1. Care manager: rhetoric or reality

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When Griffiths presented his report ‘Community Care - Agenda for Action’ to the Secretary of State, directors of social services heaved sighs of relief as it appeared to be some kind of confirmation that those of us responsible for delivery of a complex range of services were in reality performing an impossible set of tasks. Griffiths lent support to our view that we were being asked ‘to make bricks without straw’. Perhaps the euphoria that followed our gleeful approval of Griffiths’ recommendations addled our collective brain. Critical analysis of our capacity to manage and deliver a range of services ‘à la Griffiths’ and, in particular, the role of the care manager has not received the critical analysis that is essential if we are to have any chance of providing the services that Griffiths appears to envisage.

It is important to remember that Griffiths was not asked to define the range, quality or quantity of services, or to comment on the sufficiency of resources, and although he does identify problem areas relating to manpower and levels of skill, and the need for training and development, these are ill-defined. In short, Griffiths, in relation to the management and organisation of services, raised more questions than answers and it is time that our views were clarified and articulated on a range of organisational and managerial issues which I believe, up to now, have been dealt with superficially or taken for granted. The issues are complex but nevertheless can be reduced to one single question. Have we the capacity to deliver? I wish to examine this with particular reference to the role of the care manager, for this role...
is at the pivot of future service provision and if the pivot does not work the wheel will not turn.

**Resources**
Griffiths recommends ‘in cases where a significant level of resources are involved, a care manager should be nominated from within the social services authority’s staff to oversee the assessment and reassessment function and manage the resulting action’. Griffiths appears to be identifying the role which is equivalent to a team leader or senior social worker type role, but the term ‘managing and resulting action’ assumes a level of delegation and authority which is far from universal. It is true that there is more delegation now than ever before, but relatively little in the way of committing resources is truly at the discretion of team leaders or senior social workers. Critical decisions about resources, especially the input of high level resources, are still often taken at more senior levels in the hierarchy. I am, therefore, concerned about the care manager’s ability to have access to resources to create packages of care with ease and flexibility. Relationships within the organisation as a whole and the systems currently operating will require considerable alteration.

**Assessment**
Griffiths makes a number of comments on flexibility and obviously sees it as important, but this is a seductive concept. He proposes access to a range of services from the public, private and voluntary sectors. We would all agree that we would want to give our customers choice and, because their needs change and vary considerably over time, flexibility is essential. However, this presupposes a standardised assessment to determine needs. There is little evidence that assessment is done in a systematic way by the majority of social services departments and the question must arise as to whether we all have established explicit criteria for eligibility. Clearly many departments have established criteria for providing services but are we sure these are universally applied at operational level and how much do we do to monitor the application of criteria in order to achieve a systematic approach? What performance measures do we have in place to determine outcomes? We have not yet truly grappled with these issues and this must take place very quickly. If access to services is defined by assessment, and if we are to have a reasonable
and fair distribution of scarce resources, more sophisticated assessment techniques will be essential. There is considerable doubt in my mind as to whether we have the capacity to undertake such assessments and, in reality, the great majority of us here today have been thankful to muddle through. This ‘muddle’ will come on public view when we move down the road that Griffiths intends for us. We will no longer be able to hide behind the bureaucratic fog, a fog that in reality keeps us protected and, to some extent, safe.

We all know there are real problems of maintaining even current staffing levels within most authorities and very serious problems in some parts of the country. Shortages of skilled Level 3 workers and occupational therapists mean the possibility of providing sufficient assessments and reassessments is likely to be limited. Assessments form the basis of the contracts that we will offer and are clearly a key element in providing appropriate services. Competition for providing other services, child abuse, etc, means that the development of this capacity factor will take many years even if Government puts onto a proper footing the funding of social work training. If the current situation is difficult then the future is even more bleak.

**Contracts**

Griffiths goes on to say ‘where care is already being effectively managed, this proposal will amount to little more than making existing roles explicit’. This notion of making existing roles explicit implies the development of a contract between client and agency. In reality we have very few written contracts which relate to the level of service we provide for our clients and certainly these are not seen as a binding commitment. It is this lack of commitment which Griffiths is identifying and clearly the present arrangements serve us well because we can vary our obligations to our clients in an ‘ad hoc’ way according to changes in supply and demand for particular services. I have little doubt that each individual decision is justifiable if seen in the context of providing and prioritising scarce resources overall. The need to provide for even more needy clients coming on stream means that existing clients have services withdrawn or reduced. It is clear to me that if we develop a contract approach to our work then we will have to honour them and if we fail to do so this could ultimately result in what is an increasingly litigation oriented society action for breach of contract. The problem with this is that even if the client’s needs
change for the better and services are no longer needed to the same
degree, there is a possibility that action could be brought against us
for reducing services if there is a dispute over need and the necessary
level of service. The problem of predicting future needs of individuals
and the aggregation of these needs into definable services that can be
contracted out and with different specifications is considerable.

**Authority**
What of the nature of the authority that will be invested in the role of
care manager? The care manager will need to make demands of
various agencies to provide support on a guaranteed, and often long
term, basis. Essentially there will be a number of ‘mini’ service
agreements between the local authority and other agencies in the
private and voluntary sectors, with good neighbours and families also
involved in this process. These negotiations, up to now, have tended
to be informal and often work quite well. The proposals outlined in
Griffiths formalise these procedures. Although this in itself may not
be a bad thing this poses severe problems in terms of the time that
would be needed to be devoted to this activity. There is then a clear
possibility that our systems of service delivery will become
completely clogged and that we shall add to, rather than detract from,
the existing bureaucracy.

How will care managers operate? Will they be able to buy in
packages of care which change over time according to the needs of the
individual? Will ‘mini’ service agreements be essentially short term
(even for long term cases) in order to introduce flexibility? This is
fine in theory, but many private agencies will want long term
commitments, and too much flexibility would essentially vary the
contract to the extent that there may quickly be very few bidders.
Potential contractors are unlikely to develop packages of services
unless there is a clear profit margin in them, and are likely to be very
selective. Clearly it is likely that Government will ask us to contract
out large chunks of service but I do wonder just how many
organisations are waiting to rush in to take over the dirty, difficult and
unrewarding tasks that our staff perform so well and so loyally. How
many of our best managers will we lose as management buy-outs
become the order of the day?
Accountability
I would now like to turn to the issue of accountability. This seems to me to be the biggest problem of all. If care managers are to stitch together packages of care from a variety of sources then we will need to devote some considerable time to monitoring whether the specifications are being met in relation to individual clients. We will need to take appropriate action to ensure that the standards of care provided are within the specification and be backed up with the necessary authority to act if these specifications are consistently below standards. Clearly, situations will arise in which a variety of contributors to care are in evidence and where accountability for any problems which arise are quite unclear. Even the organisation of a good neighbour, the contribution of a health visitor, a home help, short term care, residential and day care, etc, is complex when managed in-house and by direct provision. If some, or many, of these services are being provided by external agents, it is clear that the issue of accountability, who did what and why, whether the level and quantity of service was as agreed, will figure large. It seems to be inevitable that if things go seriously wrong, scapegoats will be found and the obvious scapegoat will be the care manager. For relatively little in the way of salary, these people will take the great bulk of any criticism which arises. It is, therefore, not likely to be a job that is particularly attractive to existing staff.

Changing roles of social workers
Who will undertake the role of care manager? Given the large volume of very vulnerable people coming through the system arising from demographic changes, the numbers who will require a significant level of resources will go on increasing. Therefore, the need for care managers will increase over time. As well as senior social workers or team leaders, Level 3 social workers may need to be appointed into such roles. This in itself poses a problem, as currently the majority of elderly people, including those with quite high dependency features, are not allocated to Level 3 workers. In other words, many staff are inexperienced in this field. It seems to me that it would be impossible for team managers or senior social workers to undertake this role because they do not exist in sufficient quantity. Therefore, consideration would need to be given to home care organisers undertaking such duties. The majority of home care organisers are
untrained. The alternative is to recruit managers from outside the service, whose value system and subsequent commitment to welfare may be very different from those currently engaged in our business.

If we anticipate that social workers will have to undertake the role, have they the capacity to do so? Recent research, as yet unpublished, by the Policy Studies Institute,1 indicated that many social workers interviewed did not understand the nature of the Griffiths’ proposals and those that did felt the systems that evolved would be administratively dominated and there would be less client contact than now. They felt that if they were responsible for local budgets then this might skew their decision making. They also feared they would run out of money. Many did not wish to prioritise the services because they felt that those at the lower end would receive no service at all and that by undertaking assessment, and then giving cases priority, this could lead to a reduction in service for clients with medium/low dependency needs. They felt that the nature of their relationship with their clients would suffer, especially if services which were clearly needed could not be given. In other words they did not want to be in the rationing business.

Griffiths seems to have made the assumption that the majority of elderly people only need practical help. This is far from true and some authorities do try to provide a range of services which are not only practically based. In other words, the very essence of large elements of the social work task could be removed. Workers were also worried about having to stitch together packages of care and felt that instead of being professional social workers they would become recruiting agencies and felt they had little skill in this aspect of work. Some also felt that many clients would not want to have a ‘care manager’ and liked current arrangements. There was concern about competing with colleagues for resources and that this in itself would be divisive. Finally many felt that demands for the service would increase and that the whole system had an inflationary element.

**The voluntary and private sectors**

What is the capacity of the voluntary and private sectors to meet services demanded for the most vulnerable? By and large the private and voluntary sectors do not deal in volume with the most vulnerable. They are selective, they can afford to be. Why are they selective? Primarily because the cost of looking after the most vulnerable is high and if Government continues to contain expenditure through a policy
of not uprating state benefits in line with inflation then the incentive to take the most vulnerable will not be there. There are unlikely to be sufficient numbers of agencies to provide services and even if they spring up initially, undoubtedly, in a competitive market place, some will go to the wall. Therefore, what safety net will be sustained within the public sector if contraction begins to happen on any scale? We all know that unintended consequences arising from changes in income support can have dramatic effects. That is how Griffiths was conceived and born. Any relatively minor changes in Government approach to income support could have a considerable effect on the private and voluntary sectors. I am not convinced that Government always gets its predictions right and its failure to spot unintended consequences of policy changes has been actively criticised by the Audit Commission in a number of fields. What then happens if these packages of care, backed up by contract, cannot be honoured because of the volatility of the market place? Initially there may be other private and voluntary homes which can provide for clients but there is a real possibility that if a number of agencies go out of business we will be overwhelmed with vulnerable clients requiring immediate service.

What of the small scale voluntary organisations and individuals that give us so much valuable help? Griffiths seems to envisage that the informal voluntary sector will play a greater part. Nobody would argue with this but if the voluntary contributions need to be formalised as part of an overall contract, we may be in danger of reducing, rather than enhancing, voluntary efforts. We need to take great care of ensuring the most valuable contribution of volunteers is not formalised to the point that it implies accountability for their contribution as this could undermine the vast amount of goodwill which still exists.

Management systems
We have seen the beginnings of the development of local financial management systems in a number of authorities. However, these are seldom applied to individual clients and, although there is some decentralisation of financial decision making, these are limited and by no means universal across all social services departments - primarily because technology has lagged behind our wish to introduce such measures. The majority of authorities have not yet decentralised to team level let alone to individual care managers or practitioners. The
management information systems which would enable this to happen
do not yet exist on sufficient scale and neither do the accountancy
systems (which Griffiths refers to) enable individual accounting to
take place. If care managers are to undertake this task, they must have
personal authority to make budget commitments and switch resources
imaginatively and flexibly and to utilise various financial resources in
a variety of different ways which will vary over time. Currently
management information systems do not enable this to happen.

Future developments
Is there any way we can consider how the future scenario might pan
out? There is very little information that we can rely on but there is
a danger that, as pressures mount for social services departments to
provide services for the most vulnerable, such groups will monopolise
resources. Instead of a wider choice for the majority of our clients,
we may end up with virtually all the budget being spent on the
high-dependency clients, the very frail elderly, the physically
handicapped under 18. By establishing guidelines and criteria for
eligibility, demand may well increase and in order to deal with the
most vulnerable clients, the less vulnerable may have to be discarded.
In reality there may be more restrictions on what can be delivered
rather than less.

In conclusion Griffiths is asking for a major cultural shift in the
way practitioners manage, organise and perform their professional
tasks. Certainly my own social workers and frontline managers are
nowhere nearly equipped for such change in focus and direction at this
time. To ensure such a cultural shift would require considerable
investment in training at this time and would take a minimum of two
to three years to achieve. This, coupled with a shortage of skilled staff
in the market place, would appear to me to make the notion of the care
manager likely to be impracticable unless we take action now.
Although many elements of the concept may be sound and may
represent the way Government wishes to see services delivered in the
1990s, the practicalities could defeat us unless we are prepared to
grapple with the issue at this time.

References
1. Allen, L., Hogg, D., Peace, S., Services for Elderly People: Choice,
   Participation and Satisfaction, Policy Studies Institute, 1990
   (forthcoming).