Mapping Older People's Needs

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Abstract

This paper reviews the legal framework for, and the research evidence on the outcomes of community care planning. The literature on researching population needs and methods of mapping is then discussed and the experience and findings of one research project on mapping older people's needs reported. The paper concludes with observations on whether mapping need through population surveys is likely to make a difference to the responsiveness and quality of service provision.

Keywords: planning, needs mapping, older people, service development

Introduction

Need features prominently in community care policy and practice guidance but it is a contested concept, capable of multiple meanings. Its assessment is part of New Labour's project concerned with community and individual capacity building and social inclusion. Yet, assessment of needs is complicated by uncertainty about what should be measured and by the difficulty of knowing how to 'capture' it. Further challenges arise from the likelihood that actual and potential service users, carers, and health and welfare practitioners and managers will hold divergent perspectives. Various stakeholders' definitions of need will represent different but interacting ways of thinking about need and of determining approaches to outcomes (Godfrey and Callaghan, 2000).

Partnership between statutory agencies, and between them and non-statutory agencies also features prominently in New Labour's modernising agenda. Modern social services require a coordinated and concerted effort with health authorities, with voluntary and community organisations, and with service users and carers, to break down barriers for people who have complex and challenging needs. Such partnership and joint working at policy-making and practice levels requires social services departments to adopt an information and research based approach to commissioning and purchasing of service provision. Key elements herein are analysing the needs of population groups served, mapping current provision, and evaluating with relevant stakeholders the effectiveness of current arrangements. Hitherto, variable progress (Hamer, 2003) is indicative of the challenges involved in strategic planning.

This article reviews the legal mandates and research literature concerned with needs assessment for community care service planning. It then surveys different approaches to mapping need in the community before describing and evaluating one project that sought to identify the needs of older people for health and welfare services in one geographic area.

The Legal Framework

Section 46, National Health Service and Community Care Act 1990 requires local authorities to prepare, publish and review community care plans. This includes a duty to consult with district health authorities, family health service authorities, housing authorities and voluntary organisations. Guidance (Department of Health, 1990) has established that these plans should ensure that the needs of black and ethnic minority communities are included in the consultation process. Plans should cover a three-year period, annually reviewed and updated. They should detail how individual needs will be assessed, how needs will be incorporated into planning processes, and what the care needs of the local population are. Services and objectives should be detailed in relation to older people, disabled people, mental illness, domestic violence, HIV/Aids, with statements concerning how needs and services will be prioritised, and what practical help will be provided for carers. Plans should refer to:

1. Quality – how this will be monitored and ensured, and the arrangements for inspection and complaints;
2. Consumer choice – how this will be managed and what it will involve with various groups and agencies;
3. Publicity – how information about services will be made known to potential users;
4. Resources – the implications in terms of budgets, training and personnel;

5. Future planning – how information from assessments and from community profiling will be gathered and analysed.

Voluntary organisations and the independent sector complained about the degrees of involvement offered to them by local authorities. Accordingly, guidance (LAC(93)4) required that the independent sector be fully involved in consultation processes during preparation and review of community care plans. The same is required for voluntary organisations representing users and carers.

Later guidance (LAC(95)19) suggested that local authorities must plan strategically to provide most effectively for the needs of their populations. The guidance proposed long-term planning, three-yearly plans to arrange and purchase care, and urged local authorities to develop planning processes, for example by joint planning and consultation. The guidance suggested that the focus should be on objectives to be achieved, assessment of population needs which underpin these targets, available resources, and the progress made on previous plans. It urged joint planning with health and housing agencies, and decision-making that enables voluntary and private sector agencies to plan their services. Long-term planning was seen as providing a strategy, moving away from a simple focus on annual resources. The guidance indicated the need for a greater emphasis on planning processes in pursuit of strategic objectives and suggested that planning processes were not always sufficiently developed. For example, it reported that some local authorities had failed to properly consult all stakeholders.

The guidance suggested that the minimum components of a community care plan should include:

- A local population needs assessment, as a basis for plans;
- Purchasing decisions, based on levels of need;
- Strategic objectives, based on outcomes for service users, for the following three years.

Progress, however, appears to have been variable. Bainbridge and Ricketts (2003) conclude that population needs analysis and contracting for quality, in respect of older people's services,

remain weak in many councils. In their research, only two-thirds of councils inspected had improving or satisfactory systems for understanding population needs and for effective planning and provision of services. However, this progress was sometimes from a low base and would need to be sustained. The same research, more reassuringly, noted that councils were achieving greater engagement with independent sector providers and with older people in planning, consultation and service review.

In respect of physically disabled people and those with sensory disabilities, some councils have consulted systematically about planning and the quality of services but others have done little to ensure their effective involvement or to construct a coordinated interagency strategy for service development (SSI, 1996; 1997; 1998).

Better Services for Vulnerable People (Department of Health, 1997) recommended joint investment plans, involving health services and local authorities, based on joint assessments of need and shared objectives for working with 'vulnerable people'. This, it suggested, would facilitate people to live independently because services would be better coordinated; it would improve partnership working between agencies, and clarify service development.

Grants were made available (LAC(99)14) to develop preventative strategies and effective risk assessment to target low level support for those at risk of loss of independence. These strategies need to be based on population needs assessments and devised by social services departments in collaboration with health authorities and other relevant organisations. The resulting strategies should be designed to prevent or delay loss of independence and to improve quality of life. Older people are the main beneficiaries but all adult service user groups are included.

The *Health Act 1999* and the *Health and Social Care Act 2001* gave statutory backing to partnership between health and social (care) work authorities, enabling them to combine resources and to develop new organisational configurations. The Department of Health (1998) identified three levels for partnership working, each of which has

implications for mapping of need. The first level is strategic planning – planning jointly for the medium term and sharing information about how agencies intend to use their resources towards the achievement of common goals. Joint Investment Plans, Health Action Zones and Health Improvement Programmes are examples. The second level is service commissioning – developing a common understanding of community and population needs, and the kind of provision likely to be most effective. Care Trusts could develop new approaches to joint commissioning. The third level is service provision – ensuring that clients receive coherent, integrated and relevant care packages.

The *National Service Framework for Older People* (Department of Health, 2001; LAC(2001)12) required inclusive planning. All stakeholder agencies across the sectors, together with older people and carers, should work together to identify and tackle local priorities, and to deliver tangible improvements for older people and their carers. Plans should include the size and nature of the population to be served, a map of all current service activity, and an analysis of gaps between current and required services. Further guidance (LAC(2002)13) reiterated that councils must analyse levels and patterns of service. Local NHS organisations and local councils should build on existing arrangements for planning and joint commissioning services.

These requirements form part of the modernisation agenda, the aim of which is to improve the quality, availability and consistency of service provision.

Research Evidence on Planning

Community care planning has been made more difficult by the absence of long-term information on budgets, unclear Department of Health priorities, a reorganisation of local government boundaries, and the failure to dovetail publication dates for the plans with budget cycles. Another problem remains tight financial budgets and the attendant legal implications of recording unmet need for individuals. The experience of multi-disciplinary collaboration has been variable, and plans have been criticised for their failure to address performance evaluation and review

(Wistow et al, 1993). The Department of Health has found (Department of Health, 1993a) a widespread need to improve management and financial information and review systems, on which accurate monitoring of effectiveness in meeting needs has to be based. This has been reported again by Henwood and Wistow (1995). The Department of Health has also recognised that consultation does not necessarily equate with involvement (Department of Health, 1993b). It found that, despite progress in joint planning between agencies, not all groups were regularly covered, a finding mirrored by Bewley and Glendinning (1994) and Lovelock et al (1995) in respect of deaf people, learning disabled people, minority ethnic groups, and people with sensory impairments. Community care plans appeared to have little positive impact in helping these groups to access assessment and services. In some instances community care plans appear to have been unduly influenced by small but articulate pressure groups, which have effectively advocated for the needs of their own constituency. A broader view of needs and the way in which the needs of specific groups should be balanced by an overall view has been missing. Links between consultation and decision-making on resource allocation have been unclear, and community mapping or profiling of need has been unsophisticated.

Research has found wide variations between local authorities on community care plans for learning disabled people, with consequent doubts about the adequacy of plans as monitoring and planning documents (Turner, 1995). Concerns here include the absence of measures and statistics, and a failure to incorporate the needs of minority groups. This is despite guidance on social care for adults with learning disabilities (LAC(92)15), which lists the supports that learning disabled people might need and advises that services should be planned on an individualised basis, not on stereotypical notions and pre-determined services. It requires the involvement of other sectors to meet people's housing, education and health needs, and of user and carer groups to ensure that learning disabled people receive appropriate support and opportunities to promote their personal development. The evidence would suggest that planning is some way from equating services to

needs, and from defining objectives in terms of outcomes for users which enable service providers to perform an effective planning and monitoring role.

Many agencies do not understand patterns of need and therefore struggle to quantify the volume of actual and likely demand (Little, 1999). One review of how local and health authorities were developing preventative strategies and services for older people (Lewis et al, 1999) found variable progress on coordination and service development. Progress appeared dependent on the previous extent of inter-agency working, on leadership in each agency involved, and on dedicated staff and budgets. Whether priorities were then incorporated into (inter-) agency objectives, structures and processes was also critical.

Interlocking factors account for disability and social exclusion. Therefore, partnership working is essential for joined up policy-making and service delivery (Green et al, 2001). However, the history of collaboration between social services department, health authorities and organisations in the voluntary, independent and community sectors reveals that attempts at involvement and partnership working have not always been effective. Resulting services have not always been the result of an informed sense of direction (Department of Health, 1993b). The reasons for this appear rooted in issues of trust, values, ambivalence, roles, communication and power, now stimulated once more by the ongoing development of the mixed economy of welfare.

Moreover, new organisational configurations, pursuant upon the *Health Act 1999* and the *Health and Social Care Act 2001*, bring centre stage the interface between health and social models of care. Mapping must be appropriate for social care (Qureshi and Nicholas, 2001), that is, it must not focus solely on deficits and individual care needs. Oliver (1992) observes that research practices from an individual model of disability lead to social survey questionnaires addressed to disabled people about what is wrong with them. A social model will reframe such questionnaires to the restricting barriers in society. How issues are constructed and what is termed a problem or need, to be mapped, may reflect dominant power structures and

unreflective assumptions rather than the most productive conceptualisation (Fisher, 2002). Incorporating a service user perspective can help to ensure a broader approach. There is a link here directly to Bradshaw's typology of need (1972), which indicates that mapping should focus on felt and expressed needs alongside need as defined by professionals. It is important to explore how need is understood by different stakeholders. Additionally for service users and carers, how their definitions are shaped by their experiences and expectations (Godfrey and Callaghan, 2000), by their perceptions of what agencies can and should provide, and by what it is legitimate to request.

In summary, then, research findings about local authority planning processes and needs assessments suggest that:

- Plans have varied in quality and details, and have often not been strategic documents;
- Social Services Departments have failed to involve other agencies and sectors;
- The absence of clear statements of roles, accountability and reporting lines has resulted in inadequate commitment from partner agencies.

There has been little idea how to take principles forward via targets and performance measures:

- User and community consultation has been variable;
- There have been gaps in information, for example, population surveys on unmet need.

Researching Population Needs

Thus far, this paper has concentrated on the legal, policy and procedural frameworks within which dialogue and detailed negotiation and decision-making about needs and services can and should take place. If research is insufficiently related to the social problems, experiences and needs of local communities, it will neglect an empowerment agenda since it will marginalise the views and potential contribution of service users and practitioners. If it does not draw on quantitative and qualitative studies determined by service users and practitioners, in partnership with commissioners and researchers, it will maintain the

power of research purchasers in defining agendas, questions, data collection methodologies and scope of dissemination. It is likely to elevate a quantitative and statistical conception of evidence, devaluing users' knowledge and practitioners' experiences. To comment authoritatively on needs, problems, the effectiveness of policies and the (dis) empowering aspects of practice requires that power and the social relations of research (Fisher, 2002; Oliver, 1992) be addressed. To articulate issues of social exclusion, social justice, equality, rights, risks and needs, which results in policies and practices that are understanding and understandable, requires the involvement of service users and carers.

Older people must be seen as key partners (Lewis et al, 1999). Such a partnership, derived from ethical principles and from an understanding about the complexity and multi-layered nature of need, may also increase commitment and ownership among older people and agencies. It may reduce under-reporting and under-identification of problems, such as depression among older people, by acknowledging and addressing any reluctance to name difficulties derived from low expectations, high tolerance thresholds and feelings about envisaged dependency (Cordingley et al, 2001). Indeed, people's perceptions and expectations of health and ageing, and of health and social care services, rather than any clinical condition, can be related meaningfully to demand for services (Boniface and Denham, 1997).

This partnership also opens the way to challenge rather than reinforce service conceptions of need, of what is important and valuable for older people. These can in any case prove difficult to dislodge because of the challenges involved in managing demand with restricted and inadequate resources (Clark et al, 1998; Godfrey and Callaghan, 2000).

We turn now to potential ways to progress this agenda. One way forward is though the creation of structures for effective dialogue, which rebalance the power relationship between voluntary and community organisations and statutory organisations. Another is to enable service users and carers, and provider organisations close to them, to provide evidence on what is wanted, what is needed, and what works. Combining these two

approaches might lead to research that provided information in the form of:

- Data from satisfaction surveys – how do service users, carers and staff rate service provision?

Analysis of focus group or semi structured interview findings, exploring experiences of service provision and accessing the views of communities on gaps in services and how they might be remedied.

- A database of voluntary sector and community group activity – what organisations exist, what can and do they contribute, how can they be contacted? How can health and local authorities best support them?
- Mapping population data derived from a population survey or needs analysis by service user group – where are the gaps and pressures? What needs and preferences exist and to what extent are available services meeting them? How does this picture vary by geography and ethnicity? What does this information indicate for service planning and development priorities?

The research reported below used mapping techniques, informed by prior focus group findings, as a primary source of information.

Methods of Mapping

Mapping is a process of quantifying a population and its characteristics, and how the latter relate to each other (Green et al, 2001). In this process, there is an emerging consensus on the importance, when mapping satisfaction, of breaking the concept down into component parts, for example distinguishing between satisfaction with the way a service is given and its adequacy in terms of meeting need (Huxley and Mohammad, 1991/92). There is also emerging consensus on the areas of need to be mapped in relation to health and welfare services (Donnelly and Mays, 1995; Cordingley et al, 2001). These include the living environment, daily living tasks and activities, social contacts, morale and life satisfaction, physical and mental health, finance and housing, and informal carers. It is also important to obtain data on people's

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knowledge of alternatives, their experiences of services previously, and their expectations, as they may have restricted perspectives.

Department of Health policy (Department of Health, 1990) and practice guidance (Department of Health, 1991) draw broad boundaries around the concept of need, to include normal living, independence, quality of life, self-determination, dignity, fulfilment and choice. In similar vein, Godfrey and Callaghan (2000) argue that need should be defined in terms of services that facilitate older people's continued participation in valued activities, central to their self-esteem, to their perception of themselves as competent, and to their conceptions of what is pleasurable. They recommend beginning with people's lived experiences, with expansive and inclusive questions, which recognise diversity in older age. Therefore, mapping should focus not just on health and social care but more widely on potential sources of disadvantage and exclusion, and on possible barriers to growth and adaptation socially, psychologically and inter personally.

Available research evidence can be helpful in providing direction for the mapping endeavour. For example, research-informed practice highlights that service users' relationships with providers are as important as any help received (Clark et al, 1998; Godfrey, 1999; Raynes et al, 2001). Use of services appears associated with age, chronic illnesses, gender, mental wellbeing, living alone, income and social class (Boniface and Denham, 1997). These, and other research studies (Godfrey and Callaghan, 2000; Preston-Shoot, 2000), also demonstrate the importance for older people of:

- Feeling safe at home;
- Housework and being able to keep one's home clean;
- Continuity of relationships with care providers;
- The importance of small practical tasks to maintaining independence and social inclusion;
- Transport and telephone provision, again for social inclusion;
- Culturally appropriate services;
- Close relationships and social networks based on affection and reciprocity;

- Maintaining continuity of place, life purpose, sense of control and competence in valued areas;
- Having strategies to manage any limitations of ageing.

Such studies also illustrate how services fail to match need because of:

- Discrimination – services that are irrelevant to the needs of minority groups;
- Inequity – localities and/or groups with greater needs not having proportionately more services;
- Inadequacy and fragmentation – ineffective levels of service and missing services.

As part of this process too, the emergence of standards offers pointers for what to map. Standards for services for older people, for instance, focus on safety, health, quality of care, individuality and development. Preventative strategies focus on practical support and providing for personal and social needs within and outside the home (Lewis et al, 1999). They focus too on the local environment, which includes safety and transport, and assistance to remain socially active and, thereby, reduce the possibility of isolation and depression.

Surveys are a relatively inexpensive and rapid way of discovering characteristics of a population and of estimating the number of people experiencing problems and their range (Boniface and Denham, 1997; May, 1997). They may also be designed to access information about perspectives in a limited form – what people think – although such information is more appropriately gathered in other ways.

A number of secondary data sources can be used to inform the analysis of local survey data. Analysis of findings may be informed by the General Household Survey (Thomas et al, 1998), for example the number of older people unable to bath, shower or wash all over, with long-standing illness or disability, and/or unable to manage going outdoors. Census data and information from prevalence surveys can also inform analysis, for instance for depression, anxiety, dementia and older age abuse. Analysis may also contrast

expected need with actual demand to identify geographic areas of social exclusion and/or gaps at need (no or inadequate services) and outcome (services missing targets or objectives) levels, facilitating priority setting and service development.

While surveys are useful for collecting numerical or quantitative data, views on the nature of service provision and on how services impact on individuals are better accessed through the use of qualitative methods such as unstructured or semi structured interviews, or focus groups. Raynes and her colleagues (2001) argue that focus groups are a more efficient way of collecting information than individual interviews. However, how different methods, including interviews, focus group discussions and use of secondary data (census, service take-up rates) are combined will shape how a population's characteristics are understood as well as measured. The method used in the mapping needs research project reported here involved a population profile – gathering information on older people in the community and engaging them in defining their needs. It was not a service-led approach to needs mapping (Percy-Smith, 1996), nor did it examine referrals to different agencies in search of patterns, or scrutinise professionals' judgements about people in need of care and services (Little, 1999), alternative or additional approaches to mapping needs. It combined quantitative and qualitative methods to allow generalisations to be made and people's experiences and needs to be understood.

Mapping Older People's Needs: A Research Project

Aims
This mapping project was commissioned by a Crown Dependency island Social Services Division to gather relevant and reliable information that would inform policy development, service planning and service delivery. This was intended to stimulate an evaluation of current policies relating to older people. The research issues identified by the commissioners and the researchers, focused on:

- The number of older people with high, medium and low levels of social and health care needs, and the nature of these;

- The extent to which older people received services to meet the needs identified, and the nature of any unmet needs;
- Which agencies provided services;
- How older people viewed the quantity and quality of services received;
- The extent to which older people provided care to others and what support they thought they required to continue in this role;
- How effectively social care was targeted, particularly relating to nursing and residential care.

The project aimed to explore the above issues in terms of the location, age and gender of older people, as the commissioning authority was particularly interested in the geographical location of needs. As the project was carried out in collaboration with a Social Services Department the emphasis was on providing information that could then be related by the Department to information it already held about, for example, care packages.

Approach to Information Gathering

Stakeholder focus groups were used to inform development of the content of a questionnaire. Focus group discussions about needs and services were held with carers, service users, health practitioners and social workers, staff in voluntary organisations, wardens of sheltered housing and managers of residential and nursing care homes. These provided valuable insights into how services were perceived and evaluated by different stakeholder groups. Group members were also asked to give feedback on the initial draft of the questionnaire and to suggest additions or amendments where appropriate. This preliminary activity helped to ensure that the survey was comprehensive and relevant. Despite this, however, the client voice remained less prominent than that derived from collaboration between researchers and staff in the commissioning agency (see Fisher, 2002) since service users and carers were not involved in management of the project, data collection, or analysis and dissemination. Equally, the commissioning agency was the driver behind the project rather than an inter-agency forum, with the danger that improved coordination of planning might not result.

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Following consultation, the questionnaire was designed to collect information about mobility in and outside the home, transport, practical tasks like shopping and cooking, self-care, financial management, feelings (safety, loneliness) and care responsibilities for others. Comments boxes were included in the questionnaire to enable an informed understanding of people's needs and experiences.

The same questionnaire was used for those living in the community and those in residential or nursing homes. This reflected the research aim of identifying whether those living in care homes had different needs from those living in the community. In the area where the study was carried out there was open access to care homes; some residents had made a decision to live in a care home rather than to live in a hotel because the costs were similar. Social Services were concerned with identifying the numbers of residents living in care homes who had low dependency needs. While some questions in the interview were clearly not directly applicable to care home residents, for example whether they did their own laundry, it was important to identify whether they could do so if they needed to, so that responses could be compared with those living in the community. The limited validity of retrospective information has been well documented and, therefore, no attempt was made to gather information about how people currently living in residential care or nursing homes had coped in the community.

Additional interviews were carried out with a sample of older people, and separately with their carers (if any) and with the social workers working with them. The sample for these triangle interviews consisted of people who were 'open cases' within the previous six months. Information was gathered for 47 people. Interviews in this part of the research focused on the views of the participants in relation to services and needs and enabled the researchers to gather in depth information by analysing views on the 'same' needs. Information about these finding are available in the main project report.

Sample

A sample of 1210 representing 10 per cent of older people living on the island was drawn randomly from a Social Security Department database of older people receiving a retirement pension. The sample consisted of approximately equal numbers of older people in three age bands, to ensure that the research could illuminate a wide range of needs and unmet needs in the older age groups. If each age band had had equal proportions, only a small number of those aged 85 and over would have been included, the group likely to have the highest level of needs, compared with a very large number of those aged 65-74, the group likely to have the lowest levels of needs. This approach did not affect the conclusions, which could be drawn about levels of need amongst all older people, as the figures were re-weighted at the analysis stage to reflect the actual numbers in the population.

A pilot survey of 46 people was completed before embarking on the main survey. Since there were few changes in the questionnaire and no changes in method following this, data from the pilot was included in the main survey. The main survey of people living in the community was conducted by telephone interview in the first instance, following letters from both the government and the university giving information about the survey and its purpose. A team of experienced interviewers was recruited from the island and further training given relating to interviewing older people. To maximise inclusiveness, where the respondent had hearing and/or visual disabilities, or did not have a listed telephone number, a postal questionnaire was substituted. In five cases, information was gathered from a spouse because the identified person was not able to undertake an interview.

The survey of people living in residential or nursing homes was carried out using face-to-face interviews in a private setting within the care home. Where staff identified people as being unable to undertake an interview because of cognitive problems, the researchers in a short meeting verified this with the individual. In these cases, and where people were too ill to undertake an interview, information about needs was gathered from staff who knew the person. Basic information was gathered in these cases using Barthel scale and Leeds scale questions, data from which was then transcribed onto the main questionnaire.

Research evidence suggests that many older people

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are likely to under-report the difficulties they have compared with assessment by professionals in social or health care (Wilson, 1995). Our experience showed that this is often the case where an older person has adjusted to a particular difficulty by finding ways round it so that it is no longer perceived as a problem, for example wearing slip on shoes so that laces no longer cause difficulties. The solution becomes part of the taken for granted reality of everyday life and the difficulty disappears. Although interviewers were trained to explore what the older person was saying about their needs, this is a problem that it is difficult to overcome. Levels of need reported should therefore be taken as an indication of minimum levels.

Data Analysis

Analysis of survey forms was completed using SPSS. The data for respondents in the community was weighted by age so that the number of people in each age band in the survey now mirrored the number of people in each age band living in the community on the island. This meant that it was possible to extrapolate from the survey the number of people on the island with a particular difficulty.

The percentage of respondents from each postcode area was broadly equal, indicative that no particular area was over-represented in the sample, and providing further evidence of the randomness of the sample. The survey data was analysed by gender and by the three age groups, as well as by geographic area. Responses were obtained from 899 people, 107 of whom lived in residential or nursing homes, an overall response rate of 79 per cent (people who had moved and could not be traced were excluded, and there was an inevitable

reduction in numbers attributable to those who had recently died). A few respondents were excluded in the final analysis because of missing data in relation to age group, or postal district, giving an overall sample of 872 representing a 74 per cent response rate (see Table One).

People who had moved into residential or nursing care were interviewed there where possible, thus increasing the residential care sample above the number originally intended. A sufficiently large sample was used and response rate obtained to enable the survey findings to be generalised to all older people living on the island.

Where figures are given for the whole sample, that is all older people, responses from people in residential and nursing homes were weighted so that they were not represented disproportionately highly. Questions from the Leeds scale were integrated into the survey so that dependency information could be gathered in terms of the perceptions of the older people themselves. As the data is derived from their answers, it is possible that the figures contained a slight positive bias.

The survey generated information about the percentage of people in each geographic area who had a particular difficulty. Numbers in the overall population can then be derived from the sample. The percentages we give are mid points because no sample accurately represents the entire population from which it is drawn and, therefore, the true figure is likely to lie within a given range. Ranges were calculated using 95 per cent confidence intervals.

Overall, the findings from the survey are too extensive to report in this paper. We therefore offer indicative findings only rather than a comprehensive review of all the findings for all the variables explored.

Findings

Level of dependence
Approximately one in ten people aged 65 and over, living in the community, had high dependency needs. Predictably, people aged 85 and over were much more likely to have high dependency needs: 22 per cent compared with only 3 per cent of those aged 65-74.

Age group	Living in the community		Living in a care home (data not weighted)		Total
	Men	Women	Men	Women	
65-74	179	221	1	3	404
74-84	104	162	9	21	296
85+	29	69	12	62	172
Total	312	452	22	86	872
Table One: Respondents by age, gender and locality					

Sources of support and unmet need

Just over half of those in the community reported receiving help from someone with things they could no longer do, conversely 45 per cent did not receive help. This was directly related to age, and hence dependence, with 83 per cent of all people in the oldest age group receiving help. However, this means that 17 per cent of those aged 85 or more had needs that were not being met. Statutory services provided help to six per cent of community based respondents who said that they received help. Informal support from relatives and neighbours was widespread, especially sons and daughters (33 per cent of those receiving help quoted this source). Support from relatives and friends was more likely to concentrate on assistance with managing at home and mobility than on personal care and financial affairs, and it is therefore clear that there is considerable unmet need in the latter areas.

Looking at the percentage of older people with low, medium or high dependency scores and relating this to receiving help from any source, we found that:

- 48 per cent of those with low dependency scores received some help
- 75 per cent of those with medium dependency scores received some help
- 87 per cent of people with high dependency needs received some help.

These figures suggest that the majority of those who are in most need of help are likely to receive it from some source. However, more than one in ten (13%) of those with high dependency scores reported that they did not receive any help at all. Some of these people may not wish to receive support but, given their dependency scores, they appear to be at risk. It would be appropriate to consider other ways of ensuring that such people are aware of the existence of services to support them. The percentage of those with low and medium dependency levels who received some support is encouraging and provides a firm foundation for future work to prevent or delay loss of independence and to improve quality of life.

Social care needs

Questionnaire analysis focused on difficulties that are likely to have implications for the provision of social care, namely mobility inside and outside the home, use of transport, managing at home, managing personal care and financial affairs, the perceived need for sheltered housing, and the prevalence of social/emotional problems. Table Two summarises some key findings for those living in the community in terms of having significant difficulty with or being unable to cope with specific areas, and relates this to age group.

Difficulties reported	People aged 65 +	People aged 85+	Total expected in this community
Mobility at home	12 %	22 %	1 580
Mobility outside	23 %	48 %	3100
Getting in/ out of bed	8 %	11 %	1050
Negotiating stairs	23 %	52 %	3030
Using public transport	24 %	32 %	3160
Shopping	21 %	50 %	2770
Housework	26 %	58 %	3420
Making a meal	8 %	20 %	1050
Taking a bath	16 %	37 %	2110

Table Two: Significant difficulties in specific areas and age group

Some variables were cross-tabulated, for example aspects of managing at home, personal care, mobility and feelings. Central to independence is the ability to shop and do personal laundry. Twenty-one per cent of older people living in the community had difficulties in both these areas. Eighty-eight per cent of older people living in residential and nursing care had difficulties in both these areas. When these two difficulties were aggregated to create a general 'difficulties in managing in the home' variable and then related to other areas of difficulty, we found that:

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- 18 per cent did not receive help from relatives, neighbours, friends or statutory services – four per cent of older people living in the community;
- Eight per cent had no help and no access to private transport – two per cent of people in the community;
- 74 per cent of those with general difficulties in managing in the home did not drive – representing 15 per cent of all older people living in the community
- Eight per cent had no access to private transport – two per cent of all older people in the community

The research provided evidence that care homes in this area were providing support to people with very significant difficulties. They also revealed the potential for isolation amongst people aged 65 and over, and suggested for instance that, in this geographical area, consideration could be given to more flexible forms of public transport that are responsive to older people's needs. The findings provided strong evidence of the need for low intensity but carefully targeted help to maintain the independence of people experiencing difficulties who were unable to access other assistance.

Twenty per cent of people living in the community had difficulties getting dressed and in taking a shower or bath. Eight per cent of older people living in the community with these difficulties did not have equipment or adaptations to help. Sixteen per cent of older people with these difficulties living in the community received some help from carers or service providers. Eighteen per cent of older people living in the community had trouble with getting dressed and did not have any help. While some older people whose needs appeared to be unmet did not wish for help. Other interview data indicated that there were a number of reasons why others did not seek help. These included not knowing that help might be available, lack of confidence in service providers, and/or a reluctance to admit that support was required.

The findings suggested an urgent need to devise flexible solutions to the question of how supported bathing services and home help services should be provided. Findings in relation to toilet aids, however, suggested that this help was being targeted very effectively.

Ten per cent of older people reported that they often felt 'low'. A considerable proportion of those who experience depression in broad terms will seek support from family and friends. However, our findings highlighted the importance of the availability of support and counselling services for those unable to access this help or for whom help from family and friends was inappropriate. Services needed to be extended to address the needs of people who were less able to ask for the help that they needed to maintain good mental health. The findings relating to loneliness highlighted the need for sensitively planned and delivered services to provide support, contact, befriending and counselling, and transport schemes to break down social exclusion.

Health

The survey asked whether people had been admitted to hospital during the previous year and whether they experienced health problems that limited their quality of life or what they were able to do for themselves. Fifteen per cent of people aged 65 and over, living in the community, had been hospitalised, rising to 22 per cent of those aged over 85. Thirty two per cent reported an absence of health problems, falling to 11 per cent of those aged over 85. Of respondents reporting health problems (n=574), arthritis was most commonly cited (36%), followed by heart related conditions (25%), sight (20%) and hearing disabilities (20 per cent), orthopaedic concerns (19%) and incontinence (17%). Falls were frequently cited as the critical incident most affecting people's ability to cope.

Older People Providing Care and Support

Respondents were asked whether they were responsible for regularly looking after anyone else. Overall, 10 per cent of those living in the community reported that they regularly looked after someone else who lived in the same household. Five per cent reported the same for someone living elsewhere. There was little difference between those aged 65-74 and 75-84 in terms of the percentage providing care but predictably people in these age groups were far more likely to be providing care than those aged

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over 85. Recipients of care were almost invariably relatives (87% of cases), most often a spouse or partner.

Our findings about older people with responsibility for others should be treated with caution because of problems with communication. It appears likely that some broadly interpreted the question about having responsibility for someone else to include spouses or partners, irrespective of whether they had any support needs. Nevertheless, the importance of supporting carers was highlighted by findings relating to the number of older people reporting that they themselves were responsible for others. Seventeen per cent of those with low Leeds dependency scores, nine per cent of people with medium dependency scores and 12 per cent of those with high dependency scores said that they were responsible for someone else. Again, 13 per cent of those who were responsible for someone else had general difficulties themselves managing at home. Seven per cent had difficulties with their own personal care.

The majority of self defined carers are themselves either fully independent or have low dependency needs. However, the survey indicates that ten per cent of those in both the medium and high dependency levels were themselves caring for others. A substantial proportion of carers aged over 65 did not receive any help at all with their caring role. Lack of support for carers has important implications for the quality of life of the carer. Additionally, a breakdown in caring is now recognised as an important contributory factor in residential and nursing home admissions. There remain therefore strong arguments for exploring ways of extending the support available to carers.

Targeting and the Provision of Residential and Nursing Care

The social services division was interested in the difficulties experienced by, and the dependency levels of those in residential and nursing care, compared with those living in the community. Three quarters of people in residential or nursing homes had high dependency scores compared with only one in ten of those living in the community. There was little difference between the percentages with medium dependency scores.

Dependency level – people aged 65 and over	% of all living in residential or nursing care (n=108)	% of all living in the community (n=761)
% Fully independent	0	42
% Low dependency	8	34
% Medium dependency	17	14
% High dependency	75	9
Totals	100	100 (rounded)
Table Three: Dependency levels – people living in residential or nursing homes		

Analysing the information about dependency scores, by looking at the proportion of those in each dependency band who live in different settings, we found that:

- Seventy three per cent aged over 85 with high dependency scores lived in residential or nursing care (n=77);
- Twenty nine per cent aged over 85 with medium scores lived in care (n=41);
- Thirty nine per cent of those aged 75-84 with high dependency scores lived in care (n=57);
- Nine per cent of those aged 75-84 with medium dependency scores lived in care (n=58);

The difference relating to age group in these percentages is likely to be due to diminishing access to support from partners, relatives or friends.

Almost one in ten of those in care had low dependency needs as measured by the Leeds scale, the implication being that between 20 and 140 people then in residential or nursing homes were unlikely to need that kind of provision. The further implication is that there were people living in the community with high dependency needs for whom places were unavailable.

The survey also compared the needs of people aged 85 and over in care homes with those of similar

people in the community. In terms of needs related to mobility, about 1 in 5 of those living in the community had difficulties compared with 1 in 2 of those living in care. There was strong evidence that considerably more people who lived in care homes had mobility problems than those in the same age group living in the community and that the problems they had were more disabling. A similar consistent pattern emerged in relation to needs relating to managing at home and personal care.

Concluding Discussion - Making a Difference?

The comment boxes on the survey questionnaire were used extensively, enabling a qualitative understanding of people's lived experiences alongside a quantitative assessment of their needs. However, one drawback of postal questionnaires, and perhaps of telephone interviewing, is that these insights could not be amplified. Indeed, the different methods of completion (telephone, post and face-to-face) meant that interviewers contacted hard to reach populations but obtained variable information. It is difficult to address any defensiveness or internalised negative self-views by post, even telephone perhaps. It is similarly challenging to tackle such issues where people were unaware of their rights and possible choices.

The survey provided baseline information, using acknowledged domains and validated instruments for surveying older people's needs (Nocon and Qureshi, 1996). This helps to offset the unclear and disputed parameters of need that complicate social (care) work practice where need is the passport to provision. However, the predominantly discretionary and permissive basis of the legal framework for meeting need allows resources still to ultimately shape what is perceived as needed. The survey enabled the articulation of felt need but the modernisation goal of improved flexibility and responsiveness may be undermined since expert definitions of individual need are institutionalised in policy (Department of Health, 1990).

The survey did not measure overlap between agencies, one additional possibility (Little, 1999) where separate training and procedures, fragmented or divergent roles and responsibilities, and absence of joint planning, represent significant obstacles to

improved quality and efficiency of provision. It was accompanied, however, by a project to map needs through evaluation of referrals to service providers and the assessments reached by care managers, some findings of which have been reported (Preston-Shoot, 2003). An advantage of the approach taken here, over alternative methods of mapping, is that it generated new information about population needs, which could be linked to census data for post code areas and indicators of socio-economic distress (for example, benefit assistance, unemployment, and residential stability). It was not service-led but could inform estimates of critical, substantial, moderate and low risks when setting eligibility criteria for fair access to care services (LAC (2002) 13). It provided commissioners with legitimacy – information with which to perform their legal duties. Local authorities cannot commission appropriately, or enable service development, without understanding the needs of their populations.

Translating research findings into practice is rarely straightforward (Qureshi and Nicholas, 2001) since it involves not just communication of findings to policy formulators and to practitioners but also facilitation of organisational change. While the communication of findings is generally regarded as an integral feature of 'doing' research, researchers are less frequently involved in a broader approach to promoting organisational change. Findings must be adaptable for use. However, blocks to planning for changes in need include shortage of time to understand and use available data, lack of agency commitment, an absence of joint planning at strategic and operational levels, and contrasting remits within which different agencies operate (Green et al, 2001; Hare et al, 2002; Janzon and Sinclair, 2002; Hamer, 2003). Mapping should not become so time or resource consuming that it becomes unsustainable (LASSL (2000) 3). However, it also should be commissioned and implemented within a partnership that crosses organisational boundaries and invests in resources to deliver on agreed priorities and targets subsequently.

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