to adapt the cost information presented for their purposes and to substitute more accurate and locally applicable information wherever possible.

The aim of the series is to advance the accuracy and extent of costs knowledge, bringing Each *Unit Costs* volume consists of a set of cost 'schemata' containing specific information about the various component costs of each service covered; a commentary detailing the basis for the estimates; price indices (now with a section explaining their basis and use); a reference list of key studies; a glossary and indexes. All these are checked and updated, incorporating more detailed and accurate information, each year.

New in 1996 is coverage of services for people who misuse drugs and alcohol; of child psychology and psychiatry services; and of multidisciplinary teams for people with mental health problems. Seven original articles provide insights into current and recent research in costing and related areas.

### 'Ready Reckoner' for Unit Costs

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The Department of Health has funded a two-year project to develop a 'Ready Reckoner' for estimating unit costs. The project started in May 1996 and forms part of the Human Resources and Effectiveness Initiative. A primary objective is to provide a user-friendly piece of software which provides estimates of staff and team costs for a variety of circumstances and allows users to select assumptions and substitute values where appropriate. Another key objective is to allow users to incorporate estimates of training and education costs incurred in order to get a qualified and competent health professional to the point of service delivery.

The project will:

- develop the existing approach used in the *Unit Costs of Community Care* reports to formulate a general model for costing staff and teams;
- provide default values where available from the Unit Cost Programme;
- estimate professionally relevant training and education costs for key groups of NHS staff; and
- investigate the theoretical approaches to and empirical evidence about expected working lives in order to facilitate the incorporation of discounted training and education costs into the unit costs of service provision.

# Costing Innovative Respite Services for People with Learning Disabilities

Ann Netten

A study of innovative respite services supported by the Joseph Rowntree fund included detailed case studies of eight schemes selected because of their unusual and flexible approach to providing breaks for carers and opportunities for people with learning disabilities (Hayes et al, 1995). One element of the study was the costing of these schemes in order that those who were interested in providing or purchasing such services could get some idea about the resource implications (Netten, 1994; Netten 1995).

Although there was considerable variation in the services delivered by the eight schemes, from a costing perspective there was a pattern. Common across the schemes was the role of organisers or coordinators responsible in most schemes for (among other duties) ensuring that each user was linked to an individual worker or volunteer. This pattern allowed the development of a worksheet based on the schemata used in this report. The top half of the worksheet identified the resource requirements of the service, helping to ensure that each element was checked when estimating costs and any lack of information was noted. The information about the type of service provided in the lower half of the worksheet fed in to the estimation of the unit cost of the service and facilitated analysis of the type of service being provided. Netten (1994) describes the methodology and assumptions used in more detail.

An important first step when estimating costs is to identify the unit to be costed. One objective the schemes had in common, regardless of whether they were short-term residential, activity-based or sitting was to provide a break to users of the service and their carers. The costs of providing a source of such breaks over a year for a user and their carer is one way to conceptualise a unit cost, as is the cost of each 'break' or session. As these sessions vary from weekends and holidays to a few hours in the pub it is also useful to include the cost of an hour's provision. Taken together these give a helpful picture of how much is provided and at what cost. For example, in table 1 the comparison of the costs of different units gives an insight into the intensity with which breaks are provided. Schemes C and F have similar hourly and sessional costs but the level of provision per user is such that average annual costs per user for scheme C are more than double the costs of scheme F. Clearly scheme F provides a less intensive service than scheme C.

Another consideration is the range of costs per user within each scheme. These varied considerably depending on the type of service. Scheme A, a health authority based scheme in an early stage of development, was costed on the basis of a standard package for each user: two three hour sessions each week and four weekend breaks each year. Scheme C provided a wide range of support from linked carers who provided a few hours occasionally in an emergency to providing one user with two sessions of more than twelve hours every week.

**Table 1**  
**Average unit cost per user (1993/94)**

| Scheme | Number of users | £ per year per user | £ per average session | £ per hour |
|--------|-----------------|---------------------|-----------------------|------------|
| A      | 18              | 15,273              | 102                   | 34         |
| B      | 20              | 5,206               | 60                    | 15         |
| C      | 73              | 1,342               | 65                    | 12         |
| D      | 35              | 1,283               | 49                    | 11         |
| E      | 26              | 936                 | 23                    | 6          |
| F      | 91              | 841                 | 71                    | 18         |
| G      | 78              | 335                 | 38                    | 7          |
| H      | 25              | 1,041               | 118*                  | 5          |

Note

\* per overnight stay

An important first step before comparing costs is to consider the degree to which schemes are providing similar services. The costs of schemes providing residential services necessarily include living expenses and will normally extend over longer periods, including night time when there will be normally be no active input from carers. So although the costs of sessions would be expected to be higher than day care, activity schemes and sitting services, hourly costs would be expected to be lower. The expectation would also be that facility-based day care and activity schemes would incur more direct expenses for transport, hire of equipment and entry fees than sitting services. Clearly services which are facility-based, be they day care or residential, would incur higher capital costs than other services.

The hourly costs of the family-based short term residential scheme (scheme H) are lower than the majority of the other, primarily activity-based schemes. If the costs are compared to facility based residential care, however, the average weekly cost of £826 is considerably higher than that reported for long term local authority residential care (Netten and Dennett, 1995). The direct fees to carers were at similar levels to the direct revenue costs of a local authority bed. It would be expected that short term care would carry much higher levels of overhead cost associated with the organisation of the breaks. When the further complication is added of finding and matching carers to users it is not surprising that overheads should dominate the costs of this innovative short-term family-based residential service.

The scheme with the highest hourly cost, scheme A, catered solely for people with very high levels of disability and challenging behaviours. The effects of focusing on such users were reflected in both higher staffing levels and the skills and experience of the support workers. In contrast to the other schemes nursing staff provided at least one-to-one support for a particularly difficult to care for group of users.

Clearly with so few schemes the discussion about costs must be speculative. However, the main constraint in the discussion both in this study and more generally with respect to respite care costs is lack of information about outcomes (Gerard, 1990). The study reported here was focusing on identifying innovative and interesting approaches to providing breaks for carers and opportunities for people with learning disabilities. This is an important first step. But if those responsible for purchasing and providing such services are to target their resources and efforts in the way that best achieves value for money they need information about the cost effectiveness of these schemes. The current focus on community based care and support for carers are resulting in a growth of respite services. The cost-effectiveness of such services should be a priority for future research.

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- Netten A. and Dennett, J. (1995) *Unit Costs of Community Care 1995*, Personal Social Services Research Unit, University of Kent, Canterbury.

# PSSRU Publications

## Discussion papers

We have space here to reference only the most recent papers. A complete list is available from the PSSRU librarian in Canterbury, who will also be glad to supply copies of discussion papers: please quote the number and title and enclose payment (cheques made payable to 'UNIKENT') with your order. The prices given include postage and the VAT we are obliged to add to reproduction and postage costs. DPs are also available through the inter-library loan system: you will need to provide your library with full details of the DP and the address of the PSSRU. Where papers are subsequently published as journal articles, we advise readers to obtain the relevant journal as this will usually be more up to date and cost less.

## Journal articles

We list some recent articles on PSSRU work in journals and magazines. These are available from the publishers or at libraries.

## Books and monographs

The books and monographs listed can be obtained through bookshops and most are available (post free) direct from the PSSRU in Canterbury: an order form is included on page 48. Prices are correct at November 1996; cheques should be payable to 'UNIKENT'.

## Newsletters

The *Mental Health Research Review 3* (a joint production with the Centre for the Economics of Mental Health at the Institute of Psychiatry) and the *Mixed Economy of Care Bulletin 4* (a joint production with the Nuffield Institute for Health at the University of Leeds) were published in April and May 1996. These (and back issues where in stock) are also available free of charge from the PSSRU in Canterbury. Some back issues of the PSSRU Bulletin are available.

**Further information**, including complete book details, outlines of current projects and forthcoming seminars, and a more comprehensive list of discussion papers, is available from the PSSRU librarian in Canterbury (01227 827773), and may be viewed on the Unit's World Wide Web site at <http://www.ukc.ac.uk/PSSRU/>.

## Recent Discussion Papers

- |   |  |
|---|--|
| <p><b>1231</b> Ken Buckingham, Andrew Bebbington, Sue Campbell, Chris Dennis, Graham Evans, Peter Freeman, Neil Martin, Lynn Oliver</p> <p>Interim Needs Indicators for Community Health Services</p> <p>ISBN 0 904938 89 1</p> <p>Nov 1996</p>   | <p><b>1216</b> Justine Schneider</p> <p>Joint commissioning of services for elderly people</p> <p>Aug 1996</p> <p>£5.00</p>  |
| <p><b>1230</b> Andrew Bebbington, Pamela Brown, Robin Darton and Ann Netten</p> <p>Survey of admissions to residential care – the lifetime risk of entering residential or nursing home care for elderly people</p> <p>Sep 1996</p>   | <p><b>1213</b> Martin Knapp and Shane Kavanagh</p> <p>Economic outcomes and costs in the treatment of schizophrenia</p> <p>Jun 1996</p> <p>£5.00</p>   |
| <p><b>1227</b> Martin Knapp, Daniel Chisholm, Jack Astin, Paul Lelliott, Bernard Audini</p> <p>The cost consequences of changing the hospital-community balance: the mental health residential care study</p> <p>To be published in <i>Psychological Medicine</i>, 1997.</p> <p>Aug 1996</p> <p>£6.00</p> | <p><b>1211</b> Martin Knapp</p> <p>Economic evaluation and interventions for children and adolescents with mental health problems</p> <p>To be published in <i>Journal of Child Psychology and Psychiatry</i>, 1997</p> <p>Jan 1997</p>  |
| <p><b>1222</b> Andrew Bebbington, Pamela Brown, Robin Darton and Ann Netten</p> <p>Survey of admissions to residential and nursing homes for elderly people</p> <p>Jul 1996</p> <p>£5.00</p>  | <p><b>1206/2</b> Andrew Bebbington and Karen Turvey, with Karin Janzon</p> <p>Needs Based Planning for Community Care</p> <p>May 1996</p> <p>£19.00</p>  |
| <p><b>1218</b> Martin Knapp</p> <p>Measuring the economic benefit of treatment with atypical antipsychotics</p> <p>To be published in <i>European Psychiatry</i>, 1997</p>  | <p><b>1205</b> Andrew Bebbington and Robin Darton</p> <p>Healthy life expectancy in England and Wales: recent evidence</p> <p>May 1996</p> <p>£14.00</p>   |
|   | <p><b>1203/2</b> Andrew Bebbington</p> <p>Synthetic estimation methods for resource allocation formulae</p> <p>Jun 1996</p> <p>£5.00</p>   |
|   | <p><b>1200</b> Martin Knapp</p> <p>What do the concepts mean? Lessons from the wider field [value for money and the Guardian Ad Litem service]</p> <p>Paper presented at the National Conference on Guardian Ad Litem and Reporting Officer Service, Skipton House, Elephant and Castle, London</p> <p>Jan 1996</p> <p>£5.00</p> |

|   |        |  |        |
|---|--------|--|--------|
| <b>1192</b> Robin Saunders<br>Le maintien à domicile – l'approche du 'case management'<br>Presented by Robin Saunders to the Centre Interdisciplinaire en Travail Social, Mons, Belgium, 10 March 1996<br>Feb 1996  | £6.00  | <b>1144</b> Jack Astin and Emma McIntosh<br>Comparison of second line agents in the treatment of rheumatoid arthritis<br>May 1995  | £10.00 |
| <b>1190</b> Jennifer Beecham, Lesley Hayes, Martin Knapp, Paul Cambridge<br>Longer-term costs and consequences: community care for people with learning disabilities<br>Presented by Jennifer Beecham at the III International Workshop on Evaluacion y Costes de Las Minusvalias Psiquicas, Jerez, 22-24 June 1995<br>Feb 1996 | £5.00  | <b>1143</b> Jack Astin and Emma McIntosh<br>Review of second line agents in the treatment of rheumatoid arthritis<br>May 1995  | £6.00  |
| <b>1185</b> Andrew Bebbington<br>Health expectancy and long term care costs<br>Jan 1996   | £10.00 | <b>1142</b> Emma McIntosh<br>The cost of rheumatoid arthritis<br>May 1995  | £10.00 |
| <b>1178</b> Justine Schneider and Angela Hallam<br>Specialist work schemes and mental health<br>Final Report to Department of Health<br>Jul 1996  | £16.00 | <b>1139</b> Andrew Bebbington and Robin Darton<br>Alternatives to long-term hospital care for elderly people in London<br>April 1995   | £10.00 |
| <b>1176</b> Bleddyn Davies<br>On the targeting of care management: some implications of PSSRU research synopsis of the talk at the SSI Workshop on Targeting Care Management<br>Sep 1994  | £6.00  | <b>1138/3</b> Andrew Bebbington<br>Children in need: survey design for SSA purposes<br>May 1995  | £6.00  |
| <b>1167</b> Bleddyn Davies, John Chesterman and José Fernández<br>Implications of unmet need [UM], welfare gains [G], and gain/cost (G/C) bases for targeting criteria<br>Presented at BSG Conference, Keele<br>Sep 1995  | £10.00 | <b>1137</b> Jennifer Beecham<br>150 years of mental health services<br>April 1995  | £10.00 |
| <b>1163</b> Julien Forder<br>Incentive contracts and purchaser-provider relationships in community care<br>Sep 1995   | £8.00  | <b>1136</b> Karen Turvey<br>Needs based planning: use of information from individual assessments to develop population estimates of need and use of resources<br>April 1995  | £5.00  |
| <b>1162A</b> Bleddyn Davies, Alisoun Milne and William Warburton<br>Do different case management approaches affect who gets what? Preliminary results from a comparative British study<br>Presented at III European Congress of Gerontology, Amsterdam<br>Aug 1995  | £5.00  | <b>1135</b> Julien Forder, Shane Kavanagh and Andrew Fenyo<br>A comparison of sertraline versus tricyclic antidepressants in primary care. II: Service use and costs<br>March 1995   | £6.00  |
| <b>1161</b> Bleddyn Davies and John Chesterman<br>How case management confers benefits: estimates of the direct and indirect effects from the channeling, the Kent Community Care Project and its replications<br>Presented at the III European Congress of Gerontology, Amsterdam<br>Aug 1995                                  | £6.00  | <b>1134</b> Julien Forder, Shane Kavanagh and Andrew Fenyo<br>A comparison of sertraline versus tricyclic antidepressants in primary care. I: Efficacy and effectiveness<br>Feb 1995   | £6.00  |
| <b>1160/2</b> Ann Netten and Pat Warren<br>Working towards the ideal: the changing environment in KCHT homes<br>Sep 1995  | £6.00  | <b>1133</b> Bleddyn Davies<br>Maintaining the pressure in community care reform<br>Published in <i>Social Policy and Administration</i> , vol. 28, no. 3<br>Sep 1994   | £5.00  |
| <b>1159</b> Bleddyn Davies, José Fernandez, and Robin Saunders<br>On integrating financing and supply coordination mechanisms for the frail elderly. Are there lessons from American capitated/premium-financed risk-bearing managed care models?<br>Presented at SPA Conference, Sheffield<br>Jul 1995                         | £6.00  | <b>1130</b> Jennifer Beecham, Martin Knapp, Sinead McGilloway, Michael Donnelly, Shane Kavanagh, Andrew Fenyo and Nicholas Mays<br>The cost-effectiveness of community care for adults with learning disabilities leaving long-stay hospital in Northern Ireland<br>To be published in <i>Journal of Intellectual Disability Research</i> , 1996<br>Sep 1995 | £6.00  |
| <b>1154</b> Jeremy Kendall<br>UK annex 1 and response to questionnaire. Tables and critical notes prepared for the study 'The cooperative, mutual and non-profit sector in the European Union EUROSTAT survey'<br>Jul 1995  | £10.00 | <b>1127</b> Jennifer Beecham, Angela Hallam, Martin Knapp, Barry Baines, Andrew Fenyo, Michelle Asbury<br>The economic evaluation of community psychiatric reprovion: final report to North Thames Regional Health Authority<br>Oct 1995   | £12.00 |
|   |        | <b>1123</b> Bleddyn Davies<br>Production of welfare evidence: PSSRU's budget-devolved case management experiments<br>Nov 1994  | £8.00  |
|   |        | <b>1121</b> Bleddyn Davies<br>The production of welfare approach: conceptual framework and methodology<br>Nov 1994   | £6.00  |



# Some book chapters and journal articles published in 1996

## Book chapters

Shane Kavanagh and Martin Knapp

### **At the crossroads of health policy, health economics and family policy: whose interest to provide a family-oriented service?**

pp.335-347 in Michael Göpfert, Jeni Webster and Mary V. Seeman (eds) *Parental Psychiatric Disorder: Distressed Parents and their Children*, Cambridge University Press, Cambridge, 1996.

Martin Knapp

### **Rationing in psychiatry**

pp.78-93 in David Healy and Declan Doogan (eds) *Psychotropic Drug Development*, Chapman and Hall, London, 1996.

Martin Knapp

### **The health economics of schizophrenia treatment**

pp.385-395 of Massimo Moscarelli, Agnes Rupp and Norman Sartorius (eds), *The Economics of Schizophrenia*, Wiley and Sons, New York, 1996.

Martin Knapp

### **From psychiatric hospital to community care: reflections on the English experience**

pp.473-484 of Massimo Moscarelli, Agnes Rupp and Norman Sartorius (eds), *The Economics of Schizophrenia*, Wiley and Sons, New York, 1996.

Martin Knapp

### **Are voluntary agencies really more effective?**

in David Billis and Margaret Harris (eds), *Voluntary Agencies: Organisation and Management in Theory and Practice*, Macmillan, London, 1996.

Martin Knapp and Jennifer Beecham

### **Programme-level and system-level health economics considerations**

pp.341-364 in Helle Charlotte Knudsen and Graham Thornicroft (eds), *Mental Health Service Evaluation*, Cambridge University Press, Cambridge, 1996.

Ann Netten

### **Costing breaks and opportunities**

pp.55-70 in Kirsten Stalker (ed.) *Developments in Short-Term Care: Breaks and Opportunities*, Research Highlights in Social Work 25, Jessica Kingsley Publishers, London, 1996 (ISBN 1-85302-134-2).

Ann Netten

### **The costs of informal care**

pp.138-155 in Chris Clark and Irvine Lapsley (eds) *Planning and Costing Community Care*, Research Highlights in Social Work 27 Jessica Kingsley Publishers, London, 1996 (ISBN 1-85302-267-5).

## Academic journal articles

Jennifer Beecham and Martin Knapp

### **Analisi costo efficacia e schizofrenia (Cost-effectiveness analysis and schizophrenia)**

*Annali de Freniatria*, 2, 2, 153-157, 1996.

Pamela Brown, David Challis and Richard von Abendorff

### **The work of community mental health team for the elderly: referrals, caseloads, contact history and outcomes**

*International Journal of Geriatric Psychiatry*, vol. 11, pp.29-39, 1996.

Michael Donnelly, Sinead McGilloway, Nicholas Mays, Martin Knapp, Shane Kavanagh, Jennifer Beecham and Andrew Fenyo

### **One and two year outcomes for adults with learning disabilities discharged to the community**

*British Journal of Psychiatry*, vol. 168, May 1996, 598-606.

Martin Knapp, Vasiliki Koutsogeorgopoulou and Justin Davis Smith

### **The economics of volunteering**

*Non-Profit Studies*, volume 1, 1996.

Michael Donnelly, Sinead McGilloway, Nicholas Mays, Martin Knapp, Shane Kavanagh, Jennifer Beecham and Andrew Fenyo

### **Leaving hospital: one and two-year outcomes of long-stay psychiatric patients discharged to the community,**

*Journal of Mental Health*, vol. 5, no. 3, 245-255, 1996.

Julien Forder, Shane Kavanagh and Andrew Fenyo

### **A comparison of the cost-effectiveness of sertraline versus tricyclic antidepressants in primary care**

*Journal of Affective Disorders*, vol. 38, June 1996, 97-111.

Julien Forder, Martin Knapp and Gerald Wistow

### **Competition in the mixed economy of care**

*Journal of Social Policy*, vol. 25, part 2, April 1996, 201-22.

Martin Knapp

### **Cost-effectiveness in the treatment of schizophrenia**

*European Psychiatrist*, vol. 11, no. 2, 1996, 137-143.

Martin Knapp

### **Resource scarcity chasing scarce resources: health economics and geriatric psychiatry**

*International Journal of Geriatric Psychiatry*, 1996.

Martin Knapp

### **From asylum to community and back again: some resource reflections**

*Shaping British Psychiatry*, no. 2, pp.2-5, 1996.

Martin Knapp and Gerald Wistow

### **Social care markets in England: early postreform experiences**

*Social Service Review*, September, 1996, pp.355-377.

Martin Knapp, Vasiliki Koutsogeorgopoulou and Justin Davis Smith

### **Volunteer participation in community care**

*Policy and Politics*, vol. 24, no. 2, 1996, 171-192.

## Professional journal articles

David Challis and Raymond Warburton

### **Performance indicators for community-based social care: from theory to practice**

*Care Plan*, June 1996, 2, 4, 32-34.

Bleddyn Davies, Raymond Warburton and José Fernández

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*Care Plan*, December 1995, 2, 2, 26-30.

Paul Lelliott, Martin Knapp, Bernard Audini and Daniel Chisholm

### **The cost of living**

*Health Service Journal*, February 1996.

Raymond Warburton and David Challis

### **Good practice identified by research: I. Users' needs and circumstances**

*Care Plan*, Care Management Practice Series No. 2, March 1996, 2, 3, 32-33.

Raymond Warburton and David Challis

### **Good practice identified by research: II. Organisational and professional responses**

*Care Plan*, Care Management Practice Series No. 2, June 1996, 2, 4, 32-34.

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Gerald Wistow, Martin Knapp, Brian Hardy, Julien Forder, Jeremy Kendall and Rob Manning

- As local authorities implement the community care reforms, how are social care markets actually operating? This book is based on detailed research in 25 authorities, and is a worthy successor to the widely welcomed first book, *Social Care in a Mixed Economy*.

Open University Press, Buckingham, 1996. 208 pages. Paperback: ISBN 0 335 19546 6, £15.99, hardback: ISBN 0 335 19547 4, £45.00. Available from bookshops and Open University Press.

### ASSESSMENT IN CONTINUING CARE HOMES: TOWARDS A NATIONAL STANDARD INSTRUMENT

#### A report for the Joseph Rowntree Foundation

David Challis, Iain Carpenter and Karen Traske

- This volume includes a review of UK and overseas care systems and procedures, an examination of existing assessment documents, and recommendations for adapting and piloting a single instrument which can be used for at least six different tasks: individual care planning, management, supervision, analysis of casemix, reimbursement and quality assurance.

PSSRU, Canterbury, 1996. 96 pages, paperback, ISBN 0 904 938 93 X. Available direct from the PSSRU at £8.50 including p&p.

### THE ECONOMIC EVALUATION OF MENTAL HEALTH CARE

edited by Martin Knapp

- How can mental health services be evaluated so as to clarify their resource and outcome consequences? This book introduces and illustrates economic evaluations such as cost-effectiveness, and pulls out policy, practice and research implications.

Arena, Aldershot, 1995. 260 pages. Paperback: ISBN 1 85742 211 2, £14.95.

### THE VOLUNTARY SECTOR IN THE UK

Jeremy Kendall and Martin Knapp;

- This is the first ever comprehensive description and analysis of the scope and scale of voluntary organisations in Britain. The sector's profile is rising steadily in the context of increasing government interest and attention from the general public, as the National Lottery raises awareness of Britain's many 'good causes'. The book fills a major knowledge gap, providing a uniquely detailed mapping of the sector, accompanied by interpretation and analysis of its development and current roles.

Manchester University Press, 1996. 330 pages. Paperback: ISBN 0 7190 5038 3, £10.99, hardback: £35.00.

### VOLUNTARY MEANS, SOCIAL ENDS

Jeremy Kendall and Martin Knapp

- This report summarises the findings of the UK part of a major international study of the voluntary sector. The most comprehensive mapping of the sector to date is outlined, breaking down the sector into categories of voluntary organisation and detailing sources of income, expenditure, and numbers of employees and volunteers. Chapters discuss the sector's relationship with the state and other policy issues.

PSSRU, Canterbury, 1995; 28 pages, paperback, ISBN 0 904938 61 1. Available from the PSSRU, Canterbury, at £5.00 including post & packing.

### UNIT COSTS OF HEALTH & SOCIAL CARE 1996

compiled by Ann Netten and Jane Dennett

- This report provides a wealth of information for those involved in providing or evaluating care and those undertaking costs research. The component costs of 60 types of service are given, with detailed commentary on the basis for these, price indices and sources of the information, and articles on costing research and practice. (The 1994 and 1995 volumes, with articles on different areas of costing practice, are available at a reduced price when purchased with the 1996 issue.) See page 38 for further details.

PSSRU, Canterbury, 1996; 152 pages, paperback, ISSN 0969-4226, ISBN 0 904938 95 6. Available from the librarian at the PSSRU, Canterbury, at £7.50 including post & packing (£5 each for more than one copy). The 1995 volume (paperback, 144 pages, ISSN 0969-4226, ISBN 0 904938 56 5) and 1994 volume (paperback, 104 pages, ISSN 0969-4226, ISBN 0 904938 46 8) are available at the same prices, or at £1 per copy when purchased with the 1996 issue.

### CARE MANAGEMENT AND HEALTH CARE OF OLDER PEOPLE:

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- An innovative approach spanning the health and social care divide, using care managers and multipurpose care workers. The process of care and the outcomes for carers and clients are evaluated and the types of clients who could be most cost-effectively supported by such a project are identified.

Arena, Aldershot, 1995. 380 pages. Paperback: ISBN 1 85742 190 6, £18.95.

**A POSITIVE ENVIRONMENT?**  
**Physical and social influences on people with senile dementia in residential care**

Ann Netten

- An investigation into the relationship between the residential care environment and the welfare of residents with senile dementia.

Ashgate, Aldershot, 1993. 134 pages. Paperback: ISBN 1 85742 112 4, £12.95. Hardback: ISBN 1 85742 107 8, £28.00.

**CARE MANAGEMENT, EQUITY AND EFFICIENCY: THE INTERNATIONAL EXPERIENCE**

Bleddyn Davies

- The first international review of care management, evaluating the equity and efficiency case for its development, in the light of argument, experience and research evidence.

PSSRU, Canterbury, 1992. 183 pages. Paperback: ISBN 0 904938 28 X, available from the PSSRU at £9.50.

**CARE IN THE COMMUNITY: FIVE YEARS ON**

Paul Cambridge, Lesley Hayes and Martin Knapp with Eriko Gould and Andrew Fenyo

- A study of the lives of more than 200 people with learning disabilities who moved from long-stay hospital residence five years earlier. Outcomes, costs, staffing, care management and policy issues are covered.

Arena, Aldershot, September 1994. 121 pages. Paperback: ISBN 1 85742 275 9, £12.95.  
Hardback: ISBN 1 85742 282 1

**SOCIAL CARE IN A MIXED ECONOMY**

Gerald Wistow, Martin Knapp, Brian Hardy and Caroline Allen

- This book reports a collaborative project with the Nuffield Institute for Health, describing the mixed economy of community care in England and analysing the efforts of local authorities to promote and develop it.

Open University Press, Buckingham, 1994. 176 pages. Paperback: ISBN 0 335 19043 X, £14.99. Available from bookshops and Open University Press.

**COMMUNITY CARE IN ACTION: THE ROLE OF COSTS**

Edited by Jennifer Beecham and Ann Netten

- The proceedings of a day conference organised by the PSSRU on the importance of good quality cost information.

PSSRU, Canterbury, 1993. 68 pages. Paperback: ISBN 0 904938 40 9, available from the PSSRU at £4.00.

**COSTING COMMUNITY CARE: THEORY AND PRACTICE**

Edited by Ann Netten and Jennifer Beecham

- An integrated series of papers addressing theoretical principles, methodologies and the practical difficulties of costing social and health care.

Ashgate, Aldershot, 1993. 226 pages. Paperback: ISBN 1 85742 102 7, £14.95. Hardback: ISBN 1 85742 098 5, £32.00.

**HIV HEALTH SERVICES AND NEEDS: THE USER VIEW**

**A study in the Lambeth, Southwark and Lewisham Health Commission area**

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**COMMUNITY CARE: New agenda and challenges from the UK and overseas**

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Arena, Aldershot, 1994. 336 pages. Hardback: ISBN 1 85742 208 2, £35.00.

**Previous titles**

**OLD PEOPLE'S HOMES AND THE PRODUCTION OF WELFARE**

Bleddyn Davies and Martin Knapp

Routledge & Kegan Paul, London, 1981 (hbk, pp. ix + 256). ISBN 0 700 0700 0

Available from the PSSRU at £2.95

**THE ECONOMICS OF SOCIAL CARE**

Martin Knapp

Macmillan, London, 1984, £40.00  
(hbk, pp. xiv + 251). ISBN 0 333 289 58 2.

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*Report of a survey for Canterbury and Thanet Health Authority and Kent County Council Social Services Department*

Robin Darton

PSSRU, Canterbury, 1990 (pbk, pp. viii + 36). Available from the PSSRU, at £3.00. ISBN 0 904938 07 7

## **Titles in preparation**

David Challis, John Chesterman, Rosemary Chessum, Rosemary Luckett and Karen Traske

*Care Management in Social and Primary Health Care: The Gateshead Community Care Scheme*  
Ashgate, Aldershot.

David Challis, Robin Darton and Karen Traske (eds)  
*Community Care, Secondary Health Care and Care Management*  
PSSRU, Canterbury.

Bleddyn Davies, John Chesterman and Barry Baines  
*Budget-Devolved Care Management in Routine Programmes: Outcomes of Two Experimental Evaluations*  
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Bleddyn Davies, José Fernández and Robin Saunders  
*Effects of Benefits in Cash and Kind and Entry to Institutions for Long-term Care in England and France*  
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# Current PSSRU Research Programmes

These pages give brief descriptions of most PSSRU work current at November 1996, categorised by programme (groups of related studies, shown as boxed titles) and individual projects. Staff working on these projects are listed, and they can be contacted at one of the PSSRU's sites for further details.

## Services for Elderly People

*This work has two complementary streams: projects whose focus is care-managed community care and projects whose focus is targeting and the production of welfare in general, including other innovations. Programme directors: Bleddyn Davies and David Challis.*

### Stream 1: Care management projects

*Instigating and evaluating experimental and developmental projects.*

#### Gateshead Community Care Scheme

An evaluation of a social services scheme to delay or prevent admission to institutional care using social workers as care managers with devolved budgets.

Some results published. Monograph available and book forthcoming. David Challis, John Chesterman, Karen Traske

#### Lewisham Care Management Scheme

An evaluation of a care management service for elderly people suffering from dementia based in a multidisciplinary community mental health team.

Results to be published shortly.

David Challis, Richard von Abendorff, Pamela Brown, John Chesterman

#### Mapping and Evaluation of Care Management Arrangements

Initially, description and general analysis of patterns of variation in care management and assessment arrangements being developed in pilot projects and more generally. Later, examples to be more systematically evaluated.

David Challis, Peter Huxley, Robin Darton, Jane Hughes, Karen Traske, Richard von Abendorff, Ann Netten

#### Care Management: International Argument and Evidence

A review of care management arrangements in community and long-term care in various countries, showing how they reflect system contexts and client needs, and describing leading programmes and evaluation evidence about their impact on equity and efficiency.

Monograph published; papers also available. Material being collected for second edition.

John Chesterman, Bleddyn Davies

#### Comparative Community Care Project

Developing argument about what arrangements for case-managed community care fit what client and carer circumstances and local contexts. Based on analyses of PSSRU community care projects and other data based from UK and elsewhere.

Ongoing.

John Chesterman, Bleddyn Davies

### Stream 2: Targeting and the production of welfare in community and residential care

*Monitoring/evaluating standard and innovative mainstream provision.*

#### Evaluating Community Care of Elderly People 1995-2001 (ECCEP)

Comparable but extended collection of data on needs, resources and outcomes in the same areas as the Domiciliary Care Project (1984-90) to show effects of changes in community care policies and other factors.

First two rounds of data collection about cohort of new recipients complete and analysis proceeding.

Bleddyn Davies, Robin Saunders, José Fernández

#### Targeting, Needs, Resources and the Community Care of Elderly People

Secondary analyses to illuminate targeting dilemmas. Papers available.

Bleddyn Davies

#### Targeting Community Care in England and France

Comparison of who gets what quantities of services in three areas of France with data collected for the book *Resources, Needs and Outcomes*, and the project *Changes in Community Care of Elderly People*. Paper and monograph in draft

Bleddyn Davies, Robin Saunders

#### Methodology of Needs-Based Planning

Work with selected local authorities, evaluating the methodological basis of needs-based planning for elderly people. Started 1993. Monograph in draft.

Andrew Bebbington, Bleddyn Davies

#### Long-Term Care Demand, Supply and Finance

Bleddyn Davies, Raphael Wittenberg

## Residential Care Studies

#### Quality of Life in Residential Care

Study of factors influencing quality of life for older people in residential and nursing home settings.

David Challis, Peter Huxley, Caroline Mozley, Caroline Sutcliffe, Heather Bagley

#### Survey of Residential and Nursing Home Care

A three-stage study: census of admissions in 18 LAs, with longitudinal follow-up 6, 18, 30 and 42 months after admission, and cross sectional survey of 21 LAs.

Andrew Bebbington, Pam Brown, Robin Darton, Ann Netten

#### Charges, Resident and Facility Characteristics of Residential Care and Nursing Homes

A study in seventeen authorities.

Report and papers available.

Robin Darton, Ken Wright (CHE, York)

## Unit Costs of Community Care

#### Unit Costs

Drawing on ongoing and past research to produce an annual report on the unit costs of a wide range of services.

Ongoing. Four annual reports available.

Ann Netten, Jane Dennett, Jane Knight

#### Ready Reckoner

Development of software package for estimating health service professional costs, including costs of training and education.

Ann Netten, Jane Knight

#### Related Projects:

- costs of village communities
- costs of dementia care (with NISW)
- costs of medical negligence and mediation

## Economics of Mental Health Services

*A programme of projects evaluating mental health care arrangements. Programme director: Martin Knapp.*

#### Mixed Economy of Mental Health Care

Research on the roles of mental health care purchasers and providers, development of mental health care markets, commissioning tasks, and day care.

Began 1996.

Martin Knapp, Jeni Beecham, Justine Schneider

## Work and Mental Health

A study of seven work settings and 157 service users. Outputs include the costs of work schemes and care packages for people with severe mental illness, data on satisfaction, social support and self-esteem.

1994-96

Justine Schneider, Angela Hallam

## Secondary Analysis of the OPCS Surveys of Psychiatric Morbidity

Broad-based examination of socio-economic issues relating to mental health care. Specific issues include: national/purchasing district estimates of care; factors influencing service utilisation; and the differential provision of services by various providers to sub-groups of people with MH problems.

Began 1996.

Shane Kavanagh, Martin Knapp, Jeni Beecham

## CEMH Research

*Other mental health topics explored at the closely-linked Centre for the Economics of Mental Health, based at the Institute of Psychiatry:*

- child psychiatry
- schizophrenia treatment
- case management
- residential care costs and needs
- psychotherapy
- homelessness
- European service and cost comparisons
- medication compliance
- community reprovision for former long-stay patients

## Pharmaceutical Industry and Economics

*A programme of health economics studies of pharmaceutical products and the pharmaceutical market. In collaboration with Canterbury Business School and Pfizer Ltd.*

*Programme directors: Alan Stewart and Martin Knapp.*

Among these studies are:

- comparative costs of different categories of antidepressants
- bone marrow transplant: prophylaxis of oral fungal infections
- depression amongst the elderly
- pharmaceutical markets in the EC
- pharmacotherapy for benign prostatic hyperplasia
- osteoarthritis and non-steroidal anti-inflammatory drugs
- rheumatoid arthritis: evaluation of novel treatments
- pharmaceutical pricing policies
- drug treatment of schizophrenia

Alan Stewart, Stephen Almond

## The Mixed Economy

*Programme director: Martin Knapp.*

## Commissioning Choice and Independence

Description and evaluation of the mixed economy of care in England, particularly focused on markets. Programme components:

- social care commissioning
- provision in market contexts (residential care for elderly people; domiciliary care)
- user and carer perspectives on the mixed economy
- the contracting process
- assessment and the care management process in market settings

In collaboration with the Nuffield Institute for Health, Community Care Division, University of Leeds (Gerald Wistow) to 2000.

Martin Knapp, Julien Forder, Jeremy Kendall

## Comparative Non-Profit Sector Project: Phase 2

UK component of international comparative study of scale, scope, characteristics of the voluntary sector. Includes historical, legal and policy aspects.

In collaboration with Johns Hopkins University, USA, to 1998.

Jeremy Kendall, Martin Knapp, Stephen Almond

## Needs Indicators

*A programme of projects designed to stimulate need indicators that reflect the implications for resources of judgements about ends and means in the social care of areas' populations.*

*Programme director: Andrew Bebbington.*

## Unit Costs of Personal Social Services in London

Fieldwork stage.

This research distinguishes cost-raising factors which are beyond the control of local authorities from those which are potentially avoidable.

Andrew Bebbington

## CHS Need Indicators

Examination of need indicators for Community Health Services, for resource allocation formulae. Joint project with Plymouth University.

Andrew Bebbington

## Equity and Efficiency: Comparative Studies

The utilisation of a collection of data about local authority needs, provisions and spending since 1974 for studies of territorial justice and efficiency.

Ongoing. List of papers on request.

Andrew Bebbington, Bleddyn Davies

## Healthy Active Life Expectancy

A joint project with the OPCS which is producing quantitative estimates of HALE for the UK and examining factors that influence it.

Ongoing series of papers.

Andrew Bebbington

## Alternatives to Long-Stay Hospital Care in London

Andrew Bebbington, Robin Darton

## Information Systems

## Performance Indicators for Services for Elderly and Mentally Ill People

Development, implementation and evaluation of social services performance indicators for these client groups.

David Challis, Peter Huxley

## Health Care Resource Groupings and Care Packages

Study of the viability of these as potential as management monitoring and contracting currency.

David Challis, Peter Huxley, Jane Hughes, Justine Schneider

## National Consistency in Care Packages

A study of normative and empirical care packages in information systems

David Challis, Peter Huxley, Jane Hughes, Justine Schneider

## Other Health and Social Care Projects

*Further projects directed from the Manchester PSSRU site which are not listed above include:*

- the relationship between care programmes and care management
- national standard assessment instrument in care homes
- definition of severe mental illness and health/social services prevalence (MARC-1)
- training social workers to help carers of schizophrenia sufferers
- development of a university nursing home
- information to support planning/commissioning of mental health services
- joint commissioning
- social work intervention for adolescent self-harm
- UK800 case management study
- GP attitudes to opiate users and outcomes of treatment
- learning materials on mental health
- Care Programme Approach support system (CPASS)
- monitoring a mental health support service
- monitoring the Mental Health Act
- Lancashire Quality of Life Profile