Appendix 1

Areas of study

The study was carried out in three local authorities: an outer London borough, a southern county and a northern county.

London area
The outer London borough was made up mainly of suburban residential housing with some light industry. The area to the north of the borough was notably more residential and middle class than the other areas. The elderly population was distributed fairly evenly throughout the borough.

The borough was divided into three geographic divisions (north, east and west), each with a Divisional Manager. Seven elderly care teams were spread across these divisions. Our research was conducted in three of the elderly care teams, one from each division, giving a good geographical spread and providing examples of different social circumstances.

Elderly care teams had access to hospital and community based social work and welfare officer support, home care, meals on wheels, occupational therapy, day centres, residential homes for elderly people, day care in residential homes, dining centres, volunteer services, elderly care schemes, care in the community project and other community initiatives.

The elderly care teams were managed by a team manager, who ran all field, residential and day care provision for elderly people in their area. The teams included trained social workers, welfare officers, domiciliary care organisers and home carers and occupational therapists. Each team also had a consultant practitioner who managed the fieldwork, as well as having a small caseload.

The home care services were moving towards personal care and away from domestic assistance, with those needing domestic assistance being asked to pay privately. At the time of the study, the transition had yet to be achieved and the authority was working on a prioritisation system, which considered physical and mental dependency and an assessment of social need.

The independent domiciliary services sector was very small. A small number of agencies offered private domiciliary support and some employment agencies could be approached for cleaning services.
Allocation of cases to social workers and welfare officers followed a similar pattern in each of the areas. Referrals were made through a duty officer. Home care and OT referrals were referred for the attention of a domiciliary care officer or occupational therapist. Urgent social work enquiries were dealt with by the duty officer. Other cases were allocated at weekly allocation meetings by the team manager or consultant practitioner. The policy was for assistance and services to be offered as soon as possible and for cases to be closed and removed from the caseloads. This meant that the caseloads of social workers/welfare officers appeared rather small in comparison to those in other areas.

The borough had 11 local authority residential homes at the time of the study, but was in the process of buying an establishment from a neighbouring authority. The independent residential sector for elderly people was very small; there were only seven private homes and three voluntary homes for elderly people. The authority had one registration and inspection officer.

Southern county
The southern county was located in the south west of England. It was an area of predominantly rural farmland, with several towns and many villages. It had a coastal area to the north which had seen a large development in private residential and nursing homes for elderly people.

The authority was divided into nine social services areas, which came under five district councils. Services for elderly people were provided through a mixture of both generic and specialist trained social work teams. Each area had a Team Manager. At the time of the study, the authority was developing the use of residential homes as resource centres with field workers located within homes. This system was operating in one of the areas selected. Three of the nine social services areas were selected for this study to give a good geographical spread.

The social services teams had access to hospital and community based social work support, home care, meals on wheels, occupational therapy, day centres, residential homes for elderly people, day care in residential homes and volunteer services including voluntary visitors and a voluntary sitting service. The independent domiciliary services sector was small.

In the area where residential homes were being used as resource centres, domiciliary and residential services were integrated and managed from the homes. Three homes were selected in this area to give a good geographical spread. Two or three specialist social workers were based in each of the homes and they assessed elderly people for domiciliary care and day care, as well as for residential care. There were no home care organisers, though senior home helps were based in the homes, each responsible for a number of home helps. Cases tended to remain on the social worker’s caseload, even if they were only getting home care. Caseloads were therefore large, but individual cases were prioritised according to need and records indicated which cases were 'active’ (ie. currently being visited by a social worker). The head of the home was responsible for coordination of all services from the home.
The second area had a large generic social work team, based in an area office in one of the towns. Home care organisers and occupational therapists were also based in the office. There was some specialisation among social workers and their caseloads of elderly people reflected this.

The third area had two specialist social work teams. One dealt with children and families, and people with learning difficulties. The other dealt with elderly people, people with a physical handicap and mental health issues. The team leader was opposed to the concept of caseloads and was very service-orientated. Social workers tended to be responsible for a service, rather than having a caseload of elderly people. Some people were assessed by social workers without a file being opened and records were not always kept.

There were 26 local authority residential homes across the county. The independent residential sector was large, particularly in the north of the county. There were around 110 private homes for elderly people across the county (but only six voluntary homes). Senior assistants were line managers for the county homes, as well as being responsible for regulation and inspection of the private and voluntary homes.

**Northern county**

This county was made up of a large rural area with numerous towns and villages, two cities, both with ports and heavy industry, and a coastal area with a large number of private residential homes.

The social services department was divided into 48 neighbourhood teams, which came under nine district councils. We purposively selected three main areas across the county to give a good geographical spread and to represent the very different types of areas.

One of the areas was a large rural community to the north-west of the county. It was a mixed area, with areas of middle-class residents as well as areas of rural deprivation. We worked with one neighbourhood team which covered a large proportion of this area.

The second area was on the coast and had a concentration of private residential homes. It was generally a well-settled, residential area.

We worked with two neighbourhood teams in this area.

The third area was a district of the large city, central to the county. The district offered a good contrast to the other areas selected and was made up largely of pre-war council housing with pockets of considerable urban deprivation. We worked with two neighbourhood teams in this area.

The neighbourhood teams had access to hospital and community based social work and welfare assistant support, home care, meals on wheels, occupational therapy, day centres, residential homes for elderly people, day care in residential homes and sitting services. The independent domiciliary services sector was once again very small.

Neighbourhood teams were managed by a Neighbourhood Team Manager. All the social workers in the county were generic. This meant that in hard-pressed areas, such as the inner city area, the main priority was child abuse. Consequently,
there was little or no social work with elderly people in this area, and even in the other areas, social work support to elderly people was minimal.

The domiciliary care officers managed and organised all the domiciliary care services, as well as day care and short-stay care and some long-stay admissions to residential care. They managed a budget (of hours), made assessments and put together packages of care. They were experienced and well-trained. Most work with elderly people was undertaken by DCOs. They had heavy caseloads as they included all people receiving home help. Because of pressure on resources, all the elderly people in receipt of a home help were graded according to a five point scale. The grades reflected the elderly person’s dependency on the service and allowed the DCOs to be more flexible when allocating and reallocating home help hours.

There were 58 local authority homes across the whole county. All except three of the 48 neighbourhood teams had at least one home to manage. There was also a large, private residential sector, particularly on the coast. In total, there were around 200 private homes for elderly people. As we found in the other two areas, the voluntary sector was small; there were only six homes for elderly people run by voluntary organisations. A Principal Officer was responsible for registration and inspection of the private and voluntary homes.