

PSSRU Bulletin 11

February 1999

PSSRU

at the University of Kent at Canterbury,
the London School of Economics
and the University of Manchester

Acrobat™ version

Please note that this Acrobat™ format download may not exactly match the appearance of the original printed version of this publication (which is available from the PSSRU librarian: telephone 01227 827773).

The authors retain the copyright in this publication. While it may be freely distributed as an Acrobat™ file, quotations must be acknowledged and permission for use of longer excerpts must be obtained in advance.

We welcome comments about PSSRU publications and would appreciate notification of problems with electronic versions.

PSSRU website: <http://www.ukc.ac.uk/PSSRU/>

Contents

Introduction:	3
Projecting Demand for Long-Term Care for Elderly People	5
Community Mental Health Care: Research Insights	8
Mapping Care Management Arrangements for Older People	12
Is the Independent Sector Important in Social Care?.....	14
National Evaluation of Health Action Zones	18
A 'Ready Reckoner' for Staff Costs in the NHS.....	21
Elderly People and Primary Care.....	23
1996 Survey of Care Homes for Elderly People.....	24
Needs Based Planning for Community Care.....	27
Evaluating Community Care for Elderly People: Outcomes for Users and Carers	30
Recent PSSRU Publications	33
PSSRU Research Programmes.....	34

The PSSRU

The Personal Social Services Research Unit was established at the University of Kent at Canterbury in 1974. Since 1996 it has been a multi-site unit, with branches also at the London School of Economics (LSE) and the University of Manchester.

Its mission is policy research and analysis on equity and efficiency, and so of resources, needs and outcomes, in community and long-term care and related areas.

A brief listing of current research projects can be found on pages 34-35; contact details for the three PSSRU branches are on the back cover.

About this Bulletin

The PSSRU Bulletin is a guide to the work of the 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.

The Bulletin is distributed free of charge to all local authorities, health authorities, relevant voluntary organisations, and to others on request. If you would like further copies, please contact the PSSRU librarian, Clare Valentine (phone 01227 827773; fax 01227 827038; email C.Valentine@ukc.ac.uk). If this copy was wrongly addressed, please let us know.

We welcome comments on this Bulletin or other aspects of our work and would like to thank those readers who returned the questionnaire in issue 10.

Other PSSRU publications

A wide range of publications disseminates the PSSRU's work. Some are mentioned in the articles which follow and a more complete list is available separately.

The Unit web site (see below) gives a complete listing, with summaries of longer publications and complete versions of shorter ones (including this Bulletin and previous issues).

PSSRU web site

<http://www.ukc.ac.uk/PSSRU/>

This gives up to date details of Unit research, publications and staff.

© PSSRU 1999

This issue of the PSSRU Bulletin was edited by Andrew Bebbington and Ken Judge, sub-edited and typeset at the PSSRU by Nick Brawn and printed by the University of Kent Printing Unit.

Published by:
Personal Social Services Research Unit
Cornwallis Building
The University of Kent
Canterbury
Kent
CT2 7NF

ISSN 1350-4703

The research reported in this Bulletin was undertaken by the PSSRU, which receives support from the Department of Health; the views expressed are those of the authors and not necessarily those of the Department of Health or other PSSRU funders.

Introduction:

Modernising Social Services, Policy and System Maturity, and the PSSRU

Bleddyn Davies

How can the PSSRU contribute most to the challenge of *Modernising Social Services* (the November 1998 white paper, Cm 4169)? First, we must keep our portfolio of work abreast with and, if possible, ahead of the times. We like to think that PSSRU's record has been good on both counts. We have done as much as any to define, explore, and test methods of tackling some of the issues which are the substance to the modernisation policy. But the portfolio is substantially a reflection of our assumptions and policies. So, second, we must be quick to make the continuous changes in them. There have been fast and radical changes in policy and the process of adaptation in the PSSRU, some working through strategic choices made during the mid 1990s.

Several strands should influence our assumptions. One is the increasing maturity of policy content and systems. A second is the depth of our knowledge and expertise in some areas important to the modernisation policy; itself a form of maturity. A third is the maturity of a wide range of the researcher-managerial cadres of the PSSRU.

Maturity of policy and of the policy system

Of course, we understand that policy institutions have been kaleidoscopic and that rapid change is intended to continue. Similarly, we understand that there are areas of policy in a state of flux and that all are intended to change radically. Nevertheless, both policy and the system are becoming mature in a sense which has a direct implication for the management of the PSSRU.

Contrast the situation during PSSRU's first decade. The PSSRU was founded on the crest of the post-Seebohm wave, and so in the middle of dramatic growth and change. But it was the time when the wave was about to break. It became increasingly difficult for policy-makers and managers to set a consistent course guided by a clear vision. Over years, it became obvious that the only certainties were that growth would fall, that expectations could not be financed, that fundamental roles and priorities would have to be painfully rethought and even more painfully re-learned by a policy community whose beliefs and values had been created in a period of exceptional optimism. Still more slowly, it was realised that

efficiency as well as effectiveness would have to be taken seriously.

That chaotic world of shattering dreams and paradigms was the setting for the PSSRU's most creative and seminal period. Not that the PSSRU was particularly popular, particularly as its new ideas began to be of influence. For the first decade, budget-devolved care management was seen by some to be so dangerous that an attempt was made to declare it *ultra vires*. By some, not those who had actually read the statements of its logic or absorbed the abundant evidence about its outcomes, it was accused of undermining, not strengthening, the capacity of the social services departments to achieve those enduring policy goals of modernisation, first felt for by Seebohm. And we were asked what led us to imagine that targeting would ever do anything but make us enemies in a social services culture. But we ourselves were confident that we had something to contribute. Having the confidence of powerful allies too, we were left to get on with it. That in effect allowed us to have had ten years for developing our production of welfare approach and field experimentation before Roy Griffiths and the big guns directed everyone's attention at precisely our formulation of issues, policy and academic.

It was the very immaturity of community care policy that had allowed this. It no longer applies now that the system has matured. Therefore, much of our contribution to reformulating issues must be seen by our customers as potential value added to work which produces their certain and immediate gratification. It is largely specified in collaboration with customers, delivered within a defined time-scale, and quickly disseminated broadly and effectively to policy-makers and practitioners.

Not there are no longer areas requiring radical thought and development. There remain some strategic issues for which the best path for development is as difficult to see as ever, though the problems have long been there. The coordination of effort across agencies is an example. Health policy and the social services White Paper between them set up machinery to allow the 'partnership' issues to become better understood and to allow productive answers to be created. But they have yet to be developed, codified, and understood in the way that only evaluation can permit. A large part of the problem is that the policy-makers and managers

(like academics) have a clear vision only within the boundaries of their competence. The PSSRU's vision must not be blurred at exactly the boundaries over which its policy customers find it most difficult to peer. It would be negligent because it is the responsibility of academics more than others to enter new territory, to explore the unknown. The PSSRU is therefore committing itself to using the Health Action Zone pilots to look across this divide.

In the same way, there are areas of technology development and assessment which also require radical thought and analysis. The Manchester branch of the PSSRU is positioning itself to become the leader in the application in the UK of ideas about the relationship between the handling of evidence collected at field levels for care management purposes and other functions in community care; a field currently experiencing enormous investment from agencies and academe in all the leading countries.

It was said of the eminent biologist Alan Hodgkinson that he had the imagination to allow him to see what the leading problem would be seen to be five years later and to see how to engage it. That gave him time to have set his lab to work on it for long enough to be well on the way to solving the problem before the rest of the scientific community understood its importance and turned their attention to it. The PSSRU will need that vision in our contemporary world of mature policy and systems.

Maturity of the production of welfare approach

The protocol setting up the PSSRU in effect defined its mission to be the development and application to analysis and research of the production of welfare approach. Applying POW to analysis of equity and efficiency issues has been a hallmark of the PSSRU. It has developed the approach throughout: from the time when its questions aroused the deepest suspicion and almost slanderous attacks through reluctant acknowledgment that the issues are interesting, to its acceptance as a worthwhile part of the knowledge base for successful modern practice. The approach is now internationally acknowledged. Its applications have been of direct policy use. The application not just applies the clear application of principle, accumulated know-how, and much painstaking effort, but on occasions more than the usual technical sophistication. Only now has it managed to map productivity effects of services for a large number of outcomes and user

circumstances. Using the map gives clear policy messages with a new evidential authority. More than ever before, policy-makers and managers at all levels are conscious that they need answers to POW questions. The White Paper repeats what Roy Griffiths and the Audit Commission have so often written about with such acerbity: the informational ignorance about resources, costs, needs and outcomes in which policy-making, management and practice are undertaken.

The maturation of the PSSRU

The PSSRU will be 25 in October 1999. A quarter of a century is quite long enough for the bright new recruits, straight from the Master's degree or doctoral research *cum laude*, to grow into world-recognised academic leaders rising 50, at the peak of creativity. The Unit must now give their abilities due scope. This new generation and those of great ability following on must take the strategic management roles. Partly for this reason, the Unit has become increasingly corporately managed. The Unit's ever-increasing complexity strengthens our commitment to corporatism, and makes it necessary for this corporatism to be fully reflected in its formal structures.

To take advantage of the momentum of recent changes, and subject to DH contract review and agreement, I shall cease to be Unit Director at the beginning of the next academic year. The powers of Unit Director will be vested in a directorate consisting of the three Branch directors and myself (in a non-executive role). The Branch directors will take it in turns to be *primus inter pares* and convene the directorate for a period of years. The first of these leaders will be Professor Martin Knapp. Nothing gives an ageing academic more pleasure than to pass the leadership to stars who combine a new level of managerial experience and expertise with such personal academic prowess. With such leaders and teams, no one can doubt that the PSSRU will contribute massively during the next quarter of a century. Indeed, the promise is for an endless succession stretching out over academic generations like Banquo's descendants – God and the Department of Health willing.

Reference

Cm 4169 (1998) *Modernising Social Services: Promoting Independence, Improving Protection, Raising Standards*, The Stationery Office, London.

Projecting Demand for Long-Term Care for Elderly People

Raphael Wittenberg

How many elderly people are likely to require long-term care services in the next decades? How much are these services likely to cost? Will the cost to public funds prove affordable? These questions are considered in the Unit's recent report *Demand for Long-Term Care: Projections of Long-Term Care Finance for Elderly People* (Wittenberg et al., 1998).

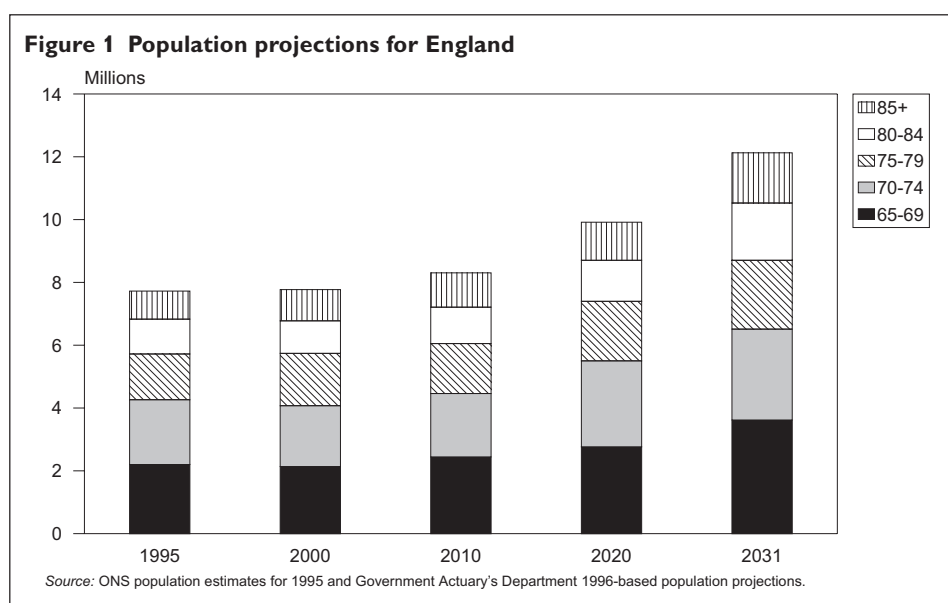
There has in recent years been some debate, and various analyses, concerning likely future demand for long-term care for elderly people. This has been prompted by the wider policy debate about how best to finance long-term care. The policy debate has culminated in the establishment of the Royal Commission on Long-Term Care for the Elderly. Its report was expected shortly as this Bulletin went to press.

To inform 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 socio-economic 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.

The Department of Health agreed a new study of long-term care demand and finance as part of the Unit's long-run programme of research at the London School of Economics. Its aims are to make projections of likely demand and expenditure on long-term care for elderly people in England to 2031. Projections had previously been made for this country by at least three agencies: the Institute of Actuaries (Nuttall et al., 1994); London Economics and the Institute for Public Policy Research (Richards et al., 1996); and the Department of Health (House of Commons Health Committee, 1996). The Unit sought to learn from and build on these earlier studies.

The study has involved the development of a computer simulation model. It has also involved literature reviews and analyses of various sources of data. The Unit's recent report describes the model, discusses some of the key issues that were addressed in producing the model, and outlines some illustrative projections made using the model.

The projected continued growth in the numbers of elderly people is one of the factors that have prompted concern about the affordability of long-term care over the next decades. The numbers of elderly people in England (aged 65 and over) are projected by the Government Actuary's Department to rise by almost 57% between 1995 and 2031. The numbers of very elderly people (aged 85 and over) are projected to rise more rapidly, by around 79%. Almost half the growth in overall numbers is expected to occur in the period 2020 to 2031. This is illustrated in figure 1.



Long-term care would need to expand by around 61% between 1995 and 2031 to keep pace with the rising numbers of elderly people if no account is taken of other factors. This is in terms of home care hours, community nurse visits, residential care weeks etc. If the numbers of very elderly people (aged 85 and over) grew by 1% per year more than expected, long-term care would need to expand by 92% rather than 61%. Projections are sensitive to the projected numbers of very elderly people.

There is considerable debate about whether age-specific dependency can be expected to rise or fall (Bone et al., 1995). An optimistic view is that there will be a compression of morbidity and that the expansion of life expectancy will be associated with a contraction in the average number of years with disability. A pessimistic view is that there will be an expansion of morbidity and that the expected continued increase in life expectancy will be associated with an increase in the average number of years with disability.

This study confirmed the findings of earlier studies that projections of long-term care expenditure are sensitive to assumptions about future rates of dependency among elderly people. If, on a pessimistic scenario, (age-specific) dependency rates rose by 1% per year, long-term care would need to expand by 121% rather than 61% on the basis of unchanged dependency rates. If, however, on an optimistic scenario, (age-specific) dependency rates fell by 1% per year, long-term care would need to expand by only 18% between 1995 and 2031.

The study considers a range of services relevant to meeting long-term care needs of elderly people. Informal care by family and friends is included both because it is important in its own right and because it is a key determinant of receipt of formal services. The formal services covered include both care in residential settings and day and domiciliary services in the community.

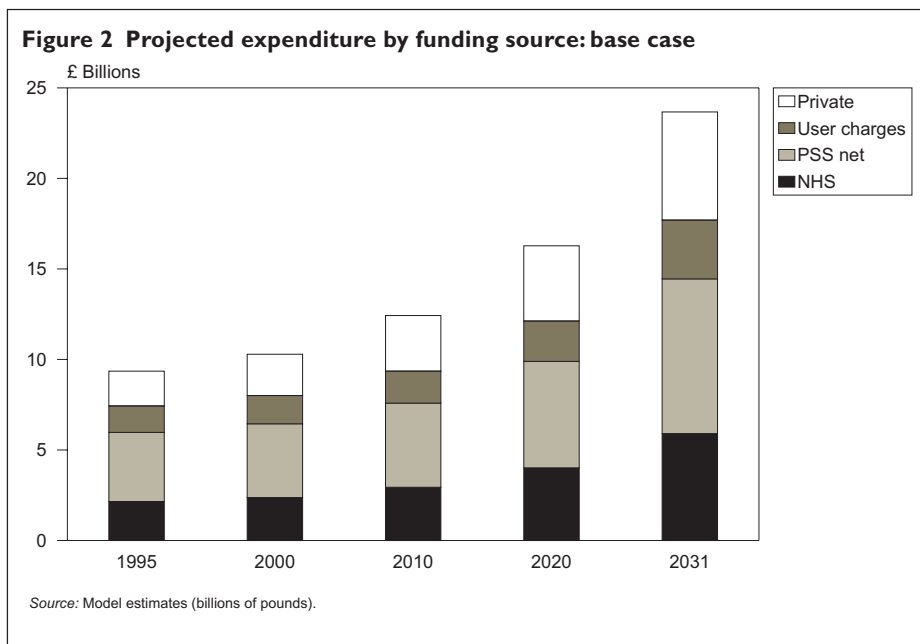
Future trends in the availability of informal care are likely to have considerable implications for demand for formal care. Yet there is much uncertainty about the future supply of informal care (Allen and Perkins, 1995). The changing age structure of the population, rises in employment rates among married women, and rises in divorce rates have all been cited as reasons for a potential decline in informal care supply relative to a growing number of elderly people. It is not, however, clear that these factors will actually result in a decline in informal care supply. The study has explored different scenarios that aim to take into account uncertainty about the future supply of informal care.

Domiciliary services covered by the model include social services, such as home care, day care and meals; health services, such as day hospital care, community nursing and chiropody; and private domestic help. The probability of receipt of each of these services was estimated, through multivariate analysis of data from the 1994/5 General Household Survey. The analysis was by age, dependency, household type, housing tenure, and receipt of informal help with domestic tasks. Intensity of service receipt, the number of hours or visits received, was also examined. The numbers of people receiving home care are projected to rise by around 62% and the numbers receiving community nursing by around 61% between 1995 and 2031. This is on the basis of an unchanged relationship between receipt of services and the factors mentioned above.

Institutional care is also included in the model. Department of Health data and data from recent Unit surveys of residential care and nursing homes were used in the model (Bebbington et al., 1996; Netten et al., 1998). Institutionalisation is treated as a function of age, gender and (previous) household type. The numbers of people in residential care homes are projected to rise by 64%, the numbers in nursing homes by 64% and the numbers in long-stay hospital care by 62% between 1995 and 2031. This is on the basis of an unchanged relationship between receipt of these services and age, gender and whether or not living alone.

Financial projections over a substantial period of time are highly sensitive to assumptions about changes in the real unit costs of services. These will be affected by a range of factors including changes in input prices especially real wages in the caring sector, changing technical efficiency of service provision, and any changes in the quality of services and expected outcomes. The study takes as a base case an assumption that social care costs will rise by 1% per year and health care costs by 1.5% per year in real terms. On this basis long-term care expenditure would need to rise by 153% between 1995 and 2031. This projection needs to be compared with expected rises in economic output. If Gross Domestic Product (GDP) rose by 2.25% per year, this would constitute a rise of 123% over the period 1995 to 2031.

A key topic of interest is how much of the projected expenditure is likely to be met from public expenditure and how much by elderly people and their families. On the basis of the current funding system, total NHS long-term care expenditure is projected to rise



by 174% between 1995 and 2031, social services net expenditure by 123% and private expenditure by 173%. These projections, which are illustrated in figure 2, should be regarded as illustrative only. They are subject to a wide range of assumptions, to which they are sensitive. They are particularly sensitive to the projected rate of growth of the very elderly population, to trends in age-specific dependency rates, and to assumptions about real rises in the unit costs of care. The breakdown between sources of funding is also sensitive to the extent of the likely rise in the proportion of residents of care

homes who do not qualify for public funding because of their housing assets.

The report sets out a range of different projections obtained using the model. These are compared to a base case. Under the base case, expenditure is projected to grow by 153% from £9.4 billion to around £23.7 billion (in constant 1995/6 prices) between 1995 and 2031. If unit costs grew by 1% more than in the base case, for example, total expenditure would rise by 260% in the same period. If, to take another example, age-specific dependency rates fell by 1% per year, total expenditure would rise by only 85% between 1995 and 2031.

The base case relates to current patterns of care. This enables the effects of changes in the level and quality of care to be clearly distinguished from the effects of demographic and social change. It does, however, mean that the base case does not take into account the potential impact of rising expectations. The effect of rising real incomes and rising expectations may be important.

Projections produced using the model have been provided to the Royal Commission on Long Term Care. It would be valuable to consider ways in which the model could be used further to help inform policy and planning. The Unit plans to continue work to develop the model and to use it to inform policy.

References

- Allen, I. and Perkins E. (eds) (1995) *The Future of Family Care for Older People*, HMSO, London.
- Bebbington, A., Brown, P., Darton, R. and Netten, A. (1996) Survey of Admissions to Residential Care, SSA Analysis Report, Discussion Paper 1217/3, PSSRU, University of Kent at Canterbury.
- Bone, M.R., Bebbington, A.C., Jagger, C., Morgan, K., Nicholaas, G. (1995) *Health Expectancy and its Uses*, HMSO, London.
- House of Commons Health Committee (1996) *Long-Term Care: Future Provision and Funding, Volume II, Minutes of Evidence and Appendices*, HC 59-II, HMSO, London.
- Netten, A., Bebbington, A., Darton, R., Forder, J. and Miles, K. (1998) 1996 Survey of Care Homes for Elderly People: Final Report. Discussion Paper 1423/2, PSSRU, University of Kent at Canterbury.
- Nuttall, S.R., Blackwood, R.J.L., Bussell, B.M.H., Cliff, J.P., Cornall, M.J., Cowley, A., Gatenby, P.L., and Webber, J.M. (1994) Financing long-term care in Great Britain, *Journal of the Institute of Actuaries*, 121, part 1, 1-68.
- Richards, E., with Wilsdon, T. and Lyons, S. (1996) *Paying for Long Term Care*, Institute for Public Policy Research, London.
- Wittenberg, R., Pickard, L., Comas-Herrera, A., Davies, B. and Darton, R. (1998) *Demand for Long-Term Care: Projections of Long-Term Care Finance for Elderly People*. PSSRU, University of Kent at Canterbury.

Further information

A brief research bulletin summarising this work is available free of charge from the PSSRU librarian in Canterbury and may be viewed/downloaded from the PSSRU Web site.

The full report *Demand for Long-Term Care: Projections of Long-Term Care Finance for Elderly People* (ISBN 0 84014 584 6) was published by the PSSRU in December 1998 and is available direct (post free) from the PSSRU in Canterbury, price £11.00.

Community Mental Health Care: Research Insights

Martin Knapp

The developing policy context

Further information

Fuller details of PSSRU research on mental health care are published in the *Mental Health Research Review*, which is jointly published with the Centre for the Economics of Mental Health.

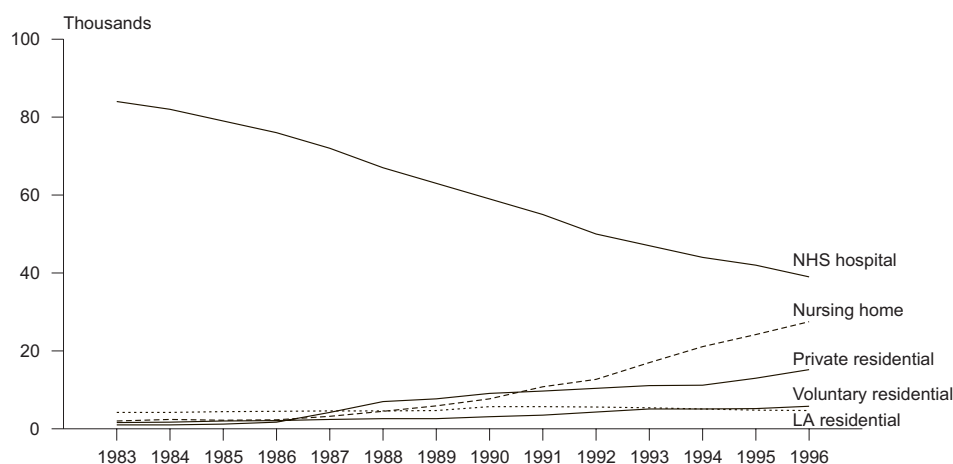
Issue 5 (May 1998) is available free of charge from the PSSRU in Canterbury and can be found on the PSSRU web site. Issue 6 is due to be published in April 1999.

In the mental health care area, one theme has dominated policy and practice discussions in Britain over the last 20 years — *community-based care*. This theme has also dominated much of the PSSRU's programme of research on mental health economics and policy. What have we found?

In the early 1980s the focus of much national discussion was predominantly on whether and how long-stay residents of the former Victorian asylums could move to community settings. Inter-service and inter-agency coordination of support was one particular emphasis at that time, and care management was beginning to be encouraged. Although misgivings were expressed in some quarters about hospital closures and the policy of community rehabilitation, public and media criticisms of community-based care were nothing like as marked, or indeed as vitriolic as they became in the 1990s. Anyway, it soon became apparent that most people with mental health problems were able to move successfully to the community without being a danger to themselves or to others.

Opposition to the policy of closing the long-stay psychiatric hospital provision was arguably initially misdirected: certainly public safety was not threatened by the former long-term hospital residents now living in community settings. Nor were these the people to be found living rough on Britain's streets. Community mental health beds grew in number to provide supported accommodation outside hospital (see figure 1). Attention turned to those people experiencing acute episodes of illness. But, as the specialist hospitals closed, so too did the acute wards within them. The relocation of these services to general hospitals rarely included sufficient provision for people who had moved to community residence but would intermittently need in-patient care. Despite rising in-patient occupancy rates (well in excess of 100% in some inner city hospitals), many people were not able to gain admission to psychiatric in-patient care or now found themselves discharged from hospital after only a short stay. Many of these people lost contact with services.

Figure 1 Hospital and community mental health beds, 1983-1996



Source: Comas and Knapp calculations from DH data.

One of the pressing questions of the 1990s has been whether it is possible to build up effective support services to allow acutely mentally ill people to remain in the community. Attention in the early years of the decade was given to service coordination (for example through the Care Programme Approach) and — in a more modest way — to agency coordination (such as via the Mental Illness Specific Grant). Certainly the funding arrangements for com-

munity-based care are far more complex than those governing in-patient care. Numerous problems can arise (Kavanagh and Knapp, 1995). For example, the new demands on some services and professional groups (such as general practitioners) have perhaps not been fully appreciated.

More recently, Health Ministers have emphasised, among other things, 24-hour crisis services, nurse-staffed hostels and assertive outreach as parts of a system of 'safe, sound and supportive mental health and social care services'. The National Service Framework for mental health is aiming to set out these and other objectives in more detail.

An economics agenda As always, there is an important ‘economic agenda’ running through mental health policy today. This agenda has both macro and micro aspects: questions are raised both about the operation of the whole mental health care system, as well as about the efficiency and equity of specific care and treatment arrangements within it.

This is also the agenda for the PSSRU mental health economics and policy programme. Since the Unit started to conduct research on mental health care in the mid 1980s, the programme’s work has been heavily influenced by the developing policy and practice contexts.

Research objectives The primary aim of the mental health economics and policy programme is to conduct inter-disciplinary research of the highest quality, informed by theory and responsive to the needs of policy and practice communities.

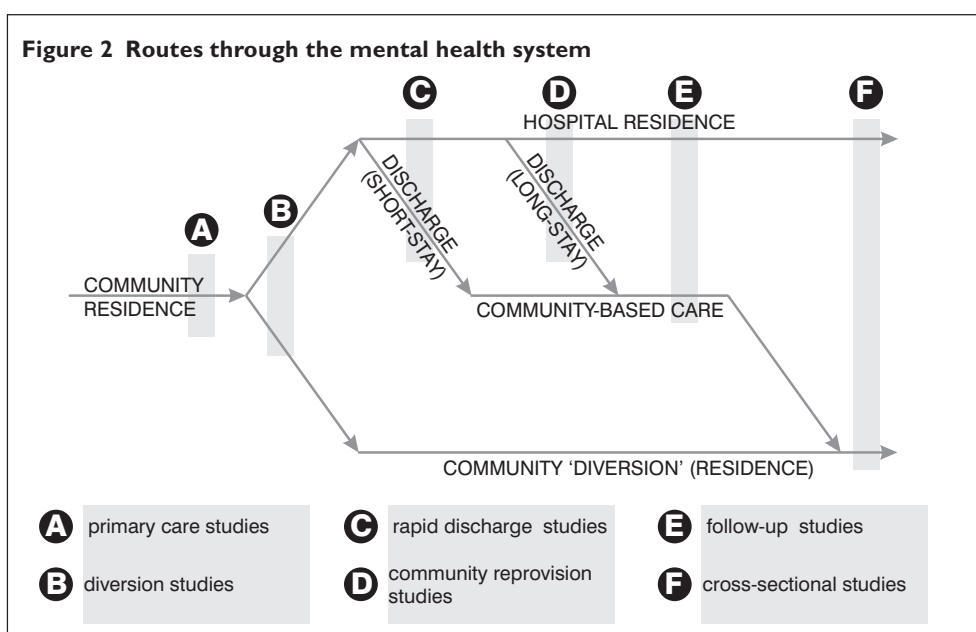
Much of the research conducted within the programme has been genuinely inter-disciplinary, but an important aim has been to make appropriate use of economic concepts, methods and techniques. This bias towards economics does not stem from the belief that this disciplinary perspective is inherently superior to others. Nor is it because some members of the programme team are economists. The reason is because the approach offers many relevant insights, for example about efficiency in the use of resources (allowing greater benefits to be achieved from given resources) and equity in the achievement of outcomes.

The Unit’s research in the mental health field is quite wide ranging, but here the spotlight is trained on a few studies which have been particularly concerned with community-based care.

Community care Figure 2 gives a highly simplified representation of the mental health care system, showing stylised routes through community and hospital-based services. Imposed upon the diagram are six types of research study. It is immediately clear that even a highly simplified model of a mental health care system and a short selection of research studies suggests a large research agenda. Not surprisingly, relatively little research evidence has yet accumulated to address the issues raised by this agenda. There are, however, two areas where evidence looks compelling: community ‘reprovision’ for former long-stay hospital residents, and community diversion (such as assertive outreach) for people with acute illnesses living in the community.

Community reprovision The most comprehensive evaluation of community-based care for former long-stay in-patients has looked at the closure of Friern and Claybury hospitals in North London (Leff, 1997). The former residents of these two hospitals have been studied for five years since their discharge from hospital, with a lot of evidence collected on their quality of life, health status, accommodation, service use patterns and costs.

The outcome findings suggest that former in-patients were enjoying a quality of life at least as good as in hospital. (These results come from as yet unpublished five-year, follow-up work by Julian Leff and col-



leagues, but the one-year follow-up results were very similar: see Leff, 1997.) There were no problems with higher-than-normal mortality, nor with homelessness or crime. Accommodation stability in the community was impressive, and care environments were much better than in hospital. Social networks were stable but sometimes unsatisfactory — a minority gained in this respect, but most people were not socially integrated into local communities. Hospital readmissions were quite common (38% of the sample had at least one readmission over a five-year period). Careful examination of clinical outcomes revealed striking stability over time in both psychiatric symptoms and social behaviour. However, users clearly preferred community living to hospital.

Our associated economic evaluation found that many services were used in the community (Beecham et al., 1997). Patterns of service use changed over the five-year follow-up period. The costs of these services when aggregated were no different from the costs of the long-stay hospital care which people had left. Consequently, the weight of the cost and outcome findings suggested that community care was more cost-effective. Higher cost community care packages appear to be associated with better individual outcomes. Care appears to be more cost-effective in the public than in the private sectors (Knapp et al., 1999).

**Community diversion
(assertive outreach)**

A lot of policy attention has been focused on the assertive community treatment or outreach model (ACT) originally developed in Madison, Wisconsin. There are, of course, many different arrangements now in place to coordinate community care for people with mental health problems, and many variants of ACT, but UK Ministers intend to include some form of this service model in their new policy framework.

The Daily Living Programme (DLP) was a UK adaptation of the Madison model. It offered intensive home-based care for seriously mentally ill people facing crisis admission to the Maudsley Hospital. The DLP was set up and evaluated by Isaac Marks and colleagues, and my colleagues and I were invited to conduct the associated cost-effectiveness analysis (a 'cost-consequences analysis' in current terminology).

A randomised controlled study examined the cost-effectiveness of the DLP compared to standard in/out-patient hospital care over 20 months, followed by a randomised controlled withdrawal of half the DLP patients into standard care. Three patient groups were therefore compared over 45 months, depending on the support they received: DLP throughout the period, DLP for 20 months followed by standard care, and standard care throughout. The economic evaluation found the DLP to be more cost-effective than standard care over months 1-20, and also over the full 45 month period, but the difference between groups may have disappeared by the end of month 45 (Knapp et al., 1998). The reduction of the cost-effectiveness advantage for home-based care was perhaps partly due to the attenuation of DLP care (particularly the loss of responsibility by the DLP team for in-patient admissions and discharges).

Employment

At a lower level of aggregation, there are important service components within community-based care which have featured strongly in the PSSRU's recent research portfolio. Two particular emphases have been employment services and day activity settings. Both are of especial concern given the high rate of unemployment among people with serious mental illness and the need for day activity services in a holistic model of care.

The research on employment looked at four broad types of provision (social firms, supported employment, sheltered employment and vocational training). The evaluative questions which the research addressed were: What sort of people use specialist work schemes? How much do work schemes cost? How do these costs compare to those of other day care settings? Are differences in life satisfaction and service use associated with different work settings?

Among the findings from the empirical research were the following:

- There were wide variations in the profit margins and staffing ratios of work schemes. These were reflected in the unit costs.
- The size of personal networks did not vary significantly between groups.
- Having a close friend was positively associated with general life satisfaction.
- People living in residential accommodation cost less for health care and more for so-

cial work, compared to people in private households, whilst work scheme and housing costs were higher.

- Newcomers had spent more time in hospital than had members of any single scheme over the preceding three months.
- The cost of subsidising a person in a work scheme was less than that for realistic day care alternatives (and see the subsection below on day activities research).

Some of these findings are reported in Schneider (1998) and Schneider and Hallam (1997).

Day activities

The Unit's research on day activities has not yet progressed quite as far, although it is already clear how important are these (under-researched) services within community care packages. In 1997 a postal survey of day activity settings for adults with mental health problems was conducted in the South Thames NHS region. *Day settings* were defined to refer to any facility (for example, day hospital, day centre or work-related scheme) in any sector (public, voluntary or private) which typically provided social or practical communal support and which had paid volunteers or staff present in a non-domiciliary and non-residential capacity.

Work is in progress (led by Jennifer Beecham), but a number of features of the sample have been examined to date. Most (85%) of the settings are in urban areas and 41% on stand-alone sites away from other service providers. Most are open only during weekday working hours, with few offering evening or weekend sessions. Regular users of the day settings attended 2-6 times each week. The principal orientation of the day settings was said to be either treatment (23%, almost all NHS), social support (54%, mostly local authority or voluntary sector) or work (23%).

The regular users of the sample day settings lived in a variety of accommodation types: 3% normally lived in a hospital ward; 13% had been in hospital for psychiatric care in the last three months; and 17% lived in staffed accommodation. Almost half (41%) were taking regular neuroleptic medication. One in twenty (6%) was subject to a Mental Health Act section. In addition to their mental health needs, 37% had some additional problem such as physical illness or disability (13%), aggressive or disruptive behaviour (7%), use of illegal drugs (7%) or misuse of alcohol (10%).

Revenue costs per user session were calculated, and ranged from as low as £0.88 to a maximum of £68.26 (mean £11.65; median £9.16). Cost variations were found to be associated more closely to the services each setting provided (as measured by the types of support and principal orientation) rather than to the management sector *per se*.

Continuing work

The policy emphasis on community-based care consequently shows no sign of lessening, nor does the need for good evaluative evidence to inform decision making. Service providers and other agencies in the mental health care system are looking to continue to improve their effectiveness whilst not anticipating major new injections of finance.

The PSSRU's ongoing research programme will be aiming to continue to contribute to the accumulation of empirical data on how the mental health care system operates, and the effectiveness and cost-effectiveness of different care arrangements.

References

- Beecham, J.K., Hallam, A., Knapp M.R.J., Baines, B., Fenyo, A.J. and Asbury, M. (1997) Costing care in the hospital and in the community, in J. Leff (ed.) *Care in the Community: Illusion or Reality?*, John Wiley & Sons, Chichester.
- Kavanagh, S., and Knapp, M.R.J. (1995) Market rationales, rationing and rationality? Mental health care reform in England, *Health Affairs*, 14, 260-268.
- Knapp, M.R.J., Marks, I., Wolstenholme, J., Beecham, J.K., Astin, J., Audini, B. and Connelly, J. (1998b) Home-based versus hospital-based care for serious mental illness. Controlled cost-effectiveness study over four years, *British Journal of Psychiatry*, 172, 6, 506-512.
- Knapp, M.R.J., Hallam, A., Beecham, J.K., Baines, B. (1998a) Private, voluntary or public? Comparative cost-effectiveness in community mental health care, *Policy and Politics*, forthcoming.
- Leff, J., (ed.) (1997) *Care in the Community: Illusion or Reality?*, John Wiley & Sons, Chichester.
- Schneider, J. (1998) Models of specialist employment for people with mental health problems, *Health and Social Care in the Community*, 6, 2, 120-129.
- Schneider, J. and Hallam, A. (1997) Specialist work schemes: user satisfaction and costs, *Psychiatric Bulletin*, 21, 331-333.

Mapping Care Management Arrangements for Older People

David Challis, Robin Darton, Jane Hughes, Karen Stewart and Kate Weiner

Further information

This article is taken from the Mapping Programme Research and Policy Update issue 1, which is available free of charge from the PSSRU in Canterbury and can be found on the PSSRU web site. Three further issues are planned.

The study is designed to delineate the variations found in care management arrangements for older people and those with mental health problems, following the implementation of the Care Programme Approach in 1991 and the community care legislation in 1993. It will identify the distinctive characteristics of different care management arrangements and discriminate between them in terms of their structures, processes and outcomes, so as to identify differences in their relative costs and benefits.

The study is being undertaken at a time when organisational forms and arrangements for assessment and care management are becoming more established. It started in 1996 and will last five years, with three phases.

The aim of the first phase is to identify and categorise the emerging models of care management. This phase includes a review of literature, questionnaires sent to all local authorities concerning assessment and care management arrangements in general and detailed arrangements for older people and those with mental health problems, and analysis of the data collected.

The second phase will formulate and examine in detail the different arrangements identified in the first phase, and will involve the collection of information in only a small number of authorities. Interviews will be conducted with staff at different levels of the organisation. In addition, there will be special data collections to describe precisely the operation of the service, for example staff time use and case reviews.

The third phase will evaluate a small number of different models to provide comparative evidence of their relative efficiency and effectiveness. This will examine operational details of identified models, their outcomes and costs. A range of information will be collected, including data on discharge and re-referral and the tracking of cases through time to collect cost data. Interviews with service users and their carers will be undertaken to collect information on outcomes and on their experience of care.

As part of the first phase of the Mapping Study, an initial overview questionnaire on care management arrangements for all adult service user groups was sent to local authorities in England in spring 1997. Responses were received from 84%. The following are some of the key findings.

How services are organised

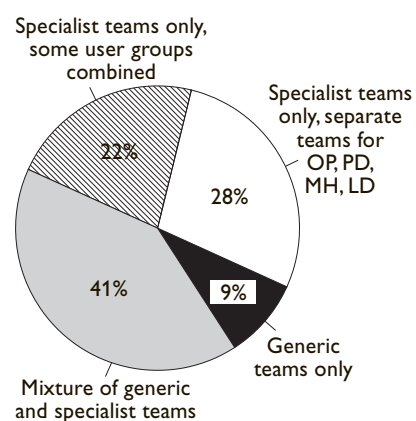
Half of all authorities provided assessment and care management in the community to adult user groups through specialist teams only (figure 1), and the proportion was greatest in London authorities. The majority of the remaining authorities operated a mixture of generic and specialist teams. Overall, specialist teams were most common for mental health and for learning disabilities (in almost 90% and almost 70% of authorities respectively).

Managing demand

Authorities used a variety of methods for managing demand, including screening, eligibility criteria, ceilings on expenditure and providing a differentiated response such as using different levels of assessment or providing different types of care management.

Professional staff were involved in screening referrals in about 80% of authorities and managerial staff were involved in about half this proportion (figure 2). Involvement of administrative staff varied from 12% of authorities for mental health services to just under a quarter of authorities for services for older people.

Figure 1 Service organisation



Over three-quarters of authorities had weekly per case ceilings on expenditure for community-based care packages for at least one service user group. Ceilings were most likely to be in place in services for older people and least likely in mental health and learning disability services (figure 3). The majority of ceilings were based on the cost of an equivalent placement in residential or nursing home care.

Across all user groups, a minority of authorities used only one level of assessment, about half had two levels and the remaining authorities used three or more levels. Most authorities defined the levels of assessment through the level of service user need. In addition, about 30% of authorities included the number of agencies involved or the cost or type of care package in the definition.

Less than a fifth of authorities provided, and less than a tenth of authorities purchased, a specialist care management service working exclusively with people with high needs or who were at risk, and carried out by staff with small caseloads. Those reported were mainly drug and alcohol, HIV and AIDS, mental health and learning disability services.

Figure 2 Staff involved in screening

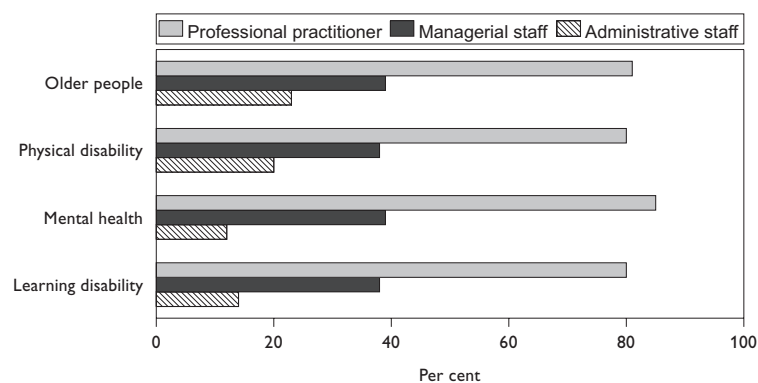
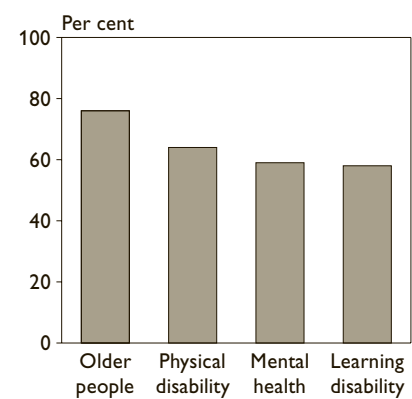


Figure 3 Per cent of authorities with expenditure ceiling



Reviews

About four-fifths of authorities had formal guidance on the review process, both for community-based care and for care in residential and nursing homes. In the majority of authorities the time at which the first and the subsequent reviews should take place was fixed for both settings. The figure ranged from about three-quarters of authorities to almost 90%, depending on the user group and the type of review.

A wide variety of staff were involved in reviews. Care managers, social workers and social work assistants were most likely to be responsible, but occupational therapists and home care managers also carried responsibilities for community-based reviews in over a third of authorities. Less than 10% of authorities reported that providers of care had responsibilities for reviewing.

Comments on service developments to date

A third of authorities reported specific aspects of the care management process which they judged to be working well, and just under a third reported satisfaction with the promotion of inter-disciplinary working. These successes were mainly attributed to appropriate organisational structures, levels of budgetary devolution, clarity of procedures and successful staff training.

The main areas judged not to be working well, both reported by about 30% of authorities, were reviews and a group of operational issues, including problems of speed of response, inequity of resource distribution and lack of flexibility. The problems were most often attributed to inappropriate infrastructure, including procedures, support systems, organisational structures and roles, and also to workload pressures and resource constraints.

Is the Independent Sector Important in Social Care?

Martin Knapp, Jeremy Kendall and Julien Forder

One of the central objectives of the previous Government's community care White Paper in 1989 was 'to promote the development of a flourishing independent sector alongside good-quality public services'. This and other White Paper objectives obviously heavily influenced the structure and development of community care during the 1990s. Many challenges were set for policy and practice, and many questions raised for research.

As community care prepares for the challenges set for the *next* decade, on the back of the November 1998 White Paper, it is helpful to take stock. In this paper we consider the position and roles of the independent sector in the developing mixed economy of care.

Is the independent sector important?

Quantitatively, the independent sector is clearly enormously important in social care provision. Indeed, as the new White Paper points out, it now employs some 1 million paid employees. These are now mainly to be found in the private sector, but just under one fifth work for voluntary organisations — which also mobilise some 220,000 full time equivalent unpaid volunteers. (For details, see the report referred to in 'Further information'.)

There is little public sector provision left in some markets and localities, and local authorities are rapidly externalising in others (especially home care and day care). Even if they wanted to, those same authorities are unlikely to be able to make sufficient funds available in the future to buy the services back into public sector control. Anyway, there are often argued to be various benefits of independent sector provision. For example:

- The independent sectors offer variety and — to a degree — also offer independence from the state. Consequently, they offer a (potentially) wider choice for users, carers, care managers and purchasers. They can be 'niche' providers in many ways: for example, voluntary sector residential homes often deliver care with a distinctive religious or other identity-based ethos; private sector nursing homes specialise in terms of scale and scope of their operations; and voluntary sector day care can be distinctive in involving volunteers as an important capacity in the discharge of care and support tasks.
- The independent sectors are sometimes argued to have the ability and willingness to respond flexibly to changing circumstances, and to be innovators in service delivery, arrangement or quality. For example, private providers pioneered evening and weekend home care services in many localities, and voluntary providers and consortia have been particularly active in pioneering new forms of care and support at the interface between housing, health care and social care.
- Some authorities are finding that some of their independent sector providers offer 'Best Value'. Costs often appear to be lower in the independent sectors. It may be that user outcomes are no worse or perhaps even better, although this is by no means well-established.
- In many situations, the rights and welfare of users and carers are promoted and protected by voluntary organisations.
- Finally, but fundamentally, many users and carers evidently prefer independent sector provision. They choose to use their services.

So what is the independent sector?

The independent sector is not, in fact, a singular entity: it is a mix of many organisational forms, legal contexts and operating interests. It includes:

- small family businesses, the traditional mainstay of private sector provision;
- rapidly emerging corporate (including publicly quoted) providers;
- traditional charities, many with very long track records pre-dating state involvement;
- housing associations, often with growing social and health care responsibilities;
- new voluntary organisations, often involving 'social entrepreneurs' creatively mixing different forms of public finance to generate resources for new types of care package;
- trusts, including 'floated off' homes and domiciliary services formerly run directly by local authorities.

Some fields (or markets) are dominated by private, for-profit providers; others by voluntary organisations. Some are proving attractive to the larger corporate bodies; others not.

Do we need to make distinctions between the two broad sectors, or even the more refined distinctions suggested above? The short answer is 'yes': these different organisational forms have different histories which affect their *modus operandi*; involve different patterns of resource dependency and styles of governance and management; and operate with contrasting legal rights and responsibilities. Moreover, their executive boards or other strategic decision-makers and their professional staff sometimes appear to operate with different motivations.

One important consequence is their different ability and willingness to respond to changes in market opportunities, new pricing regimes and competition. The for-profit sector, for example, led by an explosion of small businesses blending welfare and economic objectives, responded much more rapidly than other sectors to the opportunities in residential care for elderly people in the 1980s and early 1990s provided by the open-ended social security regime. In contrast, the voluntary sector has held its own in day care, which has generally not proved attractive or feasible for private sector operators.

Furthermore, evidence from the research literature suggests that in some markets, the different sectors may have different levels of performance. For example, a PSSRU study of public, voluntary and private providers of mental health care for people moving out of psychiatric hospitals in London found a number of interesting differences. Costs were lowest in the private (for-profit) sector, and highest in the NHS and consortium (NHS and voluntary sector partnership) sectors. However, quality of care indicators suggested that the lowest cost sector was performing least well, and the highest cost sectors offered the best quality. These quality differentials were associated with some modest differences in user outcomes.

Significantly, and potentially of considerable future importance, is the observation that different types of organisations vary in the routes through which they initiate and cultivate trust and reputation. Local authorities are seeking 'Best Value' in contexts in which the monitoring of service qualities and user outcomes is a high cost or even infeasible activity. To economise on transaction costs, they must develop strategies to nurture trust which reflects the particular supply side configuration which they inherit, and are able to develop. A well-founded trusting relationship between purchaser and the range of providers removes some of the need for the close monitoring which can be so distracting and costly for both organisations.

These potential and actual inter-sectoral differences underpin much of the discussion about the different provider sectors. But the very real differences in some respects should not blind us to the fact that demarcations between the sectors are not always as marked as made out. There are actually lots of commonalities of perspectives and motivations which cut across the different sectors and provider types at any given time. For example, staff and managers' careers often take them from one sector or type of organisation to another, and attitudes and behaviours are in part conditioned by previous experiences. Moreover, inasmuch as all independent sector organisations are sharing to some degree a common environment as contractors with local authorities, they can face similar pressures and opportunities (see also discussion below regarding 'local authority concerns').

**Are the current
'sectoral arrangements'
satisfactory?**

The PSSRU conducts a joint programme of research with the Nuffield Institute for Health at the University of Leeds (see box 1). This work on the mixed economy of care offers insights into the workings of today's social care markets.

Provider concerns

Among other things, the research suggests that many providers in the independent sectors and many local authority purchasers are not altogether happy with the present arrangements in their localities. What are the sources of their concern?

Independent sector providers appear to be unhappy about a number of things. For ex-

ample, in residential care, occupancy rates in many homes are uncomfortably low, and in many cases this is combined with a 'prices squeeze' from local authorities. As a result, profit or operating surplus can be very low or even negative, and cross-subsidising to cover the revenue gap may not be sustainable in the medium and long term. Many smaller residential care or nursing homes in the private sector have already gone to the wall; others appear to be very close. In the voluntary sector, even providers well enough resourced to draw on other sources of revenue may potentially face difficulties if by so doing they inappropriately shoulder public financial responsibilities in contravention of charity law. Some feel they are poorly treated by monopsony purchasers, who are sometimes late with their payments, dilatory with their reviews of users, absent when it comes to follow-up appointments, biased in favour of in-house providers and so on. This litany of concerns will be familiar to anyone who has worked in or conducted research on today's community care system.

Box 2 Independent sector concerns

- Low occupancy rates
- Low fees relative to costs (low profit margins)
- Late payment
- Infrequent reviews of users
- Prices inflexible in the face of changes in user dependency
- Lack of trust
- Insufficient confidence to invest in better quality

Another source of independent sector concern is about current pricing in terms of its flexibility and adjustability, rather than just in terms of its average level. Today's contracts rarely allow reimbursements to respond to contingencies such as changes in user needs. All of the risk, the providers might argue, is loaded on them rather than shared with purchasers. Because the dependency levels of most elderly users are more likely to go up than down, and because fixed prices are generally renegotiated no more frequently than annually,

the present arrangements may leave providers under-resourced, further threatening their viability as business concerns or as solvent charities.

The current contractual climate — or more generally what we might call the current governance structure — may not be conducive to trust. There is potentially a vicious circle of transaction costs. Intrusive or distracting monitoring by purchasers is not only resource-costly for providers, but breeds mistrust and can undermine their disposition to act cooperatively and constructively. Put differently, providers can feel less willing, on balance, to give purchasers the benefit of the doubt. For example, they may be less willing to respond in positive or imaginative ways to changed circumstances without the explicit approval — better still the funding — of purchasers. The consequence is that trust is neither established nor reinforced.

Facing low profits, and feeling unable to rely on supportive actions by their local purchasers in the future, investment in quality is likely to be limited. Many independent providers recognise that their staff are 'under-skilled' but worry that the future environment is not sufficiently stable or attractive for them to direct revenues into training.

Local authority concerns

On the other side of the market, local authority purchasers are also unhappy. In our work with authorities they express a number of sources of dissatisfaction. They are still worried, in many localities, about loss of control as a result of past and prospective service externalisations. This loss of control may be illusory, but is nevertheless a stage of uncertainty that most purchasers go through. Sometimes associated with it is an enduring sadness that more cannot be kept in-house: despite the many changes within the mixed economy of social care over the last ten years, there is still a strong ethos of *public service* running through social services departments.

Box 3 Purchaser concerns

- Loss of control
- Low quality of care
- Difficulties in monitoring outcomes
- Lack of variety and reduced choice
- Capability gap
- Resource levels

Authorities express concerns about quality of care, fearing that low prices can only be achieved or maintained by independent providers if they cut corners on quality or employ low-paid, low-skilled staff. Yet these same purchasers are very stretched financially, and to offer higher fees in an attempt to raise quality can often only be achieved by cutting services for some other users.

Another difficulty is that purchasers face tremendous difficulty in monitoring outcomes to their complete satisfaction, but may not have built the kind of trusting relationship with their providers which gives them the confidence to operate without it.

Box 1 The Mixed Economy of Care Programme

The Department of Health commissioned a research programme on the mixed economy of community care from the Personal Social Services Research Unit, London School of Economics and Political Science, and the Community Care Division, Nuffield Institute for Health, University of Leeds. The programme's main aims are to describe, monitor and evaluate the developing mixed economy of care, with particular reference to the policy objectives of improving choice, cost effectiveness and innovation set out in the 1989 community care White Paper.

A further source of anxiety may be that standard contracting arrangements and standard service specifications can lead to an over-standardised service. That is, experiencing the same environmental pressures and responding defensively to a chronic atmosphere of uncertainty, providers can become more and more similar both to each other and to in-house services. The result, of course, could be *reduction* in variety and potential choice, not extension.

Two other concerns are sometimes expressed by authorities. One is their own 'capability gap' — a recognition that, whilst they have moved an enormous way up the collective learning curve in terms of market management, and are no longer so under-resourced or under-skilled when it comes to negotiations with providers, they are generally not engaged in the longer-term strategic shaping of markets. Shaping of local and wider markets so as to secure the best services for their populations at an affordable price is now a central responsibility of local authorities, yet it is one for which very few of them have been adequately prepared.

A final concern has been rumbling for a long time: it is the overall level of resourcing for social care. Available funding levels for local authorities make it impossible for them to provide the kinds of preventive home care services that would save them money in the longer term. The announcement of a new 'Prevention Grant' in this year's White Paper is in part a response to precisely this concern.

What is to be done?

Few of these problems would be solved simply by throwing extra money at social services, although more resources would undoubtedly help. A better funding base would go some way to easing some of today's difficulties, but there are also deeper-seated problems.

Local authorities need to develop better governance arrangements. One example would be to make greater use of contingency pricing, built into better contracts which are more sensitive to users' initial dependency, as well as to the changes in dependency that occur while users are receiving care. There also needs to be better mutual understanding of motives, behaviours and responses. More careful consideration of how to balance trust and monitoring, with careful tailoring of arrangements to local contexts and conditions, is vital. In many localities there is also scope for improved sensitivity to the needs and preferences of users and carers, with the potential to improve quality and outcomes. Both purchasers and providers need to have uppermost in their minds that any improvements secured in their own bilateral relationships are a means to an end: the objective of delivering the best care that resources allow.

Further information

The Mixed Economy of Care Bulletin 5 is available free of charge from the PSSRU and can be viewed/downloaded from the PSSRU web site.

A short report *The UK Voluntary (Third) Sector in Comparative Perspective: Exceptional Growth and Transformation*, by Jeremy Kendall with Stephen Almond, was published by the PSSRU in November 1998 and is available (price £2.00 including p&p) from the PSSRU librarian in Canterbury.

Other publications from this programme of work are detailed on the PSSRU web site.

National Evaluation of Health Action Zones

Ken Judge

One of the main aims of the new Labour government's social policy agenda is to tackle social exclusion. A large number of initiatives have been launched to do this, which include:

- The new deals for young people without work and lone parents keen to return to the labour market;
- Area-based initiatives to regenerate blighted urban areas;
- Improving educational standards in poor areas.

However, one of the most important initiatives in relation to social exclusion in the health and social field is the establishment of Health Action Zones (HAZs). The PSSRU at UKC in collaboration with colleagues at LSE Health and elsewhere has been commissioned to conduct the national evaluation of HAZs. The aim of this short piece is to introduce the zones and some aspects of the approach we will be adopting in relation to their evaluation.

What are Health Action Zones?

- Health Action Zones (HAZs) are new kinds of local partnerships established in England to pioneer creative approaches to modernising services and responding to social exclusion.
- The 11 first wave HAZs started life in 1998 and the 15 second wave HAZs begin work in the spring of 1999.
- Their strategic aim is to bring together a multiplicity of public, private and voluntary organisations to reshape health and social services and to improve the health of their local populations, especially those who are most disadvantaged.
- The 26 areas share common problems of deprivation, social exclusion and evidence of health inequalities. They show very considerable diversity, however, in their existing partnership arrangements and vary fundamentally in their scale and complexity.

Table 1 Health Action Zones

Wave 1	Population	Wave 2	Population
Tyne & Wear	1,100,000	Merseyside	1,400,000
Manchester, Salford & Trafford	880,000	Leeds	727,000
South Yorkshire Coalfields communities of Barnsley, Doncaster & Rotherham	770,000	Nottingham	640,000
Lambeth, Southwark & Lewisham	730,000	Hull & East Riding	575,000
East London & City	580,000	Tees	558,000
Bradford	470,000	Sheffield	530,000
North Cumbria	320,000	Cornwall & Isles of Scilly	483,000
Northumberland	310,000	North Staffordshire	471,000
Sandwell	300,000	Bury & Rochdale	389,000
Plymouth	260,000	Camden & Islington	365,000
Luton	180,000	Wakefield	317,000
		Leicester City	295,000
		Walsall	263,000
		Brent	248,000
		Wolverhampton	244,000

The table lists the 26 Health Action Zones and shows the very considerable differences in the size of the population that each of them covers. Merseyside, the largest HAZ with a population of 1.4 million, is almost eight times larger than Luton, the smallest of the HAZs.

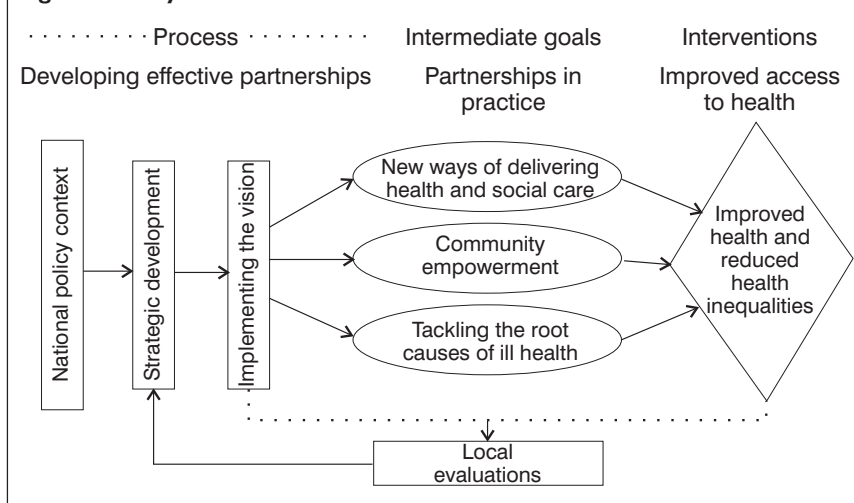
While the HAZs vary considerably in their size and complexity they do share a number of common approaches, as illustrated in figure 1. The starting point for all health action zones is the need to develop effective partnerships at

the local level that are linked to the national policy context. They all are expected to use the partnership structures that are created to reshape the health and social care system, to empower local communities and to tackle the root causes of ill health. The benefits of such partnerships are expected to result in significant improvements in population health and reductions in health inequalities.

The national evaluation

Health Action Zones are at a very early stage of development. One of the top priorities for the national evaluation team in the first phase is to look closely at the partnership and governance arrangements and the nature of community involvement that each of them is adopting. At the same time we want to elicit information about the implicit or explicit 'theories of change' being adopted by the Health Action Zones. North American experience of evaluating comprehensive community initiatives that have features not dissim-

Figure 1 A stylised model of Health Action Zones

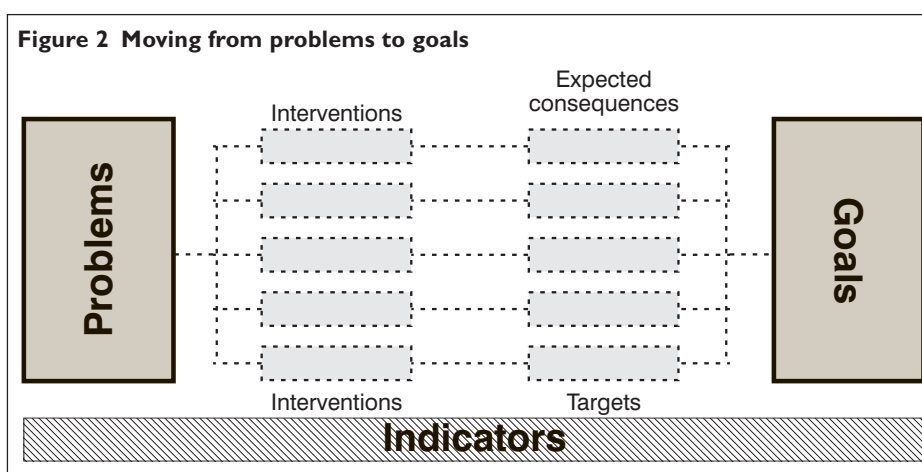


ilar to HAZs suggests that a focus on theories of change is a helpful way of approaching complex community-based interventions.

An initial reading of the operational plans submitted by first wave Health Action Zones suggests that this sort of approach to identifying theories of change will be constrained by the relatively limited extent to which planning has yet been completed. To varying degrees all of the HAZs are quite strong on identifying problems, articulating long-term objectives and specifying routinely available statistical indicators that might be used for monitoring progress. On the other hand, they are much less good at filling in the gap (as illustrated in figure 2) between problems and goals.

Many of the first wave Health Action Zones find it difficult to specify precisely how they will intervene to address problems at this stage, and what consequences they expect to flow from such interventions and how precisely these relate to their strategic goals. Yet, if real learning is to be generated

Figure 2 Moving from problems to goals



ated by monitoring and evaluating Health Action Zones then what is known as a 'realistic' approach to evaluation is required. The essence of realistic evaluation is that targets and goals should be linked by eliciting knowledge about theories or strategies of change from local actors.

It has to be acknowledged that there is considerable scope for semantic debate about the differences between targets, goals, objectives, outcomes and other similar terms. Nevertheless, if the term 'target' is to be a meaningful one for the purposes of policy and practice learning it needs to be clearly linked to beliefs about the expected consequences of interventions purposefully selected to address particular problems. In the language of realistic evaluation this is closely related to what are known as context — mechanism — outcome configurations.

The taxonomy set out below explains how *targets* might be located in a logical process.

- HAZ *targets* and milestones should be regarded as an integral part of a *community health improvement process*
- That begins with *stakeholder ownership* of a needs assessment and priority setting process
- And perceives targets as the *expected consequences* within specified timescales
- Of *purposeful investments* in processes, activities and interventions
- Directed at achieving *strategic goals*
- Which may require *synergistic change* arising from multiple interventions.

The implementation plans submitted by the first wave HAZs begin to place targets within this process, but stop short of completing the task. Nevertheless, there is much of value in the plans. Those that have developed and included detailed proposals for specific programmes and workstreams are especially useful. From the perspective of the

national evaluation team it is also very helpful to have a clear sense from some of the plans of their mission and priorities and the strategic goals that they have in mind. Others have helpfully indicated the criteria used to determine priorities. There is no lack of ambition or commitment to address the problems that all of the HAZs have identified. But far too often it proves to be profoundly difficult to link well-specified interventions or activities to credible consequences or targets that have some logical association with strategic objectives. For some HAZs there appears not to have been sufficient time to plan or to consult with stakeholders, but even in the more well-developed plans really well specified interventions are very much the exception rather than the rule. Among the enormously diverse lists of projects and activities and aspirations that are to be found in the plans, however, there are a few examples that begin to get reasonably close to what one would hope to see. None of them is as well developed as one would hope for. Perhaps that is unrealistic at this stage. One of the clearest examples identified to date is from the plans prepared by Sandwell. The box shows very clearly how one approach to social exclusion can be linked to a well-specified intervention that is expected to produce desirable outcomes.

Box 1 Housing and health in Sandwell

Purpose

To improve the health of disadvantaged people by tackling poor housing conditions in the Borough. The initial focus is to be on (1) working with low income home owners to access financial support to undertake repairs and improvements and (2) to target public housing repairs to families of children with asthma identified by health care professionals.

Activity: (2) repairs on prescription

Repairs to Council stock and private housing (central heating, insulation, draught-proofing, loft insulation and damp proof course works) will be targeted to households containing young people who suffer moderate or severe asthma, which also warrants regular out-patient observation and treatment. Hospital consultants will select suitable candidates and be involved in developing the research methodology to assess the impact of this intervention. At the same time, a public information campaign will seek to promote awareness and knowledge of asthma and its management.

Selected outcomes

- reductions in deaths from hypothermia, asthma and infectious diseases
- improvement in educational attainment of participating children
- reductions in number of GP and hospital visits by beneficiaries of the programme
- reductions in sickness absence from school of participating children

One of the top priorities for the national evaluation team in the coming months will be to work closely with all of the Health Action Zones. First, to obtain a much clearer picture of the rationale for the interventions and activities that emerge as priorities for them. Second, to elicit as much information as possible about the beneficial consequences or outcomes that are expected to result within a given time period.

Further information

The members of the HAZ national evaluation team are: Linda Bauld, Ken Judge, Michael Marinetto and Sarah Wehner at the PSSRU at UKC; Michaela Benzeval, Ray Robinson and Rachel Wigglesworth at LSE Health; Marian Barnes at the University of Birmingham; and Amanda Killoran at the Health Education Authority.

For further information contact: Sarah Wehner, telephone: 01227 827953, fax: 01227 827038, email: S.K.Weherner@ukc.ac.uk.

A 'Ready Reckoner' for Staff Costs in the NHS

Ann Netten, Jane Knight and Jane Dennett

Background

The NHS workforce is large, highly trained, and very costly. The degree to which this workforce is employed in a cost-effective way clearly has important implications for what can be produced from such a large-scale operation. Concerns about the best way to use this workforce underlie many innovative ways of using this workforce (such as nurses taking over tasks traditionally undertaken by doctors). When evaluating the consequences of innovative patterns of staff working, it is essential that all the associated costs are appropriately identified so those involved in planning for the future can consider the full implications of variations in skill-mix. It is also important that consistent approaches are used to cost estimation so that like is compared with like when alternative courses of action are under consideration.

A research project to develop a Ready Reckoner for estimating health staff costs was funded by the Department of Health as part of the Human Resources and Effectiveness Initiative. The aim of the research was to develop an approach to estimating health service staff costs in a consistent and comprehensive way that is appropriate to use when evaluating the cost consequences of innovative uses of staff resources. Table 1 shows the types of staff included in the Ready Reckoner.

Health services are critically dependent on the skills of professionals. These skills can be described as human capital and are like physical capital in that they are not used up in the process of producing the service. The costs of acquiring these skills are the costs of specific courses, ongoing professional development and the initial investment in qualifications. The project identified the costs of ongoing training as an annual cost, the basis for estimation depending on the type of professional. A rather more complex approach was required for the inclusion of the investment costs of qualifications.

The components of the initial investment in training are:

- the costs of tuition;
- infrastructure costs (such as libraries);
- costs or benefits from clinical placement activities; and
- lost production costs during the period of training.

Before discounting to reflect the distribution of these costs over time the investment costs of pre-registration training are estimated as £35,670 for nurses, £197,660 for doctors and £41,200 for physiotherapists. Estimates have also been made of the costs of post-registration training of community nurses and doctors (SHOs, registrars, GPs and consultants) on a similar basis. A nurse is estimated to cost £12,120 in order to become qualified with a community qualification. Before discounting to reflect the distribution of costs over time consultants are estimated to cost £98,430 in post-registration training.

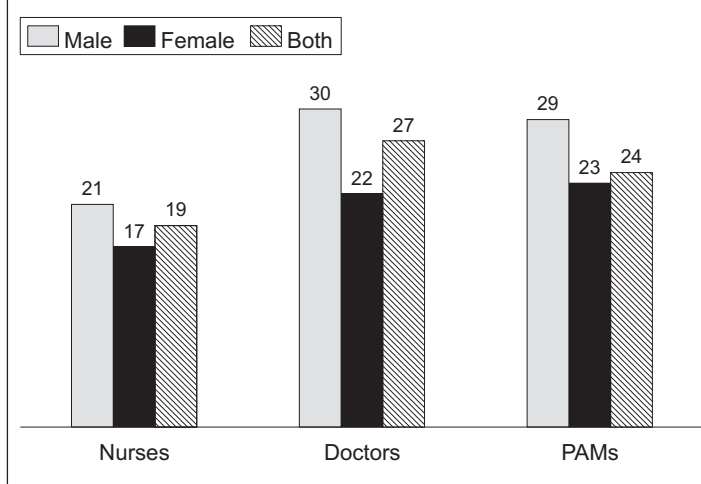
Table 1 Health service staff included in the Ready Reckoner

Community Care	Acute Sector	Primary Care
District nurse Community psychiatric nurse Health visitor Auxiliary nurse	Day ward manager 24-hour ward manager Staff nurse, day ward Staff nurse, 24-hour ward Auxiliary nurse	Practice nurse
Physiotherapist Occupational therapist Speech and language therapist	Physiotherapist Dietitian Speech and language therapist Radiographer Occupational therapist Therapy support worker	
	Pre-registration house officer Senior house officer Registrar Consultant psychiatrist Consultant surgeon Consultant physician	General practitioner

The initial investment costs need to be discounted, to allow for their expected distribution over time, and annuitised so they can be included in the unit costs of the professional. The discounting is straightforward, with the first year of training taken as the base year. Annuitisation, however, requires that we take into account the expected returns on this initial investment. In the case of human capital this means we need an estimate of both the number of years that people will be using the skills acquired through training and the distribution of those years (taking into consideration issues such as career breaks, part-time working and early retirement).

On the basis of analyses undertaken of the 1991 census and 1996 Labour Force Survey,

Figure 1 Expected working lives (years)

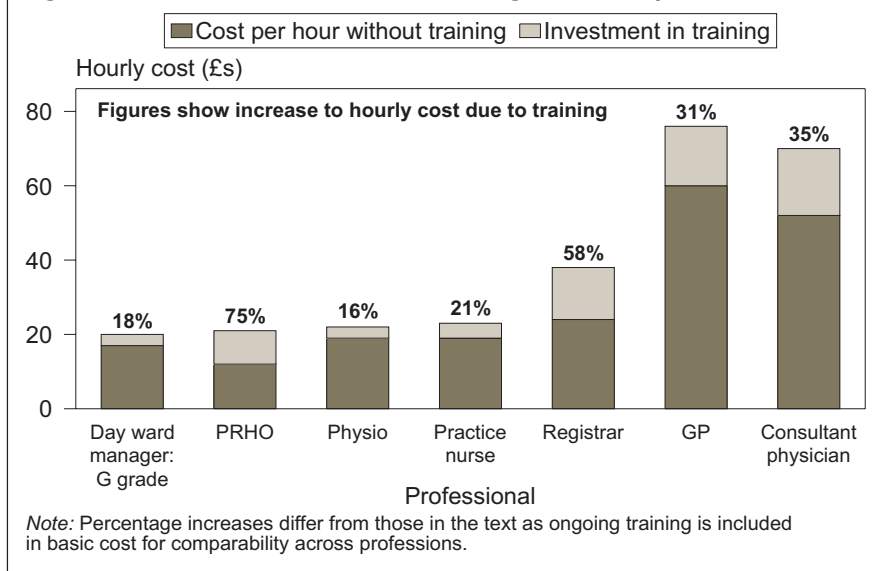


the expected working life of nurses are estimated as between 19 and 22 years, and doctors between 26 years and 29 years. Professions allied to medicine (PAMs) were estimated as working about 24 years in total (see figure 1). The data were also used to estimate the expected distribution of these working lives. On the basis of these data a method was developed for allowing for the distribution of costs and returns on the investment (in terms of time spent working in related professional roles) over time (Netten and Knight, forthcoming).

In absolute terms, the equivalent annual investment costs of training ranged from £4,520 for occupational therapists, through district nurses at £6,240, to £30,170 for consultants. The impact on unit costs of staff of including investment

costs was examined and figure 2 illustrates the findings. The impact was least on professions allied to medicine, with the lowest impact for occupational therapists (16%). The greatest impact among these professions was for speech and language therapists, where unit costs are 19% higher when investment costs of training are included. For all types of nurse the impact was slightly higher, with unit costs rising by over 20% when investment costs are included. The most marked, and varied, impact was among doctors. Given the long-term investment required for consultants, it perhaps is not surprising that the costs including investment in training are 36% higher than without this investment cost.

Figure 2 The effect of investment in training on costs of professionals' time



But the most dramatic impact is on the costs of registrars. Because a high proportion of the investment required for a consultant is required for a registrar but pay is much lower, the net effect of including investment costs is to increase unit costs by 60%. If ongoing training costs are included costs rise by 66%.

For the most part these investment costs are borne by the wider NHS and individuals undertaking the training rather than trusts, so those costing exercises that are concerned with narrowly defined costs to the provider organisation would not want to incorporate these investment costs. The investment costs of education should always be included, however, when evaluating the cost-effectiveness of different approaches to using health service staff as it is important to include all the costs implicit in changing the professional mix. Evaluations of any techniques which change the way that staff are used (such as tele-medicine) should also include the investment cost of training.

The approach does allow us to make a reasonable estimate of the long-term investment costs of qualifying health service professionals. Clearly the levels of investment are such that including annuitised costs is essential if appropriate conclusions are to be drawn with respect to the cost-effectiveness of changing the patterns of use of professional expertise in the long term. The analysis also shows that the distribution of returns on investment in education has an important effect on estimated equivalent annual cost. This has implications for the appropriate measurement of costs both when considering

innovative staff use and workforce planning.

The estimated costs of training a wide variety of health service professionals are contained in a report of the project (Netten et al., 1998a,b). The report is available together with free prototype software that, in addition to providing default values estimated by the project, allows users to adapt the information to reflect different assumptions or local information. Investment costs of training are also included in Netten et al. (1998c).

References

- Netten, A. and Knight J. (forthcoming) The human capital investment costs of health service professionals, *Health Economics*.
- Netten, A., Knight, J., Dennett, J., Cooley, R. and Slight, A. (1998a) A 'Ready Reckoner' for Staff Costs in the NHS. Volume I. Estimated Unit Costs, PSSRU, Canterbury.
- Netten, A., Knight, J., Dennett, J., Cooley, R. and Slight, A. (1998b) A 'Ready Reckoner' for Staff Costs in the NHS. Volume II. Methodology, PSSRU, Canterbury.
- Netten, A. and Dennett, J. (1998c) Unit Costs of Health and Social Care, PSSRU, University of Kent at Canterbury.
- Office of Population Censuses and Surveys (1991) *1991 Census 2% individual samples of records: Great Britain*, London.
- Office of Population Censuses and Surveys Social Survey Division (1995) *Quarterly Labour Force Survey 1992* (computer file), Data Archive, Colchester.

Further information

This research has been reported in two volumes, available singly at £15.00 each or £25.00 together including p&p from the PSSRU librarian in Canterbury.

Volume 1: Consists of a series of 'schemata' containing specific information about the various component costs of each professional, including a detailed breakdown of the costs of specific qualifications.

Volume 2: Provides a detailed description of the project, the methodology employed and considerations in developing software.

A prototype version of the 'Ready Reckoner' software is available which operates under all versions of windows and can be installed on individual IBM compatible PCs or on a network. It runs in 4Mb RAM and requires 13Mb hard disk storage. Installation and use is described in printed user documentation. (*Please note this software is an unsupported prototype version: it is installed and used at the user's own risk.*)

The 'Ready Reckoner' software is supplied on CD Rom free of charge with Volume 1 of the written report. The CD Rom also includes both volumes of the report in electronic format. The software is available on a set of 3.5" floppy disks on request.

For other enquiries please contact Jane Knight at the PSSRU, University of Kent at Canterbury. Telephone: 01227 824015; email J.Knight@ukc.ac.uk.

Elderly People and Primary Care

Shane Kavanagh and Martin Knapp

The policy of shifting the balance of care for elderly people away from hospital in favour of residential and nursing homes and domiciliary settings has had many consequences. A small PSSRU study looked at some of the primary care implications. The findings were published in the *British Medical Journal* in 1998.

The study found that residents with higher levels of disability, complaints of the digestive system, living in smaller local authority homes or larger voluntary residential homes were found to be more likely to consult a GP. Among those who saw a GP, higher levels of disability and morbidity, residence in a private nursing home or a larger private residential home were all associated with greater GP utilisation. Overall, controlling for resident characteristics and size of home, nursing home residents had greater predicted utilisation compared with residential care homes. People who would previously have been cared for in NHS hospitals, now cared for in nursing homes, had high predicted utilisation due to their greater morbidity and disability.

The study estimated that the 'downsizing' of NHS hospital provision for the elderly has increased demand on general practitioners by 160 whole time equivalents per annum in Britain. This is over and above the growth in demand due to demographic change.

Reference

- Kavanagh, S. and Knapp, M.R.J. (1998) The impact on general practitioners of the changing balance of care for elderly people living in institutions, *British Medical Journal*, 317, August, 322-327

1996 Survey of Care Homes for Elderly People

Ann Netten, Andrew Bebbington, Robin Darton, Julien Forder and Kathryn Miles

Introduction

The survey formed one part of a three-part study funded by the Department of Health, which was designed to examine a wide range of issues associated with the current patterns of use of residential and nursing home care for elderly people. The principal aims of the survey were to provide a baseline description of the current population of homes, and to explore the relationship between the costs or price of care and the dependency characteristics of residents.

The survey took place in the autumn of 1996. 673 homes (82% of those approached) in 21 local authorities participated. 618 homes (75% of those approached) provided information both about the home and about the characteristics of individual residents. The data were collected in a way that allowed comparison with a survey of independent homes conducted by the PSSRU and the Centre for Health Economics, University of York in 1986. Within the homes, information was collected about a sample of residents, accounting for 11,900 residents from a total population of 20,200. The sample of homes was designed to ensure a large enough number of homes for separate analyses for each of the four major types of home (local authority, private and voluntary residential homes (including dual registered homes) and nursing homes). The results reported here are weighted to reflect the national distribution of homes.

The residents

When the results were weighted to reflect the national distribution of residents, nearly 70% of all residents were permanent and publicly funded. At the time of the survey, two-thirds of publicly-funded residents in independent residential care were supported by local authorities. Nationally only 2% of residents were funded by the NHS, and a third of these were jointly funded by local authorities. Fourteen per cent of publicly-funded residents who were 65 or over at the time of the survey had originally been admitted as privately-funded residents.

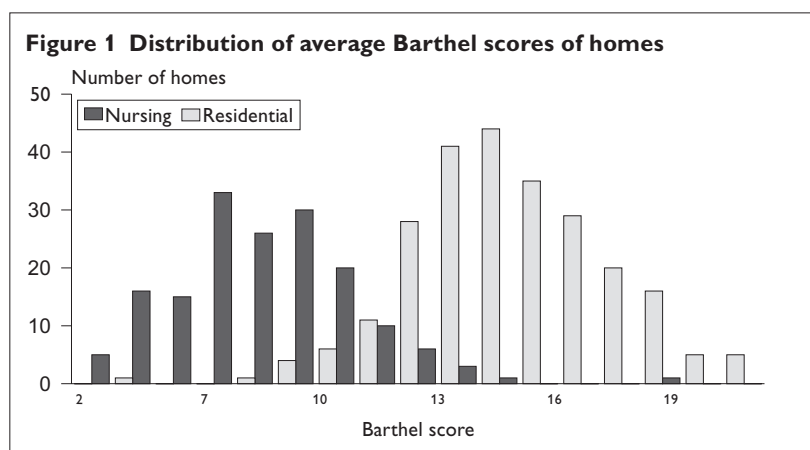
Table 1 Resident dependency by type of home

	Residential homes			Dual registered homes %	Nursing homes %	All homes %
	LA %	Private %	Voluntary %			
Severely dependent*	25	22	21	51	66	38
Needing nursing care	23	24	24	72	85	47
Severe cognitive impairment	25	21	20	31	44	28
Behavioural problems	37	30	31	33	40	34

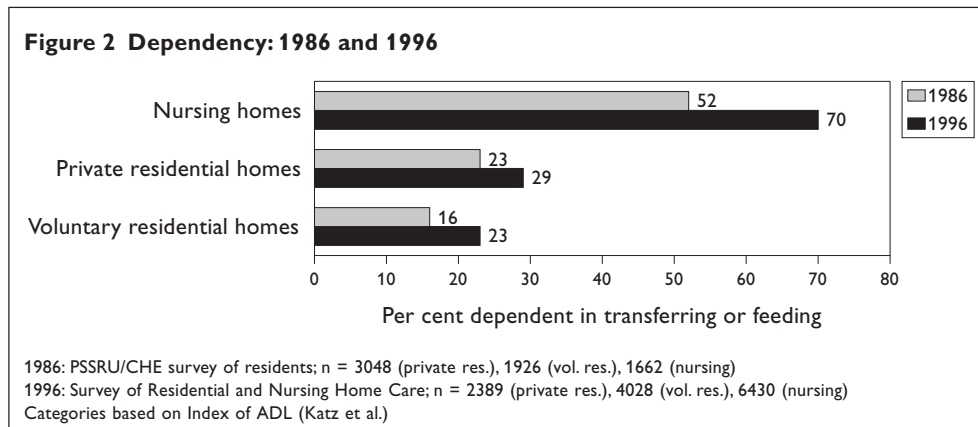
Note

* Score 0-8 on Barthel Index of ADLs (grouped).

Table 1 shows levels of dependency, cognitive impairment and behavioural problems by home type. As would be expected, residents in nursing homes were much more dependent than those in any form of residential care. Two-thirds of residents in nursing homes were classified as severely dependent, with Barthel scores of eight or less, compared with a quarter or less of residents in each category of residential home. There was some overlap, however. Figure 1 shows the distribution of average Barthel scores for independent residential and nursing homes. About 13% of residential homes had approximately the same average Barthel score as nursing homes and 20% of nursing homes shared average Barthel scores with residential homes. As expected, need for nursing care was much higher in nursing homes than in residential care, where the need was largely met by community nursing services. Levels of cognitive impairment were higher in nursing homes, but the care of people with behavioural problems was less closely associated with this type of provision.



Since the introduction of the community care reforms in April 1993, local authorities have had the responsibility for assessing all non-NHS publicly-funded admissions to residential and nursing home care. It would be expected, indeed it was one of the objectives of the reforms, that this would have a profound effect on the use of the residential and nursing home sector. In addition, the NHS has reduced its role in the provision of continuing care of frail elderly people. It is not surprising, therefore, that average levels of dependency in all types of home have risen since the 1980s, with the greatest changes evident in voluntary residential homes and nursing homes (see figure 2).



The homes

Ownership of private residential homes remained concentrated among small organisations, whereas increasing proportions of dual registered and nursing homes were being run by larger organisations. One-fifth of voluntary-run homes in the survey had been transferred from local authority management. This historical factor may go some way to explain the comparative picture of home characteristics shown in table 2. This table identifies occupancy levels, physical facilities and other uses of homes.

Table 2 Home characteristics by type of home

	Residential homes			Dual registered homes	Nursing homes	All homes
	LA	Private	Voluntary			
Mean occupancy (per cent of places)	91.0	85.0	90.5	82.7	87.1	86.3
Per cent of beds in single bedrooms	89	69	89	65	65	74
Bedrooms with en suite toilets (%)	14	68	62	64	66	61
Services for non-residents (%)						
Day care	87	40	46	37	24	42
Bathing	47	15	23	20	10	19
Meals on wheels	43	9	14	4	7	12
Laundry	39	5	16	7	6	10
Home care	21	5	12	12	9	9

Occupancy rates tended to be higher in local authority and voluntary homes, at just over 90% of places, than in the other independent sector homes, in which average occupancy ranged from 83% to 87% of places. These occupancy rates were lower than those found for independent sector homes in the 1986 survey, which recorded occupancy rates of 89% for private residential homes and 93% for voluntary residential homes and private nursing homes.

The use of purpose-built homes has increased since the mid-1980s, possibly as a consequence of the growth of larger organisations running dual registered and

nursing homes. In 1996, local authority and voluntary residential homes had a higher level of provision of single bedrooms, although the provision of single bedrooms in independent sector homes has improved significantly over the last ten years. However, en suite showers or baths and en suite toilets were much less prevalent in local authority homes.

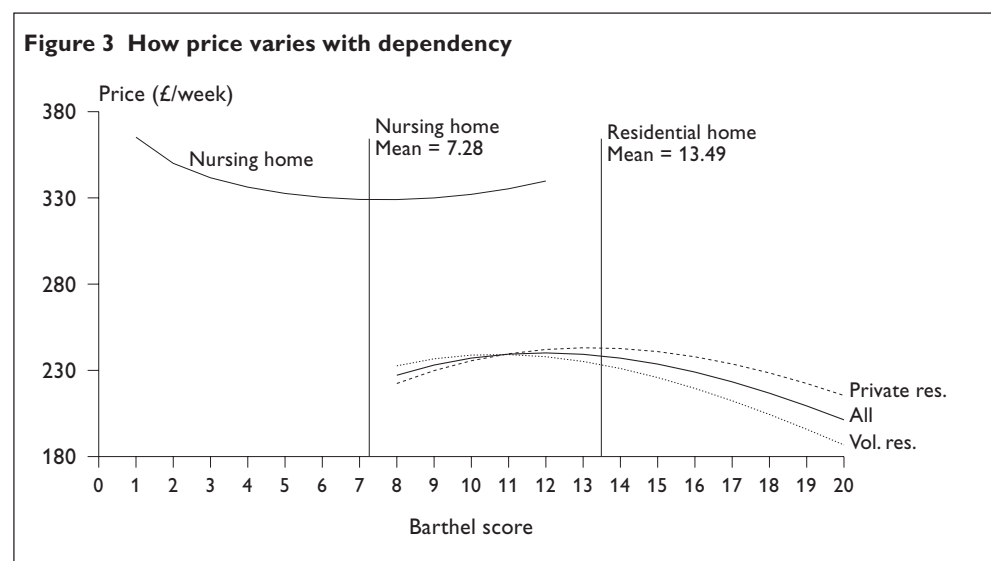
Costs and prices

At the time of the survey average weekly fees in residential homes were £237 per week and £334 per week in nursing homes. The revenue costs of local authority homes averaged £299 per week. Information about the characteristics of the homes, their location and residents was used to investigate variations in costs and prices.

The analysis of costs and prices in the independent sector found:

- a significant relationship between price and dependency, although the effects were small compared to the effects of dependency on cost, which is probably due to price-setting behaviour of local authorities;
- costs were not as sensitive to dependency as might be expected, especially in nursing homes. This is due in part to the dislocation between nursing and residential care as a result of the separate regulatory arrangements;
- voluntary sector residential prices were more sensitive to dependency variations and lower than prices in private sector residential homes;
- prices were very sensitive to variations in local wages;
- prices were higher for privately-funded than for publicly-funded residents;
- prices were about a third higher in London, for each type of home;
- estimated mark-up rates of price over cost was around 10%;
- the market for residential and nursing home care was highly competitive.

Figure 3 shows the relationship between prices and dependency in independent residential and nursing homes when all other influences are held constant.



Further information

For further details about the survey, please contact Lesley Banks at the PSSRU in Canterbury, telephone 01227 823963, email L.A.Banks@ukc.ac.uk.

A full report of the survey (Netten et al. (1998) 1996 Survey of Care Homes for Elderly People: Final Report, PSSRU Discussion Paper 1423/2) is available, price £18 including p&p, from the PSSRU librarian in Canterbury.

Needs Based Planning for Community Care

Andrew Bebbington

Purpose

Needs based planning encompasses a considerable range of the PSSRU's work. Its aim is to link client and population needs to resource inputs, service technologies, resource inputs, costs and outcomes, in the search for rationales for resource allocation that are consistent with efficiency and equity. Its chief applications include:

- Resource allocation among administrative units responsible for purchasing decisions, such as local and district health authorities and patch teams;
- Projection of demand into the future, under assumed changes in needs or social circumstances, and consideration of the consequences of expected changes;
- Assessment of the efficiency and equity of the current pattern of resource utilisation;
- Addressing 'what-if' questions about the resource consequences of changes in policy and priorities, or of different assumptions about the appropriate interventions for particular types of need.

Box 1 Definitions

Population needs assessment aims to examine the implications for demand of a normative set of assumptions about need (needs judgements) applied equitably to a population. It is concerned with estimating the numbers of people who have particular combinations of needs related circumstances, such as disability, lack of informal support, etc.; with refining this on the basis of who can benefit from help; and with the translation of that demand into service requirements and costs under different assumptions about interventions.

Individual needs assessment (and review) is a core task with clients within care management.

Needs based planning is the process of combining evidence from both population needs assessment and individual needs assessments, with information about the supply and cost of services, statutory obligations, charging arrangements, take-up, local priorities and resource constraints, into a strategic plan for commissioning and resource allocation.

Planning within local authorities

Recent application to forecasting is described on pages 5-7 in this bulletin. Another stream of work is concerned with planning within local authorities. Needs analysis has had limited impact on policy and strategic planning at local level, but the 1990 NHS & Community Care Act both placed a duty on local authorities to assess the needs of their populations, and also changed the role of planning within local authorities in a way that made such assessment more salient. The separation of purchasing and providing reduced local authorities' traditional involvement in capital planning and labour management. At the same time needs-led assessment and client brokerage, effectively requiring increased devolution of spending decisions to care managers, made it crucial for local authorities to find ways of monitoring and controlling resource use as well as to ensure equity, for example through eligibility criteria. There was a need to assess the implications of new responsibilities, in particular the transfer of responsibility for residential and nursing home care.

Needs based planning offered a means of planning in these circumstances, as a rational alternative to incremental budgeting. Guidance on needs based planning had been provided by Price Waterhouse/Department of Health (1993); and in Scotland by the Social Work Services Inspectorate (1996). However, neither of these was able to illustrate their guidance with a full-scale real-life example. Most local authorities lacked the expertise to develop this for their own needs, and a level of scepticism remained.

The aims of the project have been:

- To elaborate the principles of needs based planning, building on the DH guidance;
- To review progress in the application of needs based planning in local authorities;
- To undertake a demonstration project which would illustrate the application of population needs assessment and assist in the equitable and efficient deployment of community care resources for elderly people.

The demonstration project

The demonstration project was undertaken with Surrey SSD, which had already developed a method of population needs assessment to inform its 1995 community care plan. Surrey had a commitment to needs based planning that combined both social services and the district health authorities and had also established a very comprehensive assessment form for elderly people which provided detailed information on states of welfare and subsequent service allocation.

The demonstration project was partly built on a simpler population needs assessment model that had been developed with Oxfordshire SSD in 1989 by the PSSRU. It illustrated how a range of policy issues might be tackled using the model. These included:

- Resource distribution consistent with equity, between patch teams for the elderly;
- Projecting likely future demand given growth in the elderly population;
- Examining the efficiency of the current pattern of allocation decisions;
- Examining the resource implications of alternative assumptions about appropriate interventions;
- Investigating unmet need.

The approach owed something to its predecessors, such as the Balance of Care model (Bowen and Forte, 1987). However, it made a major conceptual advance in that population needs assessment is regarded as a process with information requirements which correspond to the stages of the needs based planning process itself, as these were described in the Price Waterhouse/Department of Health (1993) guidance. This approach is able to integrate 'top down' evidence about population needs with 'bottom up' data from client assessments, together with other information about local priorities, budgets, prices, substitute services, etc. into an integrated system.

The process of developing such a system in the demonstration project can be described in three stages.

1. Classify elderly people into 'target groups'. The domains on which this was based included functional ability, physical health, mental health, accommodation difficulties, financial resources, social networks, informal support and carers' needs. These domains were used to classify elderly people, using in the first instance a cluster analysis based on data from 320 client assessment records but then modified by extensive discussions with health and social services staff. This produced 14 'target groups' of people broadly similar in their needs and in the level of interventions that were being made, defined in terms that were relevant to local policy-makers.
2. Estimate the overall incidence of people of each type in Surrey, and within its localities. The method chosen for this had three steps:
 - Reproduce the classification for people in the OPCS Disability Survey;
 - Establish the probability of target group membership given age, sex, limiting longstanding illness, whether living in a private household or communal establishment, and household composition — all information for which Census counts are available at local level. The result is a large matrix of probabilities;
 - Apply these probabilities to Census counts at a local level, suitably updated if required, to estimate the numbers of people in each target group in a population subgroup. This was a stock position, though flow estimates were also considered, particularly for one of the target groups, people recently discharged from hospital with short-term care problems.
3. Translate these estimates into an overall demand for long-term care, and then a cost. To do this a number of further elements were necessary:
 - Take-up rates were estimated in each target group. These rates were estimated from the Disability Survey, but adjusted to allow for the availability of substitutes: informal care and private purchased care. The adjustment factors were household composition and tenure (a wealth indicator). Target group sizes were adjusted by take-up.
 - A base-line service allocation for people in each target group was determined from the typical services provided to people in each target group.
 - A base-line price of each service was determined from current average unit costs. For some services, allowance was made for variations in supply by allowing higher prices for certain services in some localities, such as rural areas.

- Gross costs were modified by estimates of the client charges and their ability to pay.

The resulting computer model was designed so that it can readily calculate the resource consequences of changes and of different assumptions about any of the following:

- Numbers of elderly people, and changes in their age structure, household composition, pattern of disability (limiting longstanding illness), tenure (as an indicator of wealth);
- The appropriate service interventions for people in each target group;
- Changes in the prices of services or local variations in prices.

The model is designed to make it relatively easy to consider alternative options within an overall total budget constraint.

Good practice review

Those local authorities that had made most progress with needs based planning had, with a few exceptions, used outside consultants for population needs assessment. So the good practice review ultimately developed into a survey of several of the available systems of population needs assessment. Most of these turned out to be specialised to one rather specific problem. Nearly all the methods were under development, and in some cases commercial considerations limited the information about a method we were able to obtain.

Conclusions

What does the evidence tell us about the practicality of needs based planning in a local authority context? We are not yet at a stage where local authorities can routinely undertake this without some outside assistance. Even so, needs based planning still has some way to go in order to prove its worth in the local authority context. This is not just because of the technical problems of population needs assessment, but because it has to face the need to provide timely and reliable evidence that can be readily incorporated into the normal processes of decision-making under pressure. Further experimentation is required.

References

- Bowen, T. and Forte, P. (1987) *The Balance of Care Microcomputer System*, Department of Health, London.
- Price Waterhouse/Department of Health (1993) *Population Needs Assessment: Good Practice Guidance*, Department of Health, London.
- Social Work Services Inspectorate (1996) *Population Needs Assessment in Community Care*, The Scottish Office Home Department, Edinburgh.

Further information

The report *Needs Based Planning for Community Care: Matching Theory to Practice* will be available in April 1999 from the PSSRU. It gives a full description of the system of population needs assessment used in the demonstration project together with a computer model (written in SPSS).

Evaluating Community Care for Elderly People: Outcomes for Users and Carers

Linda Bauld, Bleddyn Davies, Ken Judge, John Chesterman, José Fernández, Roshni Mangalore

Following the community care reforms of the early 1990s, the PSSRU was commissioned by the Department of Health to conduct a substantial evaluation of these changes relating to services for older people and their carers. The resulting study, *Evaluating Community Care for Elderly People* (ECCEP), has been underway at the Kent and LSE branches of the Unit since 1994. ECCEP was designed as the second stage of a before and after study, with results from the first stage (the Domiciliary Care Project, or DCP) being published in *Resources, Needs and Outcomes in Community-Based Care* (Davies, Bebbington, Charnley and colleagues, 1990). Both DCP and ECCEP conducted interviews with users, carers and care managers in the same ten local authorities in England and Wales, with the DCP sample recruited during the mid 1980s and the ECCEP sample recruited in late 1995 and early 1996. In both stages of the study, users, carers and care managers were interviewed twice: once (Time I) following the user's referral to social services and once six to nine months later (Time II).

The ECCEP database is extremely detailed and contains information on a wide range of topics, including the need-related circumstances of users and carers, care management processes and interventions, the costs and content of care packages and results relating to a wide range of outcomes.

This short article focuses on two types of outcomes for users and carers: the length of time they are able to remain living in the community following referral to social services and the role that specific services play in extending that length of stay; and the satisfaction of users and carers with assessment, the services received and their ability to continue living independently.

Length of stay in the community

The length of time which older users remain in the community before death or transition to institutional care is one important indicator of service effectiveness. Table 1 illustrates destination outcomes for users one year following their referral to social services.

Amongst the original community-based sample of older people, 13% died during the year following referral. In addition to the users who did not survive, Table 1 shows that 10% of users moved from their own homes into a care

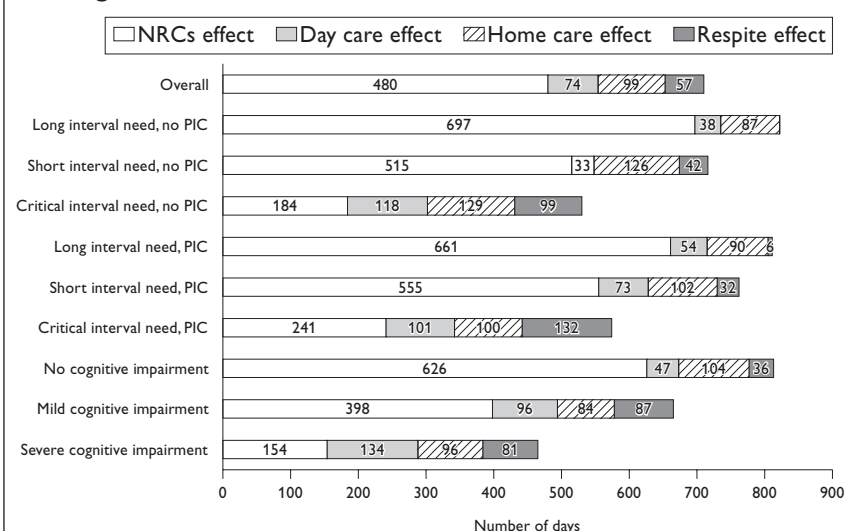
home during the first year. This is a small proportion of the overall sample and suggests that the vast majority of users avoided institutionalisation and remained in the community, with temporary or long-term support from formal services. Indeed, 57% of users were still living at home and still receiving social care services one year post referral. The remaining 21% of users were no longer receiving services from the same one year later for a variety of reasons. The most common reasons were either that they had regained independence and no longer required help (an example would be users who had recovered following discharge from hospital), the user or carer had refused services, or that the case was closed to care management but the user was still receiving services from other sources.

A variety of issues affect an older person's ability to continue living in the community, including potential risk factors such as mental and physical health and the extent of informal support available. Services do however have an important role to play in assisting older people to retain their independence. Production function analyses illustrate relationships between service inputs and welfare outcomes such as length of stay in the community. Figure 1 illustrates the combined impact of risk factors and service inputs

Table 1 Location of user twelve months post-referral

Location of user	%	n
Dead	12.6	53
In care home	9.8	41
Living in the community	56.6	237
Other	20.8	87
Total	100.0	418

Figure 1 Contributions of services and risk factors to days living at home prior to entering institutions



on survival at home for different groups of users.

The first bar in the figure illustrates the effects for all users. The predicted effect of risk factors (need-related circumstances (NRCs)) is survival for 480 days to which the provision of home care (99 days) day care (74 days) and respite care (57 days) add an additional 230 days. The effects vary between different groups of users based on their level of dependency (from long to critical interval needs), the availability of a carer (PIC) and the presence or extent of cognitive impairment. What is clear from the figure is that the service contribution is greatest for the groups of users for whom the prognosis from risk factors was most pessimistic.

Satisfaction

Users and carers were asked at both Time I and Time II how they felt about the assessment process and the services they had received. In relation to the way which social services had *assessed their needs and tried to help*, satisfaction levels were high, with 80% of users and 73% of carers reporting that they were either satisfied or very satisfied. While there were no significant differences in satisfaction levels between users with long, short or critical interval needs, those with a carer were slightly more likely to report that they were satisfied or very satisfied with the assessment and help (80%) than users without a carer (72%). Table 2 illustrates the level of carer satisfaction at Time I with the services provided following assessment.

As Table 2 shows, the vast majority of carers reported that they were satisfied or very satisfied (76%), with satisfaction levels slightly higher amongst the carers of users without a cognitive impairment. The carers of the frailest users — those with critical interval

Table 2 How satisfied is carer with help and support from social services by interval need and CI or BD of user among community-based sample

Satisfaction of carer with help and support from social services	INTERVAL NEED						Total n =
	Critical		Short		Long		
	CI/BD %	Not CI/BD %	CI/BD %	Not CI/BD %	Not CI/BD %	CI/BD %	
Very satisfied	28.7	37.1	21.9	24.3	7.2	30.1	60
Satisfied	42.2	45.8	56.2	61.5	71.1	44.8	110
Mixed feelings	16.7	10.5	8.8	12.1	0.0	17.6	28
Dissatisfied	4.8	2.2	8.8	2.0	7.2	7.5	10
Very dissatisfied	5.6	2.2	4.4	0.0	14.5	0.0	7
Don't know	2.0	2.2	0.0	0.0	0.0	0.0	2
Total n =	49	45	22	48	13	39	216

Missing cases: 4

Note: CI/BD means cognitive impairment or behavioural disorder.

needs and a cognitive impairment — reported the lowest levels of satisfaction overall, with just over one in four of these carers describing themselves as having mixed feelings, being dissatisfied or being very dissatisfied.

Users and carers were also asked to assess their satisfaction at Time I with the user's ability to remain living independently in the community. More than three-quarters of the user sample were either very satisfied or satisfied with their ability to remain at home, although the level of satisfaction varied with interval need. Services were viewed by users as playing a key role in the maintenance of their independence. Over half of users at Time I, excluding those with a severe cognitive impairment, reported that services helped them to remain at home 'to a great extent', while an additional 37% reported that they assisted 'to a degree'. Just 7% of users stated that services made no difference to their ability to continue living at home. Table 3 illustrates how responses to this question varied between Time I and Time II.

Table 3 Change in extent that help allows user to live as he/she would like from Time I to Time II by interval need and social support among community based sample

Did ability of help to improve user's life increase	Critical		INTERVAL NEED				Total n =
	No PIC %	PIC %	No PIC %	PIC %	No PIC %	PIC %	
Got worse	14.3	16.0	25.0	11.4	24.0	16.4	27
No change	28.6	53.5	37.5	60.0	56.0	54.4	88
Improved	57.1	30.5	37.5	28.6	20.0	29.2	48
Total n =	7	36	8	34	24	53	163

Missing cases: 23

Sample: Cases with user interviewed in community at Time I and Time II and Katzman score below 22 at both these times. Katzman scores of 22 and above indicate severe cognitive impairment.

When asked if services were making a difference in their ability to live as they wished, the single largest group of users gave the same response at both Time I and Time II (54%). Amongst those users who indicated a change in their views once services had been in place for several months, the proportion reporting an improvement in the extent to which they felt that services helped them remain at home was greater (29%) than those reporting a deterioration (17%). Table 3 also illustrates a clear pattern by interval need, with more dependent users indicating greater confidence in the role of social services than less dependent users. When combined with the presence or absence of a carer, it is evident that critical and short interval need users without a carer were particularly positive regarding support from social services over time, suggesting that the targeting of more intensive resources on these users is making an impact on this particular aspect of quality of life.

Further information

More detailed results from the ECCEP project have recently been published in a separate bulletin, which is available free of charge from the PSSRU librarian in Canterbury and may be viewed/downloaded from the PSSRU Web site.

The project secretary is Sarah Wehner: telephone 01227 827953 or e-mail S.K.Weher@ukc.ac.uk.

Recent PSSRU Publications

This page lists selected books and reports published by PSSRU authors in 1997 and 1998. Other publications relevant to particular studies are referenced in the articles above and in the 'Further information' boxes.

Books and monographs

PSSRU books and monographs are available (post free) direct from the PSSRU in Canterbury or obtained through bookshops. Prices are correct at January 1999; cheques should be payable to 'UniKent'.

Newsletters

The *Mental Health Research Review 5* (a joint production with the Centre for the Economics of Mental Health at the Institute of Psychiatry) was published in May 1998 and issue 6 is due to be published in April 1999. Back issues of some editions of the PSSRU Bulletin, the *Mental Health Research Review*, and the *Mixed Economy of Care Bulletin* are available. All these are available free of charge from the PSSRU in Canterbury.

Discussion papers

There was not space to list discussion papers separately, although some are referenced in the articles. The PSSRU librarian in Canterbury will be glad to supply copies of these: where a price is not given, please confirm this in advance. 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.

Further details, enquiries and orders

Fuller details of all PSSRU books in print, as well as journal articles by PSSRU authors and over 250 discussion papers available for purchase, can be obtained from the PSSRU librarian, Clare Valentine, in Canterbury (01227 827773, email C.Valentine@ukc.ac.uk) and may be viewed on the Unit's world wide web site at <http://www.ukc.ac.uk/PSSRU/>. The web site also includes text of shorter publications such as this and previous Bulletins, outlines of current research, details of staff, announcements of seminars and other news about the Unit.

Community Care in England and France

Bleddyn Davies, José Luis Fernández and Robin Saunders

Ashgate, Aldershot, 1998, 228 + xxiv pages.
ISBN 1 84014 584 6 (hbk). Price £37.50.

This book compares the recent history and the equity, effectiveness and efficiency of community care of elderly people in England and France.

From Vision to Reality in Community Care: Changing Direction at the Local Level

Chris Gostick, Bleddyn Davies, Robyn Lawson and Charlotte Salter

Arena, Aldershot, 1997, 200 pages. ISBN 1 85742 409 3 (pbk, £16.95); 1 85742 408 5 (hbk, £35.00).

How is the policy vision of the 1989 *Caring for People* White Paper and the NHS and Community Care Act of 1990 being implemented at the local level? The authors analyse detailed interviews and other material collected from five local authorities as well as the policy documentation.

Unit Costs of Health and Social Care 1998

Ann Netten, Jane Dennett and Jane Knight

PSSRU, Canterbury, 160 pages, ISBN 0904938859 (pbk). Price £11.00

Now in its sixth year, this report brings together a wealth of information for those involved in providing or evaluating research and those undertaking costs research.

Detailed information on the component costs of many types of service is given, with a commentary detailing the basis of the estimates; price indices; a reference list of key studies; a glossary and indexes.

(See page 23 for details about the related 'Ready Reckoner' report and software.)

Community Care, Secondary Health Care and Care Management

David Challis, Robin Darton and Karen Stewart

Ashgate, Aldershot, 1998, 183 pages. ISBN 1840145811 (hbk). Price £29.95.

Building on PSSRU research, this book considers the key elements of the relationship between secondary health service provision and intensive care management for older people.

The Cost of Caring: The Economics of Providing for the Intellectually Disabled

Shane Kavanagh and Louis Opit

Politeia, London, 1998, 82 pages (pbk), ISBN 1 900525 32 1. Price £10.00.

Demand for Long-Term Care: Projections of Long-Term Care Finance for Elderly People

Raphael Wittenberg, Linda Pickard, Adelina Comas-Herrera, Bleddyn Davies and Robin Darton

PSSRU, Canterbury, 133 pages (pbk), ISBN 0 84014 584 6. Price £11.00.

See pages 5-7 for a discussion of the research reported here.

In collaboration with authors at other institutions (available from bookshops but not the PSSRU)

London's Mental Health

Sonia Johnson, Rosalind Ramsey, Graham Thornicroft, Liz Brooks, Paul Lelliott, Edward Peck, Helen Smith, Daniel Chisholm, Bernard Audini, Martin Knapp and David Goldberg

King's Fund, London, 1997, 400 pages. ISBN 185717139X (hbk)

The Contract Culture in Public Services: Studies from Britain, Europe and the USA

Perri 6 and Jeremy Kendall

Ashgate, Aldershot, 1997, 216+xii pages. ISBN 1857422872 (hbk)

PSSRU Research Programmes

These two pages give a brief listing of most PSSRU work current at January 1999, 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. The PSSRU web site – <http://www.ukc.ac/PSSRU/> – gives more information and staff telephone, mail and email contact details.

Care management and coordination of care

The value of multi-disciplinary assessment of vulnerable older people

Evaluating the effect of the provision of a clinical contribution to the assessment of vulnerable older people. Examining the costs and benefits of this multi-disciplinary process of assessment for older people and their carers, and also for health and social services.

David Challis, Jane Hughes, Melanie Nixon, Ashley Weinberg, Janine Williamson (PSSRU) and Alistair Burns

Eligibility criteria in local authority services for older people

National study of eligibility criteria for social services, looking at the different forms of eligibility criteria used by local authorities for different service sectors; the link between eligibility criteria and assessment systems; and the utility of the systems of eligibility and assessment which are in operation and the difficulties associated with their implementation.

David Challis, Jane Hughes, Julia Gill, Angela Worden (PSSRU) and Sherrill Evans

Estimating the balance of care in a local authority

Estimating the cost and feasibility of shifting the balance of care from residential to community support, focusing on the patterns of admission to residential and nursing care for older people in one LA area.

David Challis, Robin Darton, Jane Hughes, Karen Stewart, Angela Worden (PSSRU) and Sherrill Evans, Faye McNiven

The evaluation of a national standard assessment instrument in care homes for older people

The development, piloting and evaluation of the costs and benefits of the Minimum Data Set – Resident Assessment Instrument for nursing and residential care settings in the UK. Monograph available.

David Challis, Karen Stewart, Glenys Harrison

Towards a national standard assessment instrument in continuing care homes: translation of the MDS-RAI into a manual for use by staff in the UK

Continuation of the above study, translating the MDS-RAI from its US format for use in UK residential and nursing homes.

David Challis, Angela Worden (PSSRU) and Deborah Sturdy, Iain Carpenter (CHSS, UKC)

Evaluation of Lewisham care management scheme for the cognitively impaired

Evaluation of a care management service for elderly people suffering from dementia, based in a multi-disciplinary community mental health team.

David Challis, Pamela Brown, John Chesterman, Jane Hughes, Melanie Nixon

Mapping and evaluation of care management arrangements for older people and those with mental health problems

Project aims to identify the distinctive characteristics of different care management arrangements and discriminate between these in terms of their structures, processes and outcomes, in order to identify differences in their relative costs and benefits. (See pages 12-13 for more details.)

David Challis, Robin Darton, Jane Hughes, Peter Huxley, Ann Netten, Karen Stewart, Kate Weiner, Angela Worden, Glenys Harrison

Performance Indicators in Social Care for Older People

Project commissioned by a social services department with assistance from the Social Services Inspectorate with the aim of developing, implementing and monitoring a set of performance indicators for services to older people.

David Challis, Paul Clarkin (PSSRU) and Raymond Warburton (SSI)

The quality of life study

An outcome study involving interviewing a large cohort of elderly people newly admitted to residential or nursing home care in three areas of North West England. Characteristics of the home environments are assessed by staff questionnaires and interviews, and direct observation.

Peter Huxley, David Challis, Ann Netten, Caroline Sutcliffe, Heather Bagley, Leonie Price, Gill Lomas, Robin Darton, Caroline Mozley, Lis Cordingley (PSSRU) and Alistair Burns

North West Region Dementia Research and Development Centre

The centre aims to promote effective research in the care of people with dementia and raise awareness of effective approaches to the care of people with dementia through dissemination of findings. First research links with the Mapping Study but focuses on dementia services alone.

David Challis, Jane Hughes, Helen Gilchrist, Mandy Bryant (PSSRU) and Alistair Burns, Ken Wilson, Charlie Brooker

Children and young people

Economics of child social care

A review of the need for economic perspectives on child social care, the ways in which economic evaluations can examine child social care policies and practices, and a summary of the UK literature.

Martin Knapp, Ana Lowin

Evaluating community care for elderly people (ECCEP)

Evaluating community care of elderly people (ECCEP)

The ECCEP project is the most recent phase of a programme launched during the early 1980s, designed to evaluate the effects of the community care reforms. (See pages 30-32 for more details.)

Bleddyn Davies, Ken Judge, John Chesterman, Robin Saunders, Linda Pickard, José Luis Fernández, Linda Bauld, Roshni Mangalore

Measurement of costs and outcomes

Developing a measure of social care outcome for older people (SCOOP)

As part of a research initiative on outcomes of social care for adults (OSCA) the Department of Health has commissioned the PSSRU to develop a utility measure specific to the social care of older people.

Ann Netten, David Challis, Daniel Chisholm, Andrew Healey, Martin Knapp, Paul Smith

Unit costs of health and social care

The primary aims are to collate state of the art unit costs research; to identify important gaps in knowledge about unit costs; and to contribute to the discussion about an agreed approach to costs estimation and standard of costing which could prove of value to local and health authorities. Unit Cost reports have been published annually since 1993.

Ann Netten, Jane Knight, Jane Dennett, Jennifer Beecham, Martin Knapp

Development of a ready reckoner for staff costs in the NHS

see pages 21-23

Ann Netten, Jane Knight, Jane Dennett

Mental health economics and policy

Village communities: quality and costs of residential supports for people with learning disabilities

As part of a programme of research being carried out by the Hester Adrian Research Centre (HARC) in Manchester, the Department of Health has commissioned the PSSRU/CEMH to conduct a cost and effectiveness evaluation of different forms of residential support.

Angela Hallam, Martin Knapp, Ann Netten

The relationship between the Care Programme Approach and care management

A two year study, beginning in March 1997 carried out by a project team from the Universities of Durham, Kent, and Manchester. The initial stages will be conducted in parallel with the care mapping project also funded by the DH, in order to avoid overlap and maximise the data available to both studies. Funded by the DH Mental Health R&D Initiative.

David Challis, Peter Huxley, Martin Knapp

Health Resource Groups for people with learning disabilities

Collection and analysis of service utilisation and cost data for adults with learning disabilities with reference to their characteristics, specifically to build health resource groups for use by the NHS.

Jennifer Beecham, Martin Knapp, Adelina Comas-Herrera

Conduct disorder

A clutch of four studies looking at the lifestyles, service use patterns and costs of children with conduct disorders at various ages (including adulthood follow-ups).

Martin Knapp, Juliet Henderson, Stephen Scott

Survey of day settings for people with mental health problems

Survey of day activity settings in South Thames region; characteristics of users, activities offered, management arrangements and costs.

Jennifer Beecham, Martin Knapp

Pfizer health economics programme

Economic evaluation of treatment of elderly people with depression with the SSRI drug sertraline.

Martin Knapp, Steve Almond, Jack Astin

Secondary analysis of the OPCS/ONS surveys of psychiatric morbidity

Study of the service use patterns and costs of supporting people with schizophrenia in Britain, and in relation to their needs and circumstances, including comparisons with previous national estimates.

Shane Kavanagh, Martin Knapp

Psychiatric reprovion in North London

Five-year follow-up of former long-stay psychiatric hospital residents who moved to community-based care settings as part of the closure programme for Friern and Claybury hospitals in North London.

Martin Knapp, Jennifer Beecham, Angela Hallam, Andrew Fenyo

Ten years on: outcomes and costs of community care for people with learning disabilities and mental health problems

Ten-year study of community-based care for two groups of people – one with mental health problems and one with learning difficulties – who left long-term hospital care for carefully planned community accommodation.

Martin Knapp, Jennifer Beecham, Angela Hallam

Cost-effectiveness analysis of Zotepine vs Haloperidol in the treatment of schizophrenia

Steve Almond

The mixed economy of care

Comparative cross national research project

Comprehensive study of the UK voluntary (non-profit) sector, including a complete statistical mapping of the scope and scale, a review of the legal position, examination of the policy treatment, and evaluation of impact.

Martin Knapp, Jeremy Kendall, Steve Almond, Rachel Wigglesworth

The mixed economy of care

A long-running programme, jointly conducted with the Nuffield Institute for Health (University of Leeds), focusing on purchasing strategies, commissioning, providers and markets for social care services in England.

Martin Knapp, Julien Forder, Jeremy Kendall, Rachel Wigglesworth

Measuring the outcomes of voluntary activity

A review of the performance domains for voluntary (non-profit) organisations in Northern Ireland, based on theories of the existence and roles of these organisations.

Martin Knapp, Jeremy Kendall

Needs-based planning

Resource allocation methodology

see pages 27-29

Andrew Bebbington

Long-term care demand and finance for elderly people

Construction of models for projection to 2030 of numbers of elderly people in need of help with tasks of daily living, demands for formal care, costs to public funds under various policy assumptions; and prediction of the consequences of alternative packages of financing mechanisms. (See pages 5-7 for more details.)

Bleddyn Davies, Raphael Wittenberg, Linda Pickard, Robin Darton, Adelina Comas-Herrera

Partnerships and performance

Health action zones (HAZ)

The first phase of the national evaluation of health action zones, beginning in 1999. The initial priority is to look closely at the partnership and governance arrangements being adopted in each zone and at the establishment of links with community organisations. At the same time, we plan to identify local rationales for investments in particular interventions and activities, and to elicit information about their expected consequences. (See pages 18-20 for more details.)

Ken Judge, Linda Bauld, Rachel Wigglesworth, Michael Marinetto

Residential care and nursing home care of elderly people

Survey of admissions to residential care and nursing homes for elderly people

A DH-funded survey of 2,500 publicly funded admissions, conducted in the autumn of 1995 in 18 local authorities in England.

Estimating the costs of regulation of residential and nursing home care for adults

A study of the costs to health and local authorities in England of regulation and inspection of residential and nursing homes for adults in order to provide a basis for setting cost-related fees at a national level.

Ann Netten, Julien Forder, Jane Knight

Cross-sectional survey of residential and nursing homes for elderly people

A survey of 600 residential and nursing homes in England conducted in 1996, which investigated characteristics of homes and residents, and investigated the link between costs, fees and dependency.

Ann Netten, Robin Darton, Pamela Brown, Andrew Bebbington, Kathryn Miles with Julien Forder

Longitudinal study of elderly people admitted to residential and nursing homes

A follow-up survey of residents identified in the survey of admissions (see above) which tracks mortality, changes in location and dependency characteristics up to 3.5 years after admission.

Ann Netten, Robin Darton, Pamela Brown, Kathryn Miles

Survey of privately-funded admissions to residential and nursing homes

A DSS-funded survey investigating the circumstances of admission of self-funders entering residential and nursing home care in Great Britain.

Ann Netten, Robin Darton and Kathryn Miles

The **PERSONAL SOCIAL SERVICES RESEARCH UNIT** (*Director: Professor Bleddyn Davies*) undertakes social and health care research, focusing particularly on policy research and analysis of equity and efficiency in community care and long term care and related areas, including services for elderly people, people with mental health problems and children in care. The Unit's work is funded mainly by the Department of Health. The PSSRU was established at the University of Kent at Canterbury in 1974, and from 1996 it has operated from three sites:

PSSRU, Cornwallis Building, University of Kent at Canterbury, Canterbury, Kent, CT2 7NF.

PSSRU, London School of Economics, Houghton Street, London, WC2A 2AE.

PSSRU, University of Manchester, Dover Street Building, Oxford Road, Manchester, M13 9PL.

The PSSRU Bulletin and publication lists are available free of charge from the PSSRU librarian in Canterbury (01227 837773).

The Unit website can be found at <http://www.ukc.ac.uk/PSSRU/> and gives details of PSSRU publications (with downloadable versions of some of them) research programmes and staff.