BUCKINGHAMSHIRE

NEEDS ACTION

CARE ASSESSMENT PROJECT

FIRST INTERIM REPORT
OF THE COMMUNITY CARE ASSESSMENT PROJECT

OCTOBER 1991

KING'S FUND COLLEGE

2 Palace Court
LONDON W2 4HS
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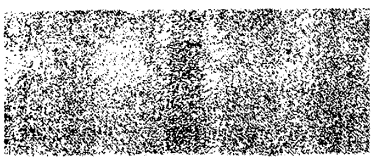

Acknowledgements

The King's Fund College project team wishes to acknowledge the help and assistance of all in Buckinghamshire who have contributed to the project so far. In particular members of the Steering Group have met on a number of occasions and provided invaluable ideas and support. The team wishes to thank Kate Garnett who has provided secretarial and administrative support.

King's Fund College project team

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Buckinghamshire Care Assessment Project

FIRST INTERIM REPORT OCTOBER 1991

Mapping of Care Assessment Systems in Buckinghamshire

Contents

This report is the first in a series to be published on the care assessment project initiated by Buckinghamshire County Council Social Services Department in conjunction with the Family Health Service Authority and Milton Keynes, Aylesbury Vale, and Wycombe District Health Authorities.

Interim Report: Phase 1

1. Executive Summary

1.1 The objective of the Buckinghamshire Care Assessment Project is to identify all existing needs assessments proformas, systems, policies and procedures for community health and social care provision to the priority client groups and to develop a core assessment procedure with agreed interagency, interprofessional assessment systems for community care.

1.2 Phase 1 of the project has gathered as many assessment proformas, systems, policies and procedures as available from the Social Services Department, from the Family Health Services Authority and general practitioners, and from the three coterminous District Health Authorities — Milton Keynes, Aylesbury Vale and Wycombe. Some systems are still outstanding and will be assimilated into the continuing work once available.

1.3 To date fifty-four proformas, systems, policies and procedures have been received and analysed using a number of simple checklists and maps. The analysis has identified those systems which are care-group or agency specific, those which have generic application and those which put emphasis on health or social function.

1.4 The wide variety of type and application of current needs assessments suggests fragmentation of service and duplication of effort in assessing client/patient need. Some systems are very sophisticated, others very simple. All are different in one way or another even though they may ask similar questions in a different order and within varying frameworks. In particular few of the existing systems directly indicate the need for action, outcome statements or review mechanisms. Many professional staff will provide such action plans but this is not clearly directed by or set out in the forms and systems received.

1.5 None of the systems received were truly generic. All were related to some degree to one care group or another, and usually were relevant to a particular agency and /or professional group. Six of the systems however, were *relatively* low on care-group specificity *and* agency specificity and were moderately directive towards service provision. These will be used as an initial base for the development of the core assessment procedure.

1.6 The core assessment procedure will include 3 components: an initial screen related to 'first gate eligibility', an 'envelope' mainstream assessment with a series of 'sockets' into which specialist assessments can be 'plugged'; and a range of specialist/complex assessments for people with special needs. The development of the assessment tools within this framework is the subject of Phase 2 of the programme.

1.7 It is evident that a great deal of further work is needed to develop a core assessment procedure. At this stage in the work the project team believes the best way forward is to develop an initial screen which can be undertaken by any professional worker and the client/patient, and which will indicate the need for a mainstream assessment for continuing community health and social care.

The mainstream assessment will be developed as an harmonisation of existing tools and methods. Initially a series of outcome state-

ments will be developed which any component specialist assessment must try to answer. This will provide the opportunity to continue with a plurality of assessment methods (where these are demanded by professional staff) but within an "envelope" which creates integration, maximum commonality, and minimises duplication and resource wastage.

1.8 This report is issued for consultation. Comments should be returned to the address below as soon as possible but in any event no later than 19 December 1991. Work is already continuing into Phase 2 of the project — developing the core assessment procedure with detailed assessment components; but any comments and additional proformas, systems, policies and procedures will be assimilated into the work.

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(NOTE: A full bibliography and reference list will be issued with the Phase 2 Report.)

2. Introduction

2.1 Background

This report is the first of three staged reports which will be issued in connection with this project. The Buckinghamshire Care Assessment Project was established in July 1991 with the main purpose of developing an agreed cross-agency inter-professional core assessment procedure for community care. The project has four phases:

Phase 1: mapping of current assessment pro-formas, systems, policies and procedures;

Phase 2: development of a core assessment procedure and draft assessment pro-forma systems;

Phase 3: preparation of pilot project materials for the initial case management pilots to be run within Buckinghamshire from 1st April 1991; and

Phase 4: action research and evaluation of the core assessment procedures in practice during the pilot project.

The project is supported by Buckinghamshire Social Services Department, Buckinghamshire Family Health Service Authority and the three district health authorities which are fully coterminous with Buckinghamshire — Milton Keynes, Aylesbury Vale, and Wycombe. A project steering group was established in June and meets monthly. The King's Fund College, London was asked to undertake the work on a consultancy basis and provide progress reports to the steering group monthly. Three progress reports have now been issued and these are available from the King's Fund College on request.

In the first phase of the project, fifty-four different assessment pro-formas, systems, policies and procedures have been identified throughout Buckinghamshire in use by the five statutory authorities and general practitioners.

Some of the systems are simple, others remarkably sophisticated. Some are used with one client group — for example, elderly people — others can be used for any client group — for example, GP record cards. A wide diversity of type, approach, level of detail and usefulness is apparent in the systems surveyed.

This report lists all the assessment pro-formas, systems, policies and procedures which have been considered by the project team during the initial mapping exercise. An analysis has been completed of the systems in order to identify those which may:

(i) be used for an initial screening device for entry to a "community care channel";

(ii) be appropriate for a mainstream assessment for clients/ patients accepted for community care provision; and

(iii) appear appropriate for detailed professional and client group specific assessment of people with substantial or complex needs.

The report provides "maps" of all the systems analysed using a variety of dimensions appropriate to the task. From these maps it has been possible to identify those pro-formas, systems, policies or procedures which seem best to take forward into the development of

the core assessment procedure. Inevitably, the project team will not have been able to identify every system in operation. In particular, general practitioners are likely to have their own specific approach which may not have been identified during this first phase. In order to ensure that everyone has the opportunity to influence the discussion, this report has been issued for consultation purposes.

2.2 Consultation Period

This report is a consultative document intended to open debate on the development of a core assessment procedure for community care. The report is being sent to all general practitioners, a number of hospital based clinicians, community health service managers and staff, social services department managers and staff, voluntary agencies and representatives of clients/patients. It should be noted that the project will continue into Phase 2 — the development of the core assessment procedure — during the consultation period. That does not negate the consultation — in fact the reverse. Because of the tight time scale, the project team must begin working on the core assessment procedure and the assessment systems whilst receiving further information. As the work develops, new evidence will be assimilated and there will be further opportunities to influence the pattern of the assessment systems which emerge.

There is thus no set time to the consultation period. However, it it important that the project team receive responses as soon as possible. Consequently, all those receiving this document are asked to respond by December 19, 1991 at the latest. Any response which is made after that date will of course be considered. To assist the project team, however, early responses are requested.

2.3 Major Undertaking

It will be obvious from this description that the Care Assessment Project is both a major undertaking and requires a great deal of goodwill on all sides. The project attempts to develop an acceptable and accepted core assessment procedure available across client groups, agencies and professional boundaries. The project thus seeks to develop a system which will be acceptable as much to general practitioners as to clinicians, say, working with elderly people, community psychiatric nurses or social work case managers.

The system should be equally at home in providing a screen for further assessment for any client group — for example, elderly people, people with mental illnesses, people with learning difficulties, physically or sensorily disabled people. If successful, the system will be extended to children, but it is not the intention of the project team to consider in detail the needs of children at this stage, other than where children with disabilities would naturally fall into one of the groups set out above. A series of Consultation Meetings will be held around Buckinghamshire to ensure that everyone has had a chance to consider and comment on the report.

3. Description of the Overall Project

3.1 Introduction

The Buckinghamshire Care Assessment Project seeks to develop a common needs assessment process for community care management. The white paper 'Caring for People' requires that local authorities with health authorities develop care management procedures in order to effect the best possible community care services for people with disabilities and disadvantages. Local authorities, are responsible for developing care management in conjunction with other authorities. The time-table for care management development is as follows:

3.1.1. From April 1991 local authorities will establish 'arms length' inspectorates to monitor, regulate and evaluate care provided by the local authority itself and by private and voluntary agencies used by the local authority in meeting the needs of clients; and must provide a complaints procedure;

3.1.2. From April 1992 local authorities, together with health authorities, must have produced community care plans setting out how it is intended to meet the needs of the "priority" groups; and

3.1.3. From April 1993 local authorities must have in place appropriate care management procedures to ensure that they are able to undertake their responsibility for:

(i) assessing the needs of all clients requiring long term and continuing care;

(ii) developing appropriate packages of care to meet assessed need; and

(iii) contracting internally and externally with a range of agencies to provide care appropriate to the package developed.

From April 1993 the government's proposals are to change the current social security funding mechanisms for residential care. Enhanced income support will not be available from that date automatically to pay for a residential placement. Local authorities will become responsible for "purchasing" all community care resources, including residential services.

Many health and local authorities already have assessment systems for client need, geared to deciding on services to be provided to those clients. Often these systems are patchy, uncoordinated and based on different values or criteria. Whilst there is much good work being undertaken within Buckinghamshire, nonetheless the current system is fragmented with many different systems in use across the county. Effective care management will require that all clients, whether or not identified as requiring continuing care, should be able to enter a system geared to meeting their needs. Entry to that system may be direct, following hospitalization, or may be via some form of screening mechanism to determine which clients need some form of service from one of the relevant agencies.

3.2 Describing Assessment Systems

In order to provide effective community care it will be essential to have an initial screening system which is relatively non-specific for clients or for the professional staff who may be responsible for completing such a system, and which then allows clients to be referred on for

a fuller assessment where necessary. Any core assessment procedure of this sort must be acceptable to a wide range of professional staff, all agencies involved, and be usable across client groups. In addition, it will be essential that client group specific assessments can continue to be undertaken particular professional groups within individual agencies.

There are many ways of describing how assessment systems and procedures may fit together. The director of social services has described it as rather like an onion — peeling off layer by layer to get to the core requirements of the client. Another approach, described by Dr. Chris Foote of Wycombe Health Authority, is to see needs as an iceberg — only the tip of the iceberg is usually evident initially when a client is first referred. Over time however, the extent of the individual's needs become apparent. A further way of considering this is as a pyramid (Diagram 1). The top part of the pyramid are those initial needs which identify a client as requiring further care or some form of limited initial service. The second level is wider and deeper, and some clients may be dealt with at this level. Those clients with complex requirements, however, will be considered in the third level which is wider and deeper still.

A further approach is shown in Diagram 2, which relates closely to the analytical approach developed by the project team. Some systems are highly professional specific, some can be completed by any professional group. Some systems are highly client group specific and others generic. The three stages of a core assessment procedure can thus be shown as:

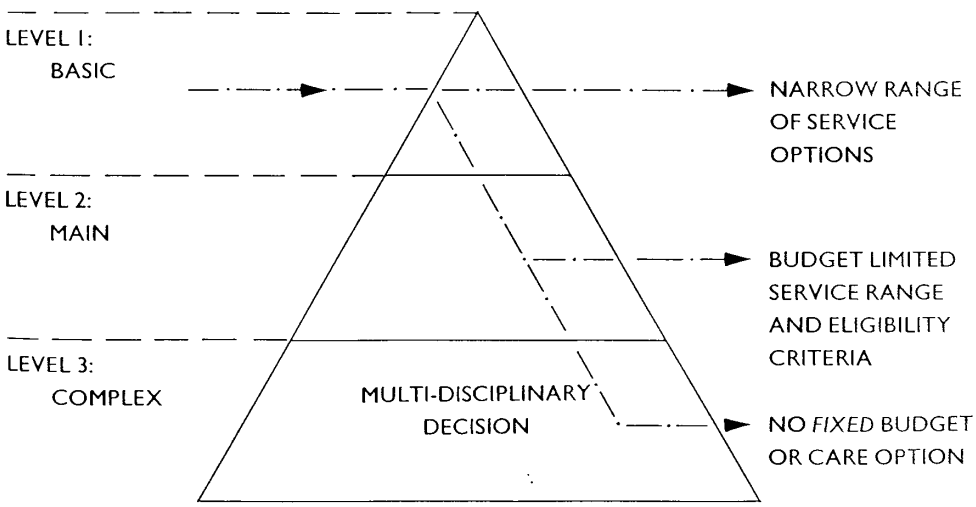


DIAGRAM 1: ***GRAPHIC REPRESENTATION OF NEEDS LEVELS***

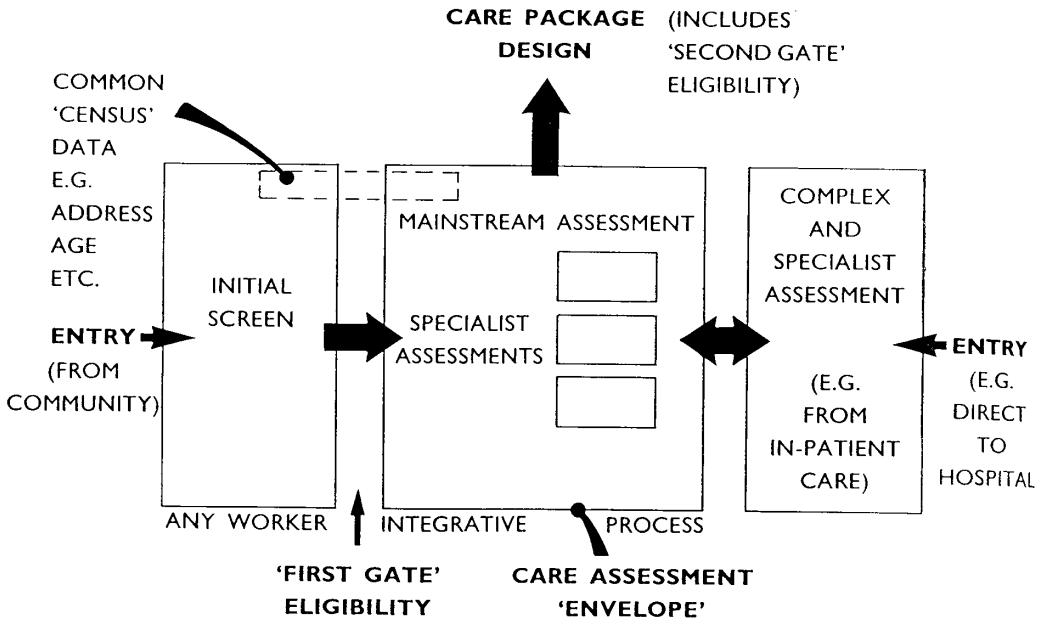


DIAGRAM 2: ***INTER-RELATIONSHIP BETWEEN ASSESSMENT LEVELS. THE WHOLE IS A 'CORE ASSESSMENT PROCEDURE' INTO WHICH SPECIFIC ASSESSMENTS CAN BE PLUGGED.***

(i) an initial screen (low professional specific, low client group specific);

(ii) a mainstream assessment (in overview moderately professional specific and moderately client group specific, but which incorporates integrated sub-systems which are both highly professional/client group specific);

(iii) complex assessments for individual clients usually undertaken by specific professional groups with appropriate training or possibly through multi-disciplinary teams.

It does not matter a great deal which of these models is considered at present. What matters most is that a workable conceptual model is developed to aid thinking about the best form of core assessment procedure and assessment systems at each level. The models suggested here are simply to aid clarity in thinking — readers of this report may favour one model over another.

The purpose of the needs assessment project, particularly in Phase 1, is to discover the systems in use and to "map" those systems on a range of dimensions. This will achieve a number of things:

3.2.1. identify the wide range and diversity of systems available;

3.2.2. suggest which systems can be used as a basis for discussing the core assessment procedure and the assessment systems at each level;

3.2.3. provide some information about the possible interrelationship between systems;

3.2.4. offer pointers to where current systems may be weak or where further work is required;

3.2.5. provide everyone within Buckinghamshire with a picture of the types of systems in use and thus the need for some greater integration and coordination of systems and agencies/professional staff;

3.2.6. offer patients/clients some understanding of the complexity of providing assessment and suggest ways in which clients/patients may be able to have a greater say and involvement both in the development of assessment systems, in the use of such systems and in the implementation and retention of assessments and care packages once undertaken.

3.3 Dangers and Benefits

The work is complex and difficult. There is no one obvious approach which can be adopted. Much good work has been done and the project team have identified a number of systems in use in Buckinghamshire which could be used as a basis for further work. Some are mutually consistent, others contradictory. Some individual professionals may wish to continue with the system they have developed rather than using a common procedure within the county.

The project team hopes that everyone receiving this document and considering the future of community care in Buckinghamshire will recognise the need to develop agreed core systems and the dangers of not doing so. Those dangers are continued fragmentation, an inability to relate professional groups and agencies together, continued bureaucratic problems, clients/patients subject to multiple assessments by different staff, and confusion about which assessment should be used to create a care package and thus provision of care.

The benefits of developing an integrated system are clear. They are:

(i) to provide all agencies, clinicians, social workers, other professional staff and clients/patients with a common assessment system agreed and understood by all;

(ii) to provide a common system for developing care packages;

(iii) to establish agreements on definitions of required care and eligibility across client groups, agencies and professional staff;

(iv) to provide the basis for common agreed future IT systems;

(v) to minimise, or ideally stop, duplicate (sometimes multiple) assessments of the same client;

(vi) to provide a common language and common definition for client/patient assessment, and for planning purposes.

3.4 Equity and Efficiency

It is unlikely that the results of this exercise will please everybody. However, the project team and the steering group believe that only by developing this type of approach will it be possible to ensure equity in the provision of community care, and efficiency in the use of resources. At present resources are wasted due to the inefficient use of professional staff undertaking multiple assessments,together with an inability to translate those assessments into effective care packages. That is not to say that professional staff do not undertake their work with diligence and try to develop the best possible care for clients. Rather, the system militates against their best efforts. This project is intended to assist professional staff in developing their work both to the benefit of themselves and their clients.

Needs assessment of itself is a complex task and there is no one agreement in the literature on what constitutes community care and continuing need. Bradshaw described need on four levels:

comparative, normative, felt, and expressed.

Deriving the right balance of comparative, normative, felt and expressed need is problematic. Comparative need ranges over what has been described as a *vertical equity*, i.e. equitable distribution of resources within a client group to people who have a greater or lesser need. At the same time it is important to recognise *horizontal equity*, i.e. equity in resource distribution between different client groups. Yet any comparison of need between individuals, either across client group or within client groups must also consider what is expected (or normative). Normative need will change over time as expectations increase or decrease.

At the same time some clients will "feel" needs, some of which they will, and some of which they will not, express. This will be true, too, of professional staff working with clients in assessing the client/patient's needs.

The Buckinghamshire care assessment project must work with these constraints and challenges to develop an assessment procedure and assessment systems which try to draw on best practice relevant to the circumstances in Buckinghamshire. That is what the project is concerned to do, and thus the project team make no apology for providing, at this stage, a broad outline of the issues and of the systems in use. It is inappropriate at this stage to delve into too much detail — though detailed systems must be developed during the next few months. This Phase I interim report is intended to provide an overview of work to date, of the systems in use, and of the possibilities for developing more detailed systems.

4. Outline of Work in Phase 1

Phase 1 of the project ran from the end of July until the end of September 1991. In this relatively short period the project team obtained as many of the assessment systems in use for community care planning across all care groups within Buckinghamshire. Altogether some fifty-four systems have been obtained and analysed using a number of instruments specifically developed for the task.* (These are shown at Annex 2 and described more fully below). A number of interviews were held with senior managers and staff on the use of their assessment systems in order to elicit as much information as possible about the way in which the systems are used and to give information about the project teams work.

This phase of the project is intended to identify all those proformas, systems, policies and procedures which may be relevant to the development of a core assessment procedure and agreed inter-agency assessment systems. It was considered likely that many systems would be agency and care group specific, some quite complex and undertaken by particular professional groups. It was hoped however that a number of systems would emerge which had a more generic base and could be used across agencies, across care groups and by a range of professional staff. The initial analysis has thus been done to identify those systems which can be used in Phase 2 of the project as a basis for development of a core assessment procedure and specific inter-agency assessment systems.

The process of the project has two main advantages. It:

1. provides further time if necessary for recipients of this report to send the project team any additional assessment systems in use for consideration;

2. identifies those systems which can be used as the starting point but does not discard any material. That material may well be used at a later stage of the project for the development of more complex assessment procedure for specific purposes

This first phase is thus one of initial discovery, helping the project team to identify those systems on which further work should be done.

All the proformas, systems, policies and procedures were grouped initially by:

* Professional Group

* Agency

* Care Group

in order to see what overlap and possible contention may exist. Secondly, all systems have been analysed using a twenty dimension measurement tool developed from the initial work reported in the first progress report. This is shown in Annex 2. Although this is a fairly blunt instrument, it provides an indication of the extent to which systems are geared to maximising community care — in particular assisting individuals to remain in the home of their choice for as long as possible.

*The project team are aware of a number of other systems which were either received too late to be included, or which will be provided. The total is likely to exceed 70 systems in use across Buckinghamshire.

This analysis has then been plotted on a number of "maps". These include the inter-relationship between agency specific systems, and care group specific systems; between health and social function; between professional group specific and care group specificity; and care group specific with the extent to which the assessment focusses on service provision (service specific).

Service specific indicators refer to the extent to which assessments focus on areas of user need (whether that is a narrow or broad focus), and this is mapped against the extent of **care group** specificity. Care group specificity refers to the extent to which the system is related to one care group or is relevant to a range of clients (e.g. elderly people, learning disabilities, mental health, or physical and sensory disabilities).

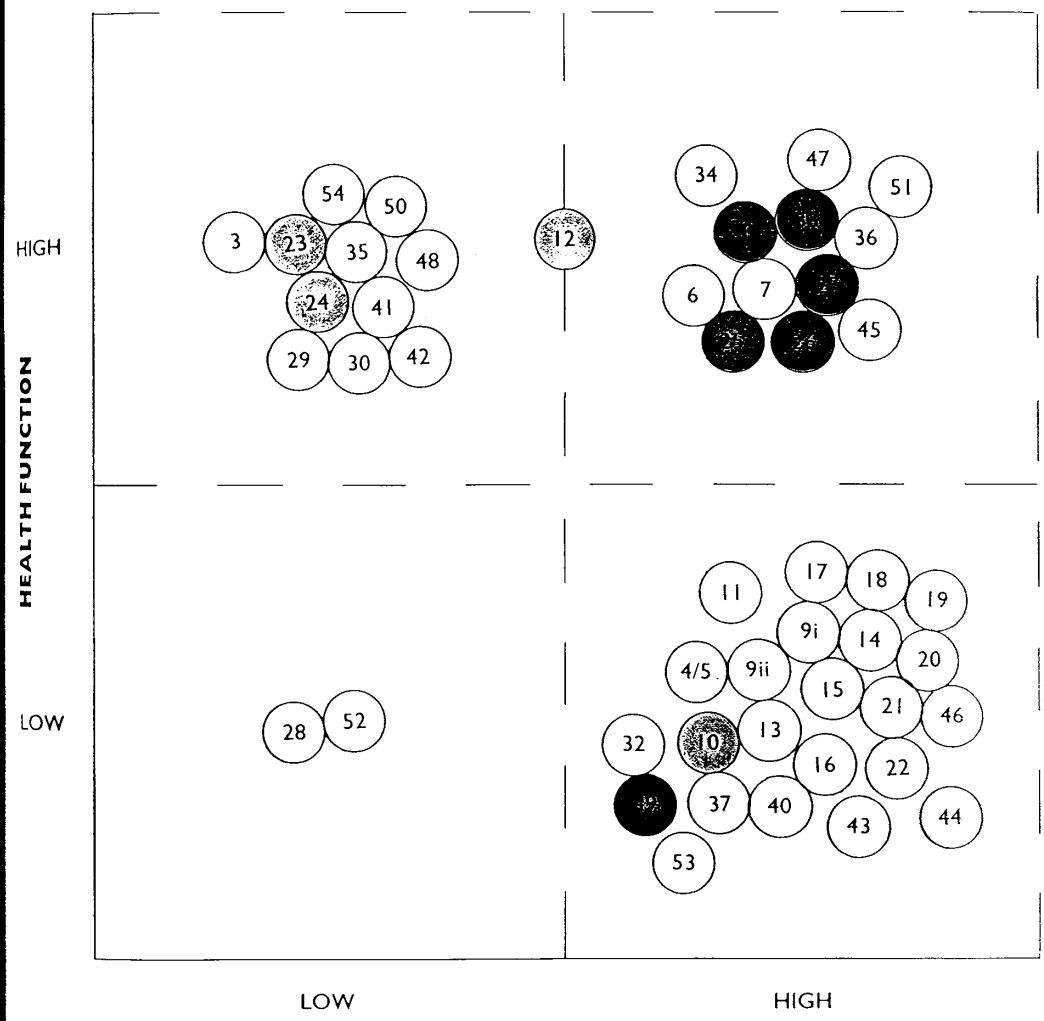
By **agency specific** is meant the extent by which the system is closely related to one particular agency or whether it can be used by/is used by a number of different agencies. If a system can only be used by one agency, then it has high agency specificity; if it can be used by many then it has low agency specificity. The same analysis is then done for **care group specific** systems, and for **professional group specific** systems.

A system which has high **health function** is one which puts greater emphasis on physical and/or mental health status; and the converse is true for low health function. **Social function** is similarly considered. By mapping the systems in this way it can be seen which may be helpful for the initial screening system, which for a main assessment system, and which for more complex systems for the "hard to place" or "difficult" clients/patients.

This form of mapping thus helps to identify with those systems worthy of further consideration for particular jobs. It does not imply criticism of the other systems though some are certainly better than others, and, it has to be said some are particularly weak. More importantly, however, it will be possible to consider in depth those systems which are valuable for particular jobs and for the project team in Phase 2 to develop a core procedure building on the best of currently available systems. To this can then be added: information from the literature; ideas and approaches from systems in use in other places; and additional items which may be introduced by the project team, all which are suggested during interview or following consultation on this document.

It is worth noting that some of the systems offer immediately, on inspection, a useful foundation. It might have been possible for the project team to take an "a priori" view of the various systems available. To do so, however, might have been to loose useful detail available from other systems; and it would not have done justice to much work which has taken place within Buckinghamshire to develop the systems presently in use.

Figure 1. Health/Social Function Comparison



● Systems which will be used as the basis for the core assessment procedure.
○ Additional systems to be incorporated in the core assessment procedure development.
See *Section 6.4*

Figure 2. Care group and professional group comparison

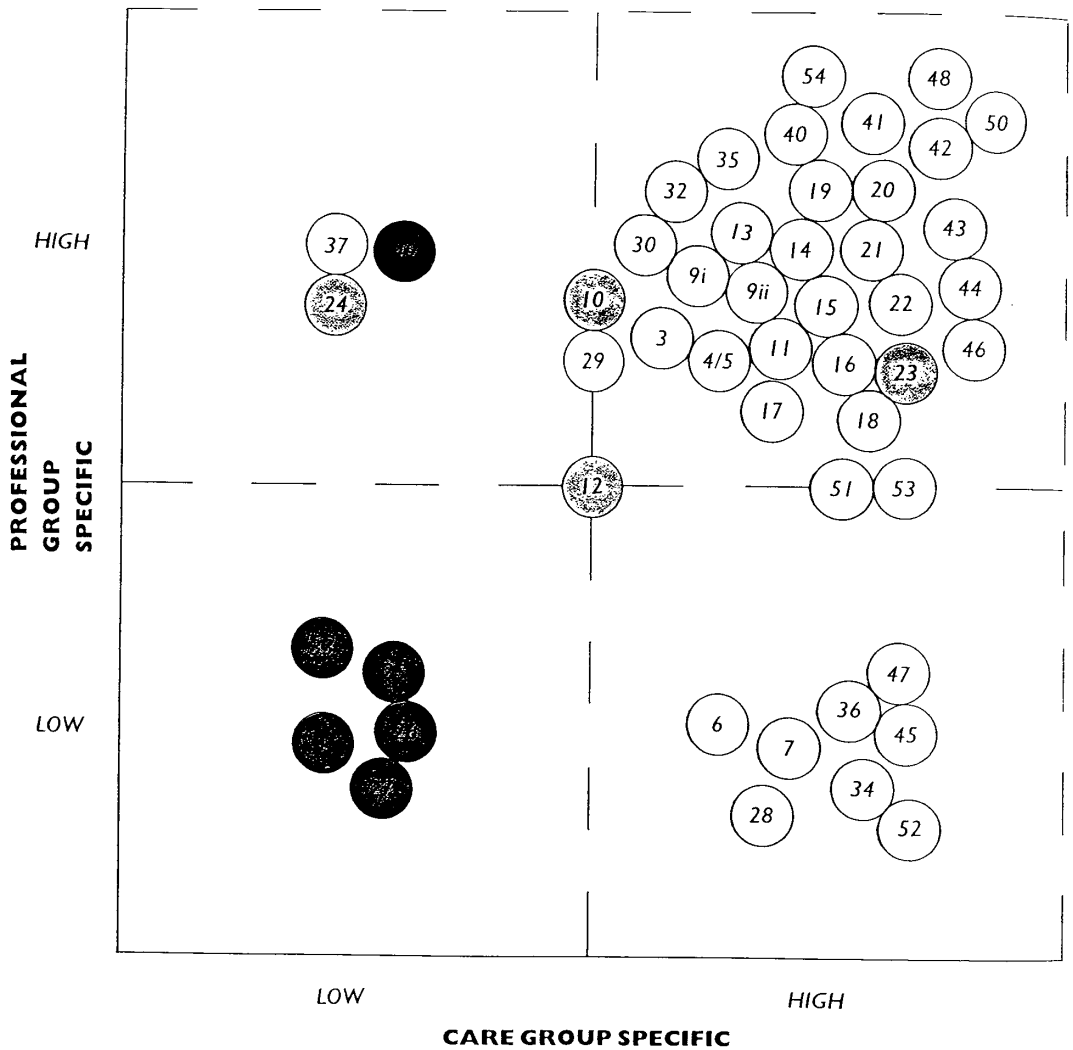


Figure 3. Comparison of service specificity with care specific indicators, also showing high and low plan

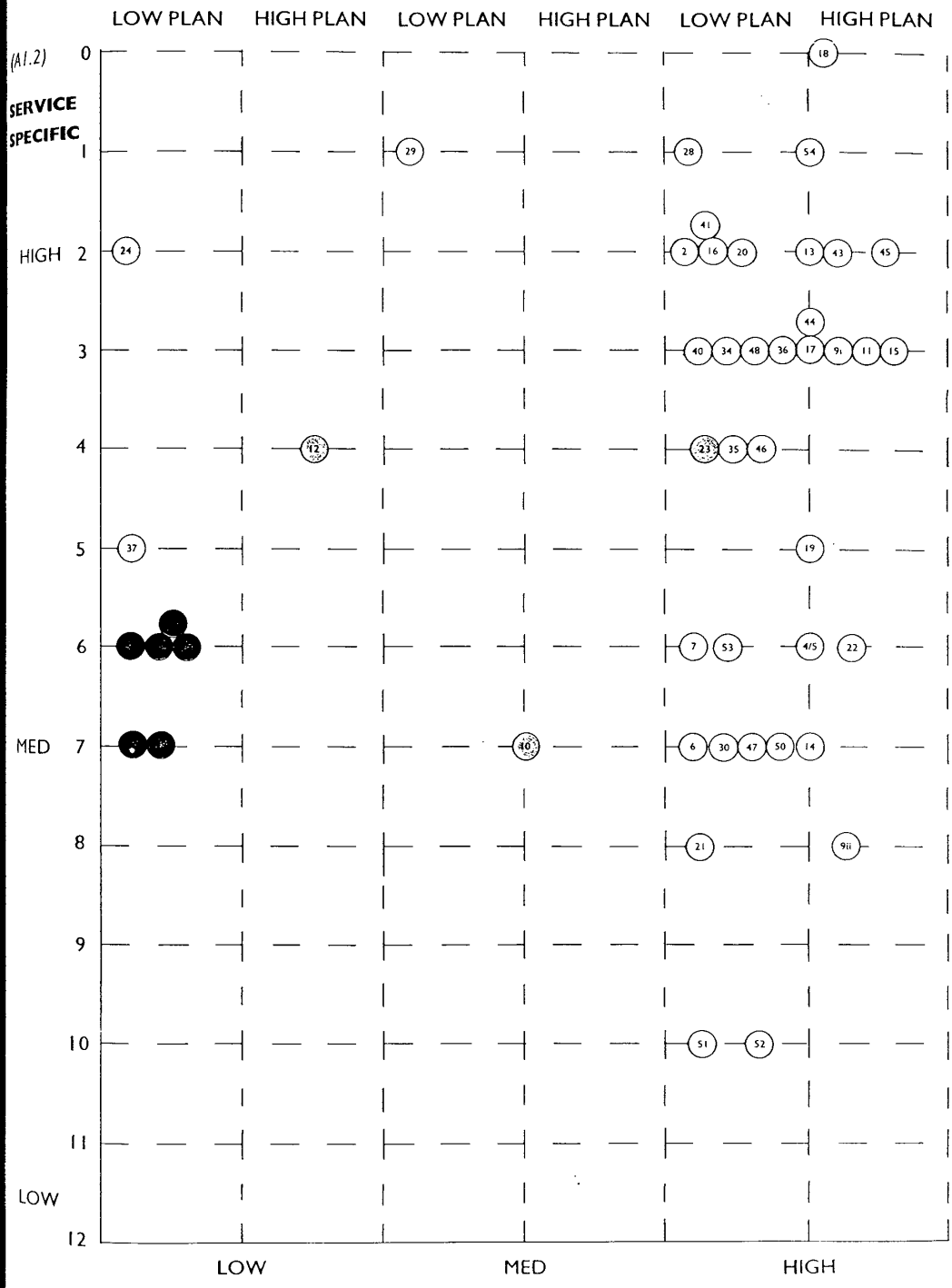


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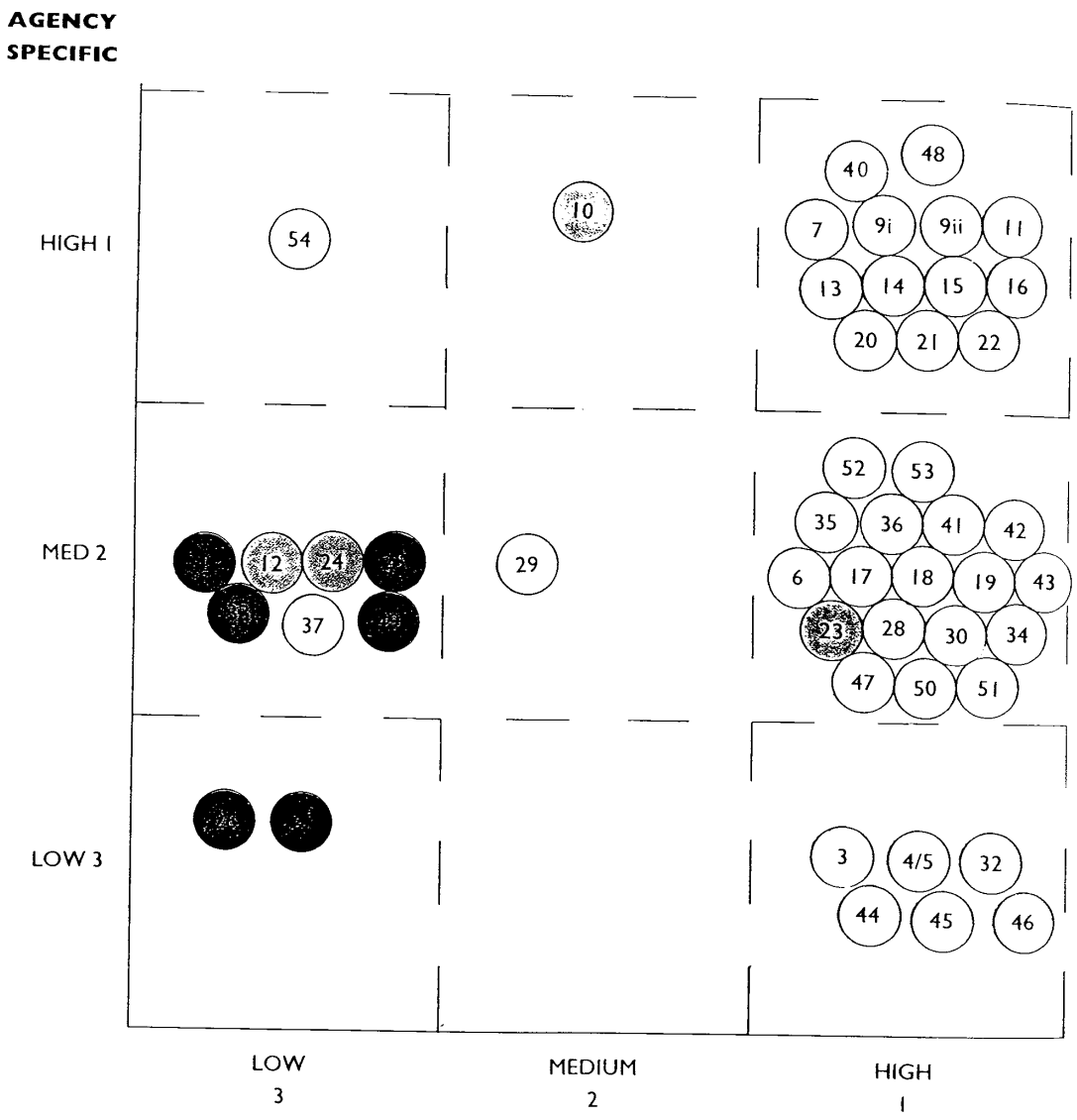
Figure 4. Agency and care group comparison



5. Results of the Mapping Exercise in Phase I

All systems, policies and procedures were evaluated using the tools described in Section 4. The full list of systems is shown in Table I and that list, with identifiers for care group specificity, agency specificity and plan level is shown in Annex 2. This information has then been transferred to the simple matrix graphs shown in Figures 1-4. A number of general conclusions can be drawn from these lists and "maps" and a number of important points are highlighted.

5.1 General Conclusions

The project teams general conclusions are as follows:

5.1.1. It is fair to say, as a generalisation, that the systems in use are not policy led or related in any direct sense to the requirements of Government circulars concerned with the white paper 'Caring for People'. It will be essential to ensure that the objectives of 'Caring for People' as moderated by relevant statutory agencies, are reflected in assessment forms and the care provision to meet those assessments;

5.1.2. The forms in use are generally insensitive to user (client/patient) and carer participation or involvement. This is an issue which must be given greater weight. Participation of the client/patient in the process of assessment and care package design is important, as is the ownership and retention by the client/patient of that assessment;

5.1.3. Perhaps surprisingly few of the systems were geared to developing better **social** support for clients. None of the systems, (the SSD Home Care Assessment and Residential forms being the possible exceptions) was good on either obtaining or avoiding residential care. These areas need to be considered carefully;

5.1.4. Emphasis on medical support was high. This is reflected in the degree of professional domination apparent in most of the systems considered;

5.1.5. The degree of concordance between systems in relation to assessment of health and social functioning was fairly low; but

5.1.6. The obverse of 5.1.5 above is that a baseline exists across all systems, and thus agencies about health and social functioning assessments, particularly the recording of factual data, even where that is not geared directly to action or outcome. This could form a good basis for building a core or agreed assessment across agencies and across professional staff;

5.1.7. Many of the systems are specific to professional group and clients. A degree of harmonisation between systems for specific client groups may be possible at the end of an initial screen, but it is likely that separate mainstream assessment systems will be required for each care group.

5.1.8. However, none of the systems is wholly appropriate as an initial screen. Some further work may be needed to use parts of existing system, separate from but carefully dovetailed into those existing systems, in order to develop an initial screening assessment.

5.1.9. Most of the systems have a narrow service focus as can be seen from Figure 3. Many are in the top right hand corner with a low score on the service specific indicator. Indeed, none had a score of greater than 10 suggesting:

(a) no system provides a truly broad service focus for any care group; and thus

(b) those systems falling in the bottom left of the map (scores between 10 and 6) will be used as a base for discussing the initial screen and envelope assessment; but that

(c) additional work will be required to develop a broader service focus, especially for the initial screen.

5.1.10. Finally, the systems were only moderately concerned with outcomes for the user or actions which should be taken to meet needs as identified. By and large all the systems reviewed are concerned with recording and analysing need (as if from an epidemiological point of view), *without* sufficient *obvious* concern for what that means for client/patient services.

5.2 Implications

The points above have significant implications both for the development of the care assessment procedures and for inter-agency policy about community care. They also raise interesting issues about the way in which needs assessments should be undertaken vis a vis eligibility criteria for services and the way in which packages are designed against resource constraints. In other words *it is essential that the needs assessment systems be developed without reference to the eligibility criteria/ resource constraints although both will have to be considered in parallel* and must be brought together at an appropriate point during the development of the pilot programmes.

The methodology adopted is a straightforward analytical framework against which each of the systems is measured as objectively as possible (whilst acknowledging the subjectivity which is inevitable). Reading policy documents and blank pro-forma systems does not give sufficient information about how they are used and the extent to which detailed information may be recorded about clients. Nor does it give sufficient information about the way in which those forms are then used to influence care plans or individual programme plans.

The interviews with key managers and staff were thus important in obtaining some "feel" or view as to the way in which the systems are used. Unfortunately, because this is not a detailed longitudinal research programme, the extent to which a large number of completed forms can be considered and related to the outcomes of patients is very limited. This will be necessary in future with those systems felt to be an appropriate basis for future development and where some test is required as to the effectiveness of the systems in operation (as seen by both professionals and clients).

5.3 Key Points

A number of key points are highlighted.

5.3.1. *Health function/social function*

Figure 1 shows the broad analysis by health and social function. For the purposes of developing

(i) an initial screen and (ii) a main stream assessment, those systems which are high health function and high social function should be chosen. It is thus necessary to compare those which fall in the top right-hand quadrant of Figure 1 with those systems which are relatively low agency/care groups specific and low professional group/care groups specific.

5.3.2. *Professional group/Care groups Specific*

From Figure 2 we can see that systems 1, 25, 26, 27 and 33 together with 12 are those which probably should be considered as a basis for initial screen. That does not preclude learning from other system but narrows the field for initial further work.

5.3.3. *Service Specific/Care group Specific*

Figure 3 demonstrates the service specific/care group specific map incorporating the further feature of low and high plan as described in Section 4 above. It can be seen by inspection that few of the systems are wholly generic (from an agency point of view). Those which are low professional group/care group specific fall somewhere in the medium range for agency specificity in the low plan column and are low on care group specifity. In addition, 10, 12 and 37 should probably be considered:

It can be seen from the analysis some consistency has emerged in the systems which are felt to be relatively generic as a basis for providing components for an initial screen.

5.3.4. *Agency Specific/Care Group Specific*

Figure 4 shows the agency/care group comparison. Many systems were designed and are being used for one care group, though may be applicable for more general use. A number were moderately agency specific (usually developed by one agency but either used by multi-disciplinary teams or obviously capable without modification of such use). Of these most were very care group specific, but some fell into the low care group area. Of these 1, 12, 25, 26, 27, 33, 37 and 49 again emerged; 29 was rejected from Figure 3.

5.4 Features to be noted

It should also be noted that there are few systems which fall in the middle area of this map. This highlights a number of features:

5.4.1. Any mainstream assessment must have a generic 'envelope' with a number of 'sockets' in which to plug professional specific assessments. In other words, the main stream assessment will need to provide a foundation for integration of a number of profession specific assessments where these are needed, as indicated by the initial screen and by any initial assessment in relation to the main stream assessment system;

5.4.2. It will be important to build on the existing specialist assessments to form the mainstream assessments. This may require a lot of work in developing an integration mechanism and in deciding which of these systems should appropriately be used;

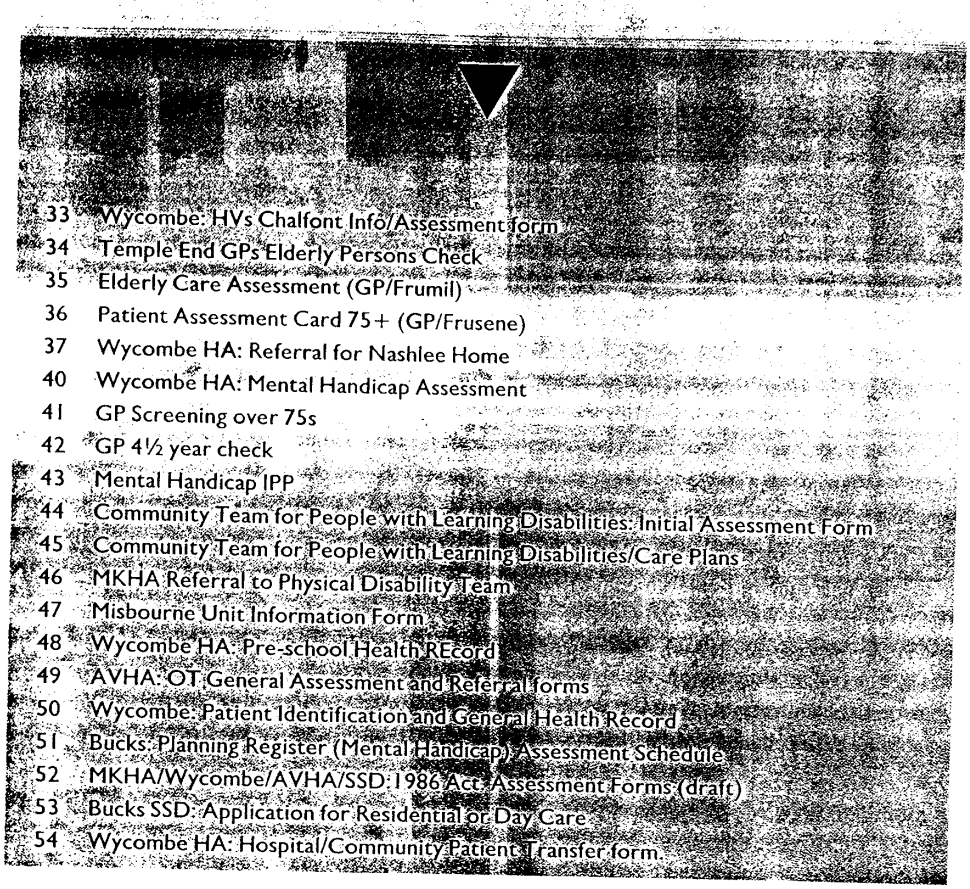
5.4.3. Some of those systems which form a good basis for the initial screen may also form the 'integration envelope' for the mainstream assessment;

5.4.4. Other ideas and information will have to be imported from the literature to enable the initial screen and mainstream assessments to be designed.

Table 1

Assessment forms systems, policies or procedures included in the study (available at 18 October 1991)

No.	Title
1	OxCASSE Assessment of Elderly
3	Geriatric Surveillance Card
4/5	Wycombe HA/Bucks SSD Policy, Assessment checklists, Information sheet and Community Care Plan
6	Wycombe Health Authority District Nursing
7	Bucks FPC/Wycombe HA Patient Assessment 75+ years (also No.8)
9i	AVHA Discharge Procedures — Buckingham Hospital
9ii	AVHA Discharge Procedures — St Johns Hospital
10	Bucks SSD Home Care Assessment Form
11	Wycombe HA/SSD Southern Division Mental Handicap Residential Assessment
12	GP Patient Assessment (Dr Gill Beck)
13	Manor House Hospital: Individual Care Plan
14	Manor House Hospital: Catalogue of Areas of Need
15	Manor House Hospital: Star Profile
16	Manor House Hospital: Adaptive Behaviour Scale (also 31)
17	Manor House Hospital: 'HALO'
18	Priority Care Services Unit (AVHA) Mental Health s 117
19	PCSU/AVHA: Elderly Mental Health, CPN/Community Care Plans
20	PCSU/AVHA: Relief Care Ward Checklist (Cromwell/Wilkes House)
21	PCSU/AVHA: Relief Care Ward Assessment (Cromwell/Wilkes House)
22	PCSU/AVHA: Harding/DMHE Admission Assessment
23	'Geriatric Medicine' Over 75s Assessment Checklist
24	Health Status Questionnaire — Quality Quest
25	MK: Health Visiting Record Card
26	MK: Patient Registration
27	MK: patient Assessment
28	MK: OT Home Assessment Checklist
29	MK: Poulton Patient Dependency Score
30	MK: CPN/Elderly Information Sheet
32	Bucks SSD Chiltern Area: Multi Disc. Assessment for referral to OPH



33 Wycombe: HVs Chalfont Info/Assessment form
34 Temple End GPs Elderly Persons Check
35 Elderly Care Assessment (GP/Frumil)
36 Patient Assessment Card 75+ (GP/Frusene)
37 Wycombe HA: Referral for Nashlee Home
40 Wycombe HA: Mental Handicap Assessment
41 GP Screening over 75s
42 GP 4½ year check
43 Mental Handicap IPP
44 Community Team for People with Learning Disabilities: Initial Assessment Form
45 Community Team for People with Learning Disabilities/Care Plans
46 MKHA Referral to Physical Disability Team
47 Misbourne Unit Information Form
48 Wycombe HA: Pre-school Health REcord
49 AVHA: OT General Assessment and Referral forms
50 Wycombe: Patient Identification and General Health Record
51 Bucks: Planning Register (Mental Handicap) Assessment Schedule
52 MKHA/Wycombe/AVHA/SSD: 1986 Act Assessment Forms (draft)
53 Bucks SSD: Application for Residential or Day Care
54 Wycombe HA: Hospital/Community Patient Transfer form

(other systems will be added as they are received)

6. Conclusions

6.1 The project team has received fifty-four assessment pro-formas, systems, policies and procedures from Buckinghamshire SSD, Buckinghamshire Family Health Service Authority and general practitioners and the three District Health Authorities — Milton Keynes, Aylesbury Vail and Wycombe. The team are aware that some systems have not been received and expect that the total will top seventy systems once others are received from services managers, clinical directors and general practitioners.

6.2 The wide variety of systems suggests substantial duplication of effort and multiple assessment of clients/patients. The systems vary enormously between those which are highly sophisticated and those which are very simple, those which are specific to an agency or professional group and those which are more generic. Some provide a great deal of 'health function' information (both physical and mental health function), some provide 'social function' information, and others are highly selective.

6.3 On the analysis undertaken here and the mapping exercise three things become apparent:

(i) all systems have some helpful questions or structure which can inform the development a core assessment procedure; but that

(ii) a number of existing systems valuable as a basis for an initial screen or a mainstream assessment envelope;

(iii) the degree of variance suggests that the mainstream assessment may have to be developed separately for each client group whilst retaining an inter-agency inter-professional approach.

6.4 The analysis undertaken identifies six systems which may offer a base for the development of the initial screen and envelope although, as noted above, considerable add itional work will be required. Those six are:

(i) OxCASSE Assessment for Elderly People;

(ii) Milton Keynes Health Authority: Health Visiting Record Card;

(iii) Milton Keynes Health Authority: Patient Registration Form;

(iv) Milton Keynes Health Authority: Patient Assessment Form;

(v) Wycombe Health Authority: Health Visitors Information/Assessment Form;

(vi) Aylesbury Vale Health Authority: Occupational Therapy General Assessment and Referral Form.

In addition to these six, a number of other systems may be useful but are more specialist. These include:

(vii) GP Patient Assessment (Elmhurst Surgery — Dr Gill Beck);

(viii) Buckinghamshire Social Services Department Home Care Assessment Form; and

(ix) Health Status Questionnaire: Quality Quest.

Although it is specialised to elderly people the following proforma will also be included in the detailed work:

(x) Over 75 assessment check-list ("Geriatric Medicine").

6.5 None of the systems are truly generic to both agency and client group. It will be necessary for the project team to derive from the systems the key components which will help to develop:

- an initial screen associated with 'first gate eligibility';
- an 'envelope' for a mainstream assessment which will include the appropriate specialist client group specific and professional specific assessments within an intergrative framework. Other ideas will be imported from the literature and for other areas as necessary. Phase 2 of the project will be reported later in the year.

6.6 Many professional staff will have strong "ownership" of the proformas, systems, policies and procedures that they have developed. The potential duplication of effort however is indicated by the wide variety of different systems in operation in one county. The project teams conclusion therefore is that it may not be possible to develop a single assessment procedure and detailed assessment tool for each client group, let alone a generic instrument for all client groups and agencies.

The Project Team will thus set a less onerous goal but nonetheless one which will be of benefit of all agencies involved and to the clients/patients of the service. That goal will be to develop a core *assessment procedure* incorporating a basic generic screen for clients entering the service from the community, and an envelope integrative mainstream assessment which will encourage the harmonisation of existing procedures within an overall approach. Where it is possible to develop unification or common methodologies and tools, this will be done and encouraged. This approach to harmonisation may enable individual staff to continue working in a way with which they are familiar whilst at the same time generating information which is common across all agencies for one client group and, where relevant, across all client groups.

7. Recommendations

7.1 It is recommended to Buckinghamshire Social Services Department, to the Family Health Service Authority and to Milton Keynes, Aylesbury Vale and Wycombe District Health Authorities that the (community) care assessment project continues into Phase 2 on the basis of the conclusions set out in paragraph 6 above. In particular it is recommended that:

7.2 A core assessment *procedure* is developed with (i) an initial generic screen; and (ii) a mainstream envelope assessment incorporating existing assessment procedures *where possible*;

7.3 That the initial screen and envelope are based in part on ten of the existing systems in use in Buckinghamshire as set out in paragraph 6.4 above, and that key components of other systems be used where appropriate;

7.4 That this report be given wide circulation to encourage involvement in the project and the adoption of the projects results when available;

7.5 That the statutory authorities give continuing high level support to the project in order to develop systems and procedures which minimise duplication and thus minimise resource wastage; and

7.6 That continued support be given to the development of generic systems and procedures which will enhance the development of seamless services for community care clients and hopefully provide the basis for effective data capture and data management in relation to assessment and subsequent care package design;

7.7 That needs assessment be kept separate from eligibility criteria and care package design whilst at the same time ensuring that in the development of pilot care programmes management the two are brought together in appropriate reporting of resource misuse and shortfall.

Effective care management requires that individuals needs are properly assessed independently of the allocation of the resources to meet all or part of those needs. Only in that way will it be possible to ensure that clients receive the services they need rather than simply the services which happen to be available, and that senior management obtain clear reports on resource misuse and shortfall in provision.

ANNEX 1
Analysis of Assessment Formats

A1.1 *The assessment systems were analysed by considering:*

(i) care group specificity;

(ii) extent of association with a particular service;

(iii) outcome planning;

(iv) agency specificity (i.e.GPs/FHSA,DHA,SSD);

(v) professional group dominance or specificity (e.g. GPs, OT, Health Visitor, etc);

(vi) extent of (a) health function (physical or mental), (b) social function.

A1.2 *The first part of the analysis explores assessment formats on two* ***dimensions****:*

the extent of association with a specific care group, (e.g. elderly people, learning disability);

the extent of association with the delivery of a specific service.

These measures are defined in the following manner:

low care group specific/ low service specific:

a wide range of factors assessed in limited depth aimed at generating a basic care support plan or identifying need for more detailed assessment.

high care group specific/low service specific:

in depth client/patient profile in single area, little service planning or potential for engaging a broad range of solutions to identified problems.

low care group specific/high service specific:

broad view of client/patient needs identified focus on service delivery in a single area.

high care group specific/high service specific:

an in depth client profile in single area focus on delivery of single service area.

Assessments also vary in the extent to which they are used to generate plans for clients/ patients. These will be very different for 'low service specific' formats and 'high service specific' formats:

low service specific/low plan:

little or no evidence of outcome planning

low service specific/high plan:

evidence of work on basic support plan across a range of need areas, involvement of a wide group of agencies. Led by policy of community care/home stay. Possibly carried out in client/patients home.

high service specific/low plan:

focus on detailed assessment in single area with no attempt to use assessment as a basis for service planning of either a broad or narrow nature.

high service specific/high plan:

focus on developing detailed action plans which may encompass other agencies. May well be service policy led.

A1.2.1 *Care Group Specific Indicators*

Four catagories can be used to discover the extent of specificity in this area:

Care needs of (1) elderly; or (2) physically disabled people usually identified by a focus on physical and sensory health/functional disability (eg. continence, mobility, sleeping); (3) Mental illness/health; (4) Extent of any learning difficulty

Assessments which cover the range indicate an interest in a generic approach ie. low care group specific. Assessments which cover only one or two areas indicate the opposite.

A1.2.2 *Service Specific Indicators*

Twenty catagories of areas in assessments can indicate the extent to which assessments focus on single areas of user need or on a broader approach to user care. These are:

Extent of existing support networks

Self care capacity
Personal and social relationships
Users hopes and ambitions
Users abilities and lifestyle
Users interests and attitudes (inc leisure)
Finances
Suitability of accommodation
Home facilities
Employment (needs)
Education/training (needs)
Emergency systems
Particular risk factors
Relationships with carer if any
Ethnic origin/cultural preferences
Religious affiliation
Existing services supplied
Process is 'user sensitive' (client/patient sensitive'
Process is 'carer sensitive'
Process includes other support agencies/ personnel

A broad range of interests indicates low service specificity. A narrow range would indicate an interest in limited areas of service provision to meet limited areas of client/ patient need.

A1.3 *Outcome Planning*

Indicators for the extent of outcome planning are obtained from the extent to which the formats include the designing of responses to client needs for:

improved health status
(i) physical
(ii) mental;

improved social function;

improved environment/physical location;

provision of practical help.

In the case of higher service specificity formats, this will be indicated by any process which links the assessment to a planned programme of action which may or may not include referral to other agencies.

A1.4 *Agency Specific*

The extent to which each assessment system is related to a single agency is rated on three levels:

high 1
medium 2
low 3

Low is accorded 3, and high 1 because the analysis is looking for those systems which are usable by all (or most) agencies. By agency is meant the main governing organisation, e.g. GPs/ FHSA, DHA (purchaser), health provider unit (community or acute), or Social Services Department. It should be noted that a number of systems are moderately usable by different agencies although designed for and or used by one at present. Few of the systems were truly generic in application at present.

A1.5 *Professional Specific*

Each system was considered for the extent to which it can only be completed by one professional group, and rated on two levels:

high (only one professional type, usually in one agency)

low (more than one professional type, and in more than one agency)

A1.6 *Health or Social Function*

This measure tests the extent to which the system provides sufficient information on:

(i) health function (or 'status') (based on physical and/or mental health function);

(ii) social function.

Only two levels were used as it was found that a system designed to test health function would do so, at least to a tolerable degree; one that was not so designed, would not provide sufficient information. The levels are:

high

low

Evaluation of Assessment Forms

Each assessment format has been rated on these variables. (Service specificity is rated according to a score obtained by counting the number of instances of items from the list given above). These are then mapped onto a matrix that incorporates the three variables (client group specific, service specific and extent of planning) to relate the various assessment formats to one another.

Scores on each variable are assessed as:

Care group specificity:

Low 3, Med 2, High 1

Service specificity:

Low 10+, Med 6-10 inc, High 0-5 inc.

Extent of planning: A measure of 'high', med' or 'low' has simply been judged from the stress placed on outcomes in the layout of the form. (It should be noted that many forms are used as the basis of a planning task by practitioners even though the forms themselves do not indicate this; the point of this exercise is to identify written formats which can be used to allow for planning to follow directly from assessment procedures.)

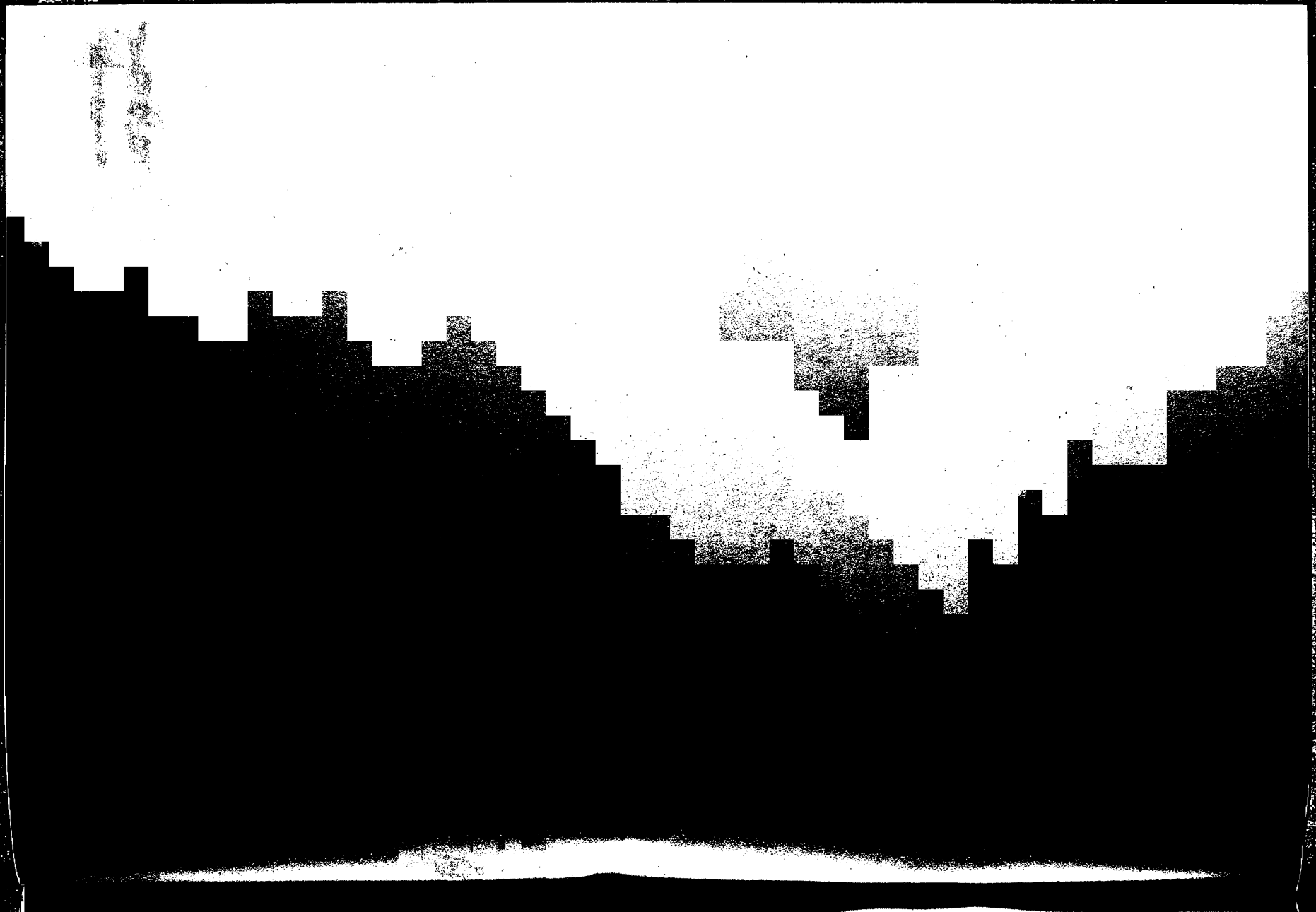
ANNEX 2

(p = primary health care use, s = service use)
(H = high health orientation S = high social care orientation)

			Care Group	Service	Plan	Agency
pHS	1	OCASSE Assessment of Elderly	3	6	low	2
pH	3	Geriatric Surveillance Card	1	2	low	2
sS	4/5	Wycombe HA/Bucks SSD Policy, Assessment checklists, Information sheet and Community Care Plan	1	6	mod	3
pHS	6	Wycombe Health Authority District Nursing	1	7	low	2
pHS	7	Bucks FPC/Wycombe HA Patient Assessment 75+years (also no8)	1	5	low	1
sS	9	i AVHA Discharge Procedures — Buckingham Hospital	1	3	high	1
sS	9	ii AVHA Discharge Procedures — St. Johns Hospital	1	8	high	1
sS	10	Bucks SSD Home Care Assessment Form	2	7	mod	1
sS	11	Wycombe HA/SSD Southern Division Mental Handicap Residential Assessment	1	3	low	1
pH	12	GP Patient Assessment (Dr Gill Beck)	3	6	mod	2
sS	13	Manor House Hospital: Individual Care Plan	1	2	mod	1
sS	14	Manor House Hospital: Catalogue of Areas of Need	1	7	mod	1
sS	15	Manor House Hospital: Star 1 Profile	1	3	high	1
sS	16	Manor House Hospital: Adaptive Behaviour Scale (also 31)	1	2	low	1
sS	17	Manor House Hospital: 'HALO'	1	3	mod	2
sS	18	Priority Care Services Unit (AVHA) Mental Health s 117	1	0	high	2

sS	19	PCSU/AVHA: Elderly Mental Health CPN/Community Care Plans	1	5	mod	2
sS	20	PCSU/AVHA: Relief Care Ward Checklist (Cromwell/Wilkes House)	1	2	low	1
sS	21	PCSU/AVHA: Relief Care Ward Assessment (Cromwell/Wilkes House)	1	8	low	1
sS	22	PCSU/AVHA: Harding/DMHE Admission Assessment	1	6	high	1
pH	23	'Geriatric Medicine' Over 75's Assessment checklist	1	4	low	2
pH	24	Health Status Questionnaire — Quality Quest	3	2	low	2
pHS	25	MK: Health Visiting Record Card	3	6	low	2
sHS	25	MK: Patient Registration	3	7	low	3
sHS	27	MK: Patient Assessment	3	6	low	3
s	28	MK: OT Home Assessment Checklist	1	1	low	2
pH	29	MK: Poulton Patient Dependency Score	2	1	low	2
sH	30	MK: CPN/ Elderly Information Sheet	1	7	low	2
sS	32	Bucks SSD Chiltern Area: Multi Disc. Assessment for referral to OPH.	1	10	high	3
pHS	33	Wycombe: HV's Chalfont Info/Assessment form	3	6	low	2
pHS	34	Temple End GP's Elderly Persons Check	1	3	low	2
pH	35	Elderly Care Assessment (GP/Frumil)	1	4	low	2
pHS	36	Patient Assessment Care 75+ (GP/Frusene)	1	3	low2	
sS	37	Wycombe HA: Referral for Nashlee Home	3	5	low	2
sS	40	Wycombe HA: Mental Handicap Assessment	1	3	low	1
pH	41	GP Screening over 75's	1	2	low	2

pH	42	GP 4½ year check	1	0	low	2
sS	43	Mental Handicap IPP	1	2	high	2
sS	44	Community Team for People with Learning Disabilities: Initial Assessment Form	1	3	mod	3
sHS	45	Community Team for People with Learning Disabilities/ Care Plans	1	2	high	3
sS	46	MKHA Referral to Physical Disability Team + Initial Assessment	1	4	low	3
sHS	47	Misbourne Unit Information Form	1	7	low	2
pH	48	Wycombe HA. Pre-school health record	1	3	low	1
sS	49	AVHA OT Assessments	3	7	mod	2
pH	50	Elderly Checklist	1	8	low	2
sHS	51	Buckinghamshire Planning Register (Mental Handicap) Assessment schedule	1	1	low	2
s	52	Bucks. Plan. Register. 1986 Act Child Health Assessment	1	8	mod	2
sS	53	Bucks. SSD. Application for Residential or Daycare	1	6	low	2
sH	54	Wycombe: Hospital/Community Patient Transfer Form	3	1	mod	1



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