Figure 11.1  Establishing and maintaining a package of care

ASSESSMENT/APPRAISAL
IDENTIFY
- Circumstances
- Resources
- Needs

MAKE CHANGES
AS SITUATION CHANGES

ACTORS INVOLVED
Elderly person
Carers
Care worker(s)
Other service providers
Neighbours/others

GIVE INFORMATION
(complete/incomplete; constraints/no constraints)

REASSESS

DISCUSSION
(participation)
NEGOTIATION
LIAISON WITH OTHER PROFESSIONALS

MONITOR SITUATION

MAKE ARRANGEMENTS
Chapter 11

Getting into the system: the professional view

For the majority of the elderly respondents in this study, their first contact with someone from the social services department had usually been suggested and organised by someone other than themselves, often by a relative, or through the hospital, or through a professional, most commonly their GP. Relatives or friends who contact the social services department directly, either in person, or more often by telephone, and are passed to a social work team, usually speak to a duty officer. The duty officer, depending on the nature of the enquiry, may either deal with the case directly or take details for the case to be allocated to a social worker or social work assistant at a later date. This system was operating in both the London borough and the southern authority and was explained by a team manager from the London borough in this way:

An initial referral comes in, say by telephone, and is recorded on a standard referral form. If there are any risk factors then these are recorded on a rapid assessment form. These are then put out to social workers who do their own assessment. You can’t get much on the standard assessment form, but as we have so many staff, the rapid assessment form focuses the duty officer on all the services provided, for example OT, home care and part III, day care, and on the reverse side is a list of risk factors. We can use this if we have calls from GPs and other professionals.

In the northern authority, referrals for home care came from a wide variety of sources but most commonly through GPs or relatives, or were passed on to the domiciliary care organisers by the generic social work teams. Allocation to a social worker in this area depended on the nature of the request, but social workers were usually only involved if the elderly person was moving into residential care or if they had particular problems such as mental infirmity.

Carrying out assessments

When an elderly person had been allocated as a new case to a social worker or domiciliary care organisers, he or she almost always made an assessment of their needs. This was true both for the majority of new referrals and for those who had already been receiving services from the social services department. All the domiciliary care organisers interviewed said that they always made an
assessment. A small minority of social workers did not make an assessment of clients who were already receiving services from the social services department. This was because they were being transferred from another social worker or receiving services through the home care service and it was not thought necessary. One social worker from the northern authority put it this way: ‘I would chat to DCOs if they have been involved for many years. I’d make a few phone calls and see if it was important.’

Two social workers from the north had never been allocated older people as clients. As members of generic teams they were involved totally in child care work. Another generic social worker described the insecurity he felt in carrying out assessments with elderly people: ‘Since April last year I’ve only had one case and that was because I’m a mental health social worker and there was some question about the woman’s mental state. In this team I wouldn’t be allocated an elderly person because I don’t know anything about services for elderly here. I’d go and ask the DCOs. I’d attempt to do an assessment but the question is whether it would be a proper assessment because I’m not au fait with the services – I wouldn’t feel equipped to do so.’

The procedures for making assessments varied greatly both within and between the authorities. All the domiciliary care organisers used a standard needs assessment form, whereas social workers varied their practice – sometimes using a form was felt appropriate, sometimes it was not. This, of course, reflected the difference between the two types of worker – the domiciliary care organisers seeing it as their role to assess for a particular type of service – home care or home help, whereas the social workers received referrals for a wide range of reasons and adopted a far less service-led approach at this stage. Only four of the 40 social workers said that they always used a standard needs assessment form, three from the London borough and one from the northern authority.

Those who used a standard form found it useful for a variety of reasons. The domiciliary care organisers felt it provided a useful written guide, a record of services and facts about the client. There were, however, plans to extend the information gathered by domiciliary care organisers in order to make a broader assessment. One domiciliary care organiser explained: ‘The county is evaluating a new form. It’s thought that the new form could be more detailed regarding the help given by carers etc. The present form is quite adequate for assessing need for domiciliary care. We would assess for other needs as part of the assessment interview. If I felt it was necessary we would add case note forms, but we have to make a basic assessment.’

The social workers felt that standard forms were valuable in providing a record of a person’s physical and mental health and were useful when liaising with other professionals. One social worker from London put it this way: ‘They are very useful. If you want to look at health or mental state or risk factors they are all included in the report. These are useful forms and helpful if the DCO came to me and asked about home care – I could look at the risk factors.’

Of course all standard forms vary and while some are fairly tight checklists with little room for embellishment, others allow for additional information. A
checklist, however, does steer the worker through a fixed list of topics and while this may prove essential in some circumstances, the value of letting the old person tell their own story in their own way may be diminished.

But while all the domiciliary care organisers interviewed used a standard form, this was not the case for social workers. Twenty-one stated that there was no standard form for assessing needs: eight from the London borough, 12 from the southern authority and one from the north, a comment confirmed by eight of the team managers.

A number of social workers actively disliked forms. One from the London borough said, ‘There are no forms, I hate forms’, and another saw forms only in relation to services and not in relation to social work: ‘We don’t have a form. We have some guidelines but basically rely on our professional judgement’.

A further nine social workers commented that forms were only used for collecting specific information, such as the initial request to the duty officer or admission to a local authority residential care home or day centre. A social worker from the southern authority commented on the formality involved in assessing for a service as opposed to the informality of a social work assessment: ‘We’ve just taken on home help assessment and social work general assessment. There is a standard checklist for home help assessment asking for things like number of hours etc. There is no standardised assessment for social work, but you do the two in tandem.’

Another social worker from the same authority commented on the detailed forms needed for a Part III assessment and how form filling sometimes had to take second place to meeting immediate needs: ‘When you’re doing an assessment specifically for Part III you use a form. It’s very formal and you have to fill in confidential records. But often a person’s needs have to be met in a hurry and you don’t do this until later.’

Forms for Part III assessment were sometimes difficult to complete and had to be modified in order for the client to feel they related to their needs as this worker explained: ‘Invariably if you’re using a Part III form you have to explain the reason since they wonder why all these questions. I say the home needs to know – not for the needs of the home but for the client. And I’ll ask questions about food preferences which are not on the form. I also fill in forms with them if they are requesting day care in a residential home.’

For many older people early interactions with a social worker were different from those with a domiciliary care organiser. The domiciliary care organiser usually had a form to complete regarding their specific service, whereas the social worker might appear to have come for an informal chat. This did not mean that domiciliary care organisers did not collect a wide range of information but the initial focus of the interaction was fixed around one particular service, and other information might or might not have been recorded.

When asked how they recorded information about elderly people, just over a third of the social workers from the south and nearly half of those in the London borough explained that they went into an interview with a ‘checklist in their mind’ – an unstructured list from which they either made notes at the meeting or wrote
up afterwards. A social worker from London expressed a commonly held view that writing notes in front of the old person did not help the worker develop a rapport and that this was of prime importance. She commented: ‘Everyone works in their own way. I never go in the first time and ask where their pension book is. There is no standard form -- just a list of headings as guidelines. I make out my own notes and then do up a contact sheet. But I don’t make a lot of notes on the first call. I don’t bombard people on that first visit, I just have a cosy chat. I introduce myself and then go back in a couple of weeks, unless it’s urgent. When I go back I complete a caseworker.’

One social worker from the southern authority used a pocket recording machine to aid her memory: ‘I prefer to use a less formal method. I go in to the elderly person and get to know them briefly and then use my own judgement. I usually use a pocket recording machine after the interview. I will make some notes if they are physically frail, but if they are mentally frail and you are writing something down, they can get worried.’

Another social worker from the south admitted that administration and record keeping were not one of her strengths: ‘We don’t have a set form, which I’m pleased about as it’s far too narrow. But I record very badly. We don’t have a typist here and I’m very bad at admin. We all write out our notes.’

However, over half of those interviewed mentioned recording information either on specific forms for specific assessments or on a range of departmental forms which were used for all kinds of cases. Much of the recording was done in the office and not with the client.

The type of information collected by social workers concerning the circumstances and needs of old people was similar in most cases and usually included the following: reason for referral, date of birth, GP, physical and mental health, social support/contacts, family relations, financial situation, current services, what the old person thinks their needs are. Some workers saw this as an opportunity to get to know the person well and to learn about their social history including details of past employment and past life experience, as a social worker from the London borough explained: ‘I ask for basic information – date of birth, their GP, the nitty gritty. But I don’t ask them directly at the initial visit. I ask them about their family, telling them about myself and my family. Then they become willing to give more, so I ask about the support they have got going in and whether they think particular services would be useful. It’s difficult to make an initial assessment on a one-off visit.’

A social worker from the south had a similar approach: ‘I tend to take the holistic approach – I look at physical disability, medication, mental disability and the social side. I look at the building and see if they need an OT assessment. I see if I need to refer back to their GP. GPs can be a bit naughty and feel that we can assess for everything, when really it’s a medical problem.’

Others built up a profile of the old person over a number of visits, often using clues from the environment as indicators of need: ‘I would tend to go for the environment, whether I felt they were in command of their place or whether it had gone to rack and ruin with food rotting etc. I’d look at their physical health
– whether they were feeding themselves or sleeping well. And I’d also try to get
a picture from a neighbour or warden or someone living with them.’

If a carer was involved, then the worker might also record any services they
were receiving, the reasons for the referral and what they thought the old person’s
needs were.

Social workers, in particular, seemed to find it difficult to find the time to
write up their cases as well as they would have liked, especially when it came to
recording every contact they might have had with a client. A social worker from
the south had this to say: ‘We are supposed to write up every contact – but there’s
only enough time to write up what seems very important. This goes in the client’s
files. The only standard forms are home help forms.’

Assessing financial circumstances
When it came to collecting information concerning people’s financial
circumstances, around a quarter of the social workers from all the authorities felt
that this was a delicate area and one into which they should not intrude unless
there was a specific reason. A social worker from the southern authority said: ‘It
depends on what you are trying to achieve. If you are trying to make sure they
are getting their benefits, then OK. But I wouldn’t go further than that unless you
are talking about residential care. Only if you felt they were having difficulty
budgeting would you go into their accounts.’

There were a range of circumstances when workers felt it was legitimate to
make enquiries about finances including such matters as: financial difficulties;
making sure the old person was claiming benefits they were entitled to; admission
to both local authority and independent sector residential care; housing benefits
and short-stay/ holiday admissions.

The emphasis placed on collecting financial information varied between
authorities with those in the London borough far more likely to see it as a routine
part of their work. Some domiciliary care organisers from the northern authority
thought they had no reason to collect financial information, as this respondent
explained: ‘Unless it’s a request for short-stay, finances shouldn’t come into it.
It’s a question of need in this area. Those with money have private help anyway.’
However, others did comment on the need to assess finances when concerned
with an admission to residential care, when property needed adapting or when
applying for an assisted telephone.

Obviously attitudes towards asking about financial resources are particularly
important if workers in the future are to help elderly people and their carers make
decision about services provided from a range of sources. There is a need for
further discussion about the boundaries of responsibility and privacy where
financial disclosure is concerned.

When enquiries were made about financial resources, workers routinely
asked about the elderly person’s main sources and size of income, as well as any
benefits they received and their housing status, for example whether they were
owner-occupiers or paying mortgages or rent. There was a feeling amongst over
a third of the social workers interviewed, particularly those from the London borough and the southern authority, that they should raise people’s awareness concerning benefits.

There was no doubt that most social workers and team managers saw it as an important part of their role to give older people advice and information about benefits. But this view was not shared by all the domiciliary care organisers. When it came to doing something about a person’s finances, domiciliary care organisers were more likely to refer a client to a welfare rights worker or the CAB. On the whole they did not see it as part of their basic role. One commented: ‘Basically we should give advice but I don’t. We are so busy I feel that it’s not my job to do so. I just give a telephone number or a leaflet and don’t get personally involved.’ Whereas a colleague referred people on to other workers: ‘I make them aware they are entitled, but I don’t give them detailed information. I refer them to the welfare rights officer.’

However, another domiciliary care organiser pointed out that the role of the welfare rights worker was limited and it was important that they give some information: ‘We are instructed to do that (give information). They employ a welfare rights officer one day a week but he can’t visit anyone as he has no transport. So any problems we can’t answer go to him. We point people in the right direction for income support, attendance allowance, mobility allowance. I try and provide the forms and often fill them in.’

Social workers were more likely than domiciliary care organisers to be involved in giving information, explaining procedures and making arrangements, especially obtaining and completing forms. A social worker from the London borough felt that an elderly person stood a greater chance of getting certain benefits if social workers were involved: ‘I claim them. I take in the forms and assess whether they can fill them in. With attendance allowance it bears more weight if the Welfare Officer sums up – we give a better summing up.’

Others felt that, if there were relatives involved with the elderly person, then they should be the first to offer assistance. One said: ‘It depends on the ability of the client. If there are relatives or neighbours, then the first suggestion is that they pursue it on their own with their help. If they have no-one and they are not able to write easily, I assist and support applications on their behalf.’

Of course the elderly person has to want to apply for assistance in the first place and, as this social worker from the south commented, this was not always the case: ‘I try to give advice but a lot of people still see it as charity and don’t want to know. Others are put off by all the hassle and the ordeal of form filling. I can assist them. I help by filling in forms and then just get them to sign. But it’s not really a social work task. It’s very time consuming and a bit "nosey parkerish".’

Comments from team managers showed that the area of welfare rights and benefits was seen as a more central part of the social work role by those in the London borough than in the other authorities. One of the team managers here emphasised the importance of keeping up to date with changes in the benefits system and said: ‘This is a very important area. We have very good links with
the special case officer at the DSS local office. He comes to see us every six months to keep us informed and has a very good relationship with the social workers.’

**Putting together a package of care**

Gathering information about the needs and circumstances of the elderly person and his or her carer is only one aspect of assessment. The worker should then move on in partnership with the client and, if appropriate, their carer, to arrive at the best available solution to their needs. Most workers have a more or less comprehensive knowledge of what may be available in terms of services and support in their locality. How do they impart this information and help the client and their carer weigh up alternatives and make decisions?

A team manager from the London borough was concerned about the importance of sharing information with elderly people and their carers:

One thing I’ve worked hard on with this team – that’s that social workers and other staff should know practically everything that’s available, for example residential care, the difference between local authority and private day care, specialist day care, DSS benefits, OT, home carers. They’re sitting in the same room as the OTs and home care organisers and know what’s available and the pressures on them. Also we’ve tried to build up relationships with voluntary bodies – big and small. The first thing is the knowledge of what is available. Keeping knowledge to yourself is power and people used to keep it to themselves. But I’ve encouraged them to share – everything is in a resources file and it is open to anyone. You can’t talk about packages of care unless you know what’s available. That’s the starting point. We also hold the belief in our team that the elderly people are _people_ who also happen to be elderly. They have a right to be involved. I know carers say that it’s only when something happens – for example incontinence – that a service is thought of, but we think they have a right to know about services. But you do have to be realistic about things. It’s a compromise between what they want and what is possible.

Much has been written about the coordinating role of key-workers in the community in putting together a ‘package of care’ which combines informal and formal support. But how is this done? And by whom? Is it a process which actively involves the old person and their carers in decision making? Are such decisions constrained by availability and accessibility of services? In this study we sought to understand something of the process of putting together and maintaining a package of care. We acknowledge that ‘package’ is too grand a term for many of the arrangements entered into. However it does imply that there are more than one or two people, or services, who need to coordinate their involvement with the older person in order to be of real assistance.

The majority of social workers and domiciliary care organisers reported that they began from their discussions with the elderly people outlining their present circumstances and resources (such as informal support or financial resources)
and identifying their needs. It was part and parcel of the assessment process. In some cases, the services offered were directly related to the reasons for referral, but in other cases a range of needs would emerge through discussion. A social worker from the southern authority said: ‘From the initial assessment, people ask for one thing but they often need something else. You have to look beneath the presenting problem.’

Discussion was the key to identifying which services to provide and this was done either by telling people about the range of services available or by the worker suggesting those which he or she felt would be most appropriate to the individual’s particular situation. There was some indication from the analysis that qualified social workers were more likely to participate in lengthy discussions with elderly people and their carers than those without training.

Some social workers felt that the term ‘package’ really only applied to cases which involved the coordination of a range of services to keep very frail elderly people living in the community – services needed on a daily basis:

I think we specifically put together packages when people are very frail or come out of hospital or on a bereavement. I write a list, write each day of the week down and discuss it with a client and the family. So for example, Monday – day in a private home; Tuesday – luncheon clubs; Wednesday – meals on wheels and home help; Thursday – luncheon clubs; Friday – home help does meals, collects pension and cooks a meal for Saturday; Saturday – on their own, and Sunday, the family cope. We plan things – then we use the laundry service and work in with the bath nurse and the district nurse calling. I use anything available really. This is where someone is frail, not all are like that – not all frail. Most would not want all this because it means that their independence is gone. One person I did this for recently was a person waiting for a hip operation, who has been waiting for years. I did say ‘try a private hospital’ which is against my principles, but they didn’t have the money.

In many ways this definition of a package fits the description of ‘intensive’ packages of care described by other respondents which are discussed below.

Another social worker saw it as an on-going process of discussion and review: ‘As part of assessment you are trying to see how you can help. You extract information from people as to what they want. You weigh up what they are saying and what their needs are against what is available. You may feel that they need day care because they are lonely and need contact. So it’s all through listening, discussing and talking to people. In the end, I say let’s try this and if it doesn’t work we’ll look at it again and review the situation. In doing this I do run through a checklist of things, but it’s a mutual process.’

When it comes to offering services, some workers felt that it was important to give the person as wide a choice as possible, but most felt that expectations should not be raised and that inevitably they had to be realistic about what was possible, as this domiciliary care organiser pointed out: ‘If I think it will help and we can provide it then I’ll tell people about services they haven’t mentioned. It
confuses people and upsets them if you tell them about things you can’t provide, and you feel inadequate.’

And this social worker from London was quite blunt about offering what she saw as scarce services: ‘I personally know what I’ve got to offer and don’t see much point in offering them things I can’t deliver – for example, day care. I know whether I can prioritise them. I said to one lady “How do you feel about it”? and she said, “I’m not a social person”. Then we talked about it and she said, “I’ll go for one day”. And I said, “No, you won’t, because there’s an awful lot of paperwork. There’s a waiting list of people who want to go”.

Most had a more diplomatic and sensitive approach. A social worker from the north talked of compromise: ‘I’ll say, “What do you need?” and they’ll say, “What have you got?” I’ll say, “We’ve got this,” and I try to be quite inventive.’ This view was echoed by a domiciliary care organiser: ‘I try to build up a picture of what the client needs, and also find out what the client wants. Then I try and balance the two with what we can offer. Say, we have this, but it’s not available at the moment. In some cases they don’t want it now, but I tell them and they’ll come back in three to six months. So we’re informing people of what may be available.’

While some workers saw things quite narrowly, in terms only of what statutory services they could offer, others considered a wider range of service providers. A social worker from the south involved informal carers in the plan: ‘You get a feeling when you are talking to people about what they want from what they say – home help and meals on wheels to provide back up and then day care to help if they are lonely. I talk to neighbours and see what they are prepared to do – maybe provide a meal at weekends. I don’t know how you make these judgements. You just do – experience I suppose.’

Another social worker from the southern authority stressed the unique nature of each individual case and how social services had to work with other agencies: ‘It varies. Some people haven’t got a clue about what is available, so you can tell them – if you have it. Other people you can supplement what they are already getting. For intensive packages, where a lot of support is needed, we work with nurses. They do some care, we do some. Although we have similar services, everyone is different and so each person has a unique mix of services. Also sometimes the help we provide is not suitable.’

For many of those interviewed, putting together a ‘package of care’ involved giving information and discussing options. For some this discussion was fairly open with the elderly person making the decisions, while for others it became a negotiation of what was possible. This social worker felt that old people were entitled to remain at risk and not accept services if that was their wish: ‘It depends on the client. You talk to some who know precisely what they want. They don’t want anything else and that’s it. You are usually asking the person to unload. I suggest various things. You offer the main services when they are at risk. They may be at risk and not want the services. They are quite entitled to that, but you have pointed out they are at risk. You tell them what’s available and then try and
work out what they might take up. It might only be someone to cut the grass or to make sure they are OK and keep an eye on them.’

Only a small number of respondents commented that these discussions and negotiations were more likely to take place with carers rather than the elderly person. The main focus was a discussion with the elderly person, involving them in making decisions.

Of course for a package of support to work effectively, someone has to take on the responsibility for liaising with service providers, making arrangements and then monitoring the situation, making reassessments and arranging for changes to be made when necessary. Figure 11.1 outlines an ideal cycle of assessment and appraisal which respondents identified through their comments.

A social worker from the London borough felt that short-term intervention had no place in long-term care, and explained the process in this way:

We’d talk and explore what’s wrong and how they see their problem. I might go away and come back. Through my mind would go certain things and I’d suggest various options. They may reject them. Then it’s no good putting the package together and running away. People are not actually ready to receive a parcel full of facts of what is available. They may be resistant to it and may only be more amenable when they realise you’re not forcing them to have it. It may take time. That’s my view. It’s not
the view of my team. They say, ‘take it or leave it – pull out and close the case’. I find it pays to wait. I had a case of abuse. The mother was slightly demented and awake at night. The daughter wanted to go to work but the demented client turned down day care. Six months later the daughter said that she had tried to strangle her mother when we withdrew our support. I hung around and then acted swiftly and the mother is now in residential care.

**Keyworkers**

When asked whether they saw it as their job to put together packages of care, ten of the eleven domiciliary care organisers, but only seventeen of the forty social workers, gave an unqualified ‘yes’. Social workers were most positive about this role in the southern area, where the majority were qualified, full-time workers. Team managers in the southern authority saw it as predominantly the social worker’s role, whereas those in the northern authority felt that in most cases the domiciliary care organiser was responsible. However, in the London borough, service coordination could be undertaken by a range of staff. A team manager commented that a key worker could be a social worker, domiciliary care organiser or an occupational therapist: ‘We have a team with only one qualified social worker at present and this makes a difference in the way you perceive your role. We identify a key worker with the client – if it’s one with a lot more social work input then they are the key worker. We do have rows over this sometimes but I tell them to talk it through. Key workers are domiciliary care organisers, social workers or OTs, not the next tier down. But there are times when a domiciliary care organiser is the key worker and they need another professional to provide counselling.’

These responses say something about how these different workers perceived their roles. The domiciliary care organisers had a more defined area of responsibility and began from the organisation of the home care service. The social workers without direct control over services sometimes appeared unsure as to whether they were responsible for the coordination of services.

A social worker from London felt strongly that she would only carry out this role with the client’s agreement: ‘I’ll only do it if they agree to it. I suggest we look at it, try a home help or day care. But it’s their decision. I inform them but it’s up to them to take things up. I encourage them, but it’s up to them to use the services.’ However another was more enthusiastic: ‘Yes, it is usually my job. No one else would do it. If other professionals are involved there may be less to do but the coordinating role is very much the social worker’s.’

Others felt that relatives should be encouraged to take on the job first before a professional was brought in. A team manager from the London borough said: ‘If the social worker is the key worker for that person then it’s their job (to put the package together and see that it’s delivered). However, some clients’ carers want the information and they want to do it. We’d always encourage the relatives to do it first. If they don’t want anything to do with it then you do it yourself.’
The constraints of a lack of time and resources were voiced by some respondents and there was a view that they were not in real control of the client’s case but could only push it with other service providers. A social worker from the London borough said that although it was her role she had no real power: ‘You’re always beholden to somebody else to ask. There’s very little we’re in control of. We hold the reins of nothing. That’s the frustrating bit. You have to pass on to others, yet someone must monitor the situation.’ The coordinating role, therefore, is one which some feel they do not have the authority to undertake alone and that it can only be carried out through liaison with other professionals, implying a shared responsibility.

A social worker from the northern authority felt strongly that the system operating in his authority did not allow social workers to take on this responsibility and that older people lost out as a consequence: ‘I would see that as part of the social worker’s job. I don’t know of any social workers doing that here. I’m amazed that it’s been allowed to go on so long. When I came here I was really surprised that there were no social workers to deal with elderly people and the handicapped. The DCOs – I’m sure a lot of their time is spent dealing with home helps and organising them. How they have time to put in any social work time I have no idea. I think the elderly are being given a second class service.’

Monitoring and reappraisal

As Figure 11.1. shows, it is not enough to establish a package of support, it also needs to be maintained. A social worker from the London borough commented: ‘It is wrong to offer help and build up hopes and then not chase it up, so that say, they get a place at a day centre but no transport. I chase things up until all is in hand. Otherwise you raise their hopes and expectations unfairly.’

The maintenance of on-going support therefore involves reappraising and reviewing the situation over time. At least two-thirds of the social workers interviewed from each authority said that this was common practice, whereas nine of the 11 domiciliary care organisers said that they did not review cases.

In the main this lack of reappraisal by domiciliary care organisers was due to their very large caseloads and to the fact that they relied upon their home helps to report changes in the circumstances of elderly people and their families. However, this system was often far from satisfactory, as the following comments by domiciliary care organisers show. One said: ‘It is set down that we should visit each client with a home help once a year. But there’s no time, so we rely on home helps to keep us informed. Some people are never seen. And another agreed: ‘I should do but it’s time. I should visit every six months whether they need it or not. I only pick up those who I think need to be reassessed, those without friends or neighbours. I’d never get around them all.’

Reviewing cases was also given a low priority by team managers in the northern authority. One said: ‘The policy says they should, the practice is that they can’t. I have very good staff who work regularly long hours. They focus on
new referrals and where there are changes in circumstances and that monopolises their time.’

Comments from the 28 social workers, seven team managers and two domiciliary care organisers who said that cases were reviewed showed that the most common time periods for review were at six-monthly and three-monthly intervals. However some workers commented that reviews were on going – carried out at every visit: ‘You see how they are. They change, they don’t want to go out any more – to the dining centre or the day centre. You don’t force them. When they’re assessed and the services are running smoothly then you don’t review unless the circumstances change. You just see how they are.’

Care workers may acquire cases at any stage within the process of establishing and maintaining a package of care. Consequently it becomes important to reassess cases that are ‘inherited’ from other workers. Once again it was the social workers in this study who were most likely to reassess cases, especially those from the London borough, where 14 out of 15 said that this was their practice. Many saw it as a part of their normal routine practice that enabled the new worker to introduce themselves and reappraise the situation. Where cases had been officially closed and then re-opened it was sometimes possible to reallocate to the same social worker, but where this was not possible reassessment was seen to be vital.

The domiciliary care organisers interviewed were split over this issue. Six said that they would reassess cases they ‘inherited’ from others, while five said they would not. As with the social workers those that did also felt that they should reappraise the situation and see whether people’s circumstances had changed.

Comments from those social workers and domiciliary care organisers who did not reassess centred on the lack of time necessary to do this properly. Consequently there was a tendency only to carry out reassessment if an old person’s physical or mental health had deteriorated. Once again the domiciliary care organisers were likely to rely on reports from their home helps. Given that the domiciliary care organisers in this northern authority had so much responsibility for the welfare of elderly people within their community, the need for regular feedback between domiciliary care organisers and home helps or home carers was obviously crucial.

**Participation by elderly people**

The process of putting together a package of support for an old person involves much discussion and negotiation. While the elderly person is at the centre of these discussions, other people will influence the outcome, particularly carers, if they are intimately involved, and professionals such as GPs who may have initiated the contact with the social services department. With opinions as to what might be the best solution coming from a number of channels, how does the social worker or domiciliary care organiser ensure that the old person participates in the decisions about which services to have or not to have? Most workers said
they tried to enable the old person to give their opinions while at the same time
telling them about available services.

Team managers, in particular, commented on the importance of making the
elderly person make the decision and making sure that they did not feel under
pressure from family and others to agree to something they did not want. One
team manager from the south stressed that nothing could be done without the
agreement of the elderly person: ‘My social workers will try and see the elderly
person on their own or will make sure that they are involved when others are
present. I think we always keep this constantly at the forefront of our minds. We
are good at explaining that we can’t do something without an elderly person’s
consent. You need to accept the elderly person’s view when a GP says they want
to go into a home and they don’t.’

A domiciliary care organiser made a similar point about family members: ‘I
always talk it through. Quite often relatives make the decisions. But I try and talk
to the elderly people themselves and see how they feel.’

A social worker from the south felt that even if she felt she knew what was
best, she had to let the elderly person make the decision: ‘They make the decision
– that’s it, they really do. There are times when you feel they should have more
of some service. But you cannot do things for people who don’t want them. They
have to be quite confused before you intervene and "enforce" things.’

However a colleague felt that some elderly people were too mentally infirm
to make such decisions: ‘I can split my clients into two types: the very confused
elderly where the carers makes the decisions and those who aren’t confused with
whom I can discuss it fully.’

Other workers felt that decisions were made very much on the basis of what
was available, as this social worker from the London borough commented: ‘There
isn’t a lot of choice. They either have it or they don’t. They can’t have four things
to choose from. They may need all four, but they are not alternatives – they are
in different categories. You say "do you want this or don’t you?" and then move
on to the next service.’

And another social worker from the south felt that there were always other
pressures on decision-making:

You can’t ensure that the elderly person participates. It would be nice to
go in with an open mind and try to portray what is available
even-handedly, and then let the client pick what he wants. But there is
usually some pressure from somewhere to do something which is bound
to cloud your judgement. You are influenced by things – what the
relatives say and want. The relatives play a large part. They have given
up a lot of time and have been driven to contacting the state or else they’ll
go up the wall. There are usually two or three problems – not one – so
there’s an incentive to come up with something from what’s available.
But the choices available are not all that great. We try and defuse
situations by offering packages.

Only in the northern authority did a team manager mention the use of a
written contract with the client over services – but this seemed problematic: ‘We
have a "contract" form which tends to be used by the DCOs. Theoretically it should be used by social workers. It gives the client a chance to state what their definition of the problem is. DCOs tend to use it where there is disagreement rather than where there is agreement. They fish out the form. It’s not automatically used for everyone. It should be used, but tends not to be. The reason social workers don’t use it is because it constantly needs changing. Really it’s a tool for planning reviews and conferences with young people.’

**How and when services are available**

There is a sense that in most cases a dialogue is taking place within the boundaries of what is possible rather than what is ideal, and this was reflected in comments made concerning whether or not elderly people made decisions about how and when services were delivered. More than half of the domiciliary care organisers interviewed felt that there was some choice available in regard to certain services, but in the main a compromise was reached.

One domiciliary care organiser said: ‘With the day centre they can request a certain day, but with home help they can only have it more or less when we’ve got a time. They can let us know when they’d like as there’s no point in putting it in when they are at the day centre. It’s a compromise really.’ While another admitted: ‘I try to get them to work round us rather than us round them. If they can’t get up very early then I ensure they get the second duty. If they want early tea, then first duty. If someone says they don’t want that day I have to say sorry they have to.’

The compromises made between the wishes of the individual and the availability of the services was common to comments from all workers. One team manager from the south mentioned the problems of delivering services through a third party – in this case volunteer-run transport: ‘You’re limited to when meals on wheels can deliver and when day care has vacancies. Also transport is done through the Volunteer Services Organiser – we’ve got some very good volunteer drivers, but we have to be careful about when drivers are available.’

Another team manager commented on how services were rationed and prioritised: ‘It’s not like Sainsbury’s where if you want a sausage roll everybody could go and buy one tomorrow. If all 700 people wanted day care tomorrow I couldn’t deliver. We prioritise all the time for the various services. If we can’t provide a service I see it as the responsibility of my social workers to try to deliver the services through other options.’

Six social workers felt that there was no choice over how and when services were delivered, and that clients did not participate, (four from the London borough, one from the north, one from the south). Some went on to add that it was the responsibility of the service provider rather than the social worker to negotiate with the old person directly how and when the service was received.

Attitudes towards ageing were also important. This social worker from the northern authority seemed to view elderly people as people with endless time on their hands, which meant that they could fit in more easily: ‘I have very little command over services. I could perhaps arrange the days for day care or home
help. But most elderly people can fit in to the time. There have been no complaints over time. The kind of day they have is very unstructured. They’re not going anywhere or waiting for anyone – so it doesn’t matter if the bus comes at 9 a.m. or 9.30 a.m.’ Here notions of choice and control seemed irrelevant.

**Obstacles to participation**

Of course, while it may not be possible to take account of the views of those users who do express an opinion or preference, it may also prove difficult to obtain the views of all potential service users. There was general agreement that not every elderly person participated to the same extent. Both team managers and social workers from all three authorities felt that older people who were mentally frail had most difficulty in making their wishes known. A social worker from the southern authority explained that sometimes the worker had to make the decisions: ‘If the elderly person is very confused then they may not participate in the decisions. You have to be firm and say you are going to give your carer a break. People are not pressurised but persuaded for the sake of the carers. I’ve never taken anyone anywhere screaming.’

The domiciliary care organisers and social workers also commented on the diverse characteristics of individual elderly people and their circumstances which could also hinder participation. A domiciliary care organiser said: ‘Some say yes to everything; some say no. They are all individuals. Some people just naturally participate more than others, while some just don’t want to know.’

Seven respondents – four social workers and three team managers – felt that some elderly people were pressurised by their family into making decisions or that a carer took over and made the decision for them. A social worker from the south stressed that the old person’s strength of personality had a lot to do with participation: ‘It depends on how determined they are. If their daughter or niece is saying they’ve got to have it, it depends on their personality. Some are pushed by relatives. Some will say I’ll have what you want. I say you have to decide.’

**The involvement of informal carers**

While many elderly people in contact with social services departments do not have a carer to help to support them at home on a routine basis, many do, and even those with no-one nearby are usually able to identify someone whom they could contact, if only in an emergency. In this study we elicited the views of informal carers about their involvement in decisions concerning service provision for their elderly relatives or friends, and both social workers and domiciliary care organisers were asked a range of questions concerning participation by carers.

But first, how do professional care workers identify informal carers? In the majority of cases, identification was obvious. They were either identified by the old person or the carer was responsible for the initial referral to the social services department. In some cases carers identified themselves or were identified by other professionals at a later stage. Carers who gave a lot of support were easily
identified. Those who might have been overlooked were those whose role was more peripheral: for example a neighbour with a key to the house who looked in once a week, or a son or daughter who lived at a distance but helped with financial support.

We have already seen that some carers can exert a great deal of influence. How did carers interact with professionals? We asked social workers and domiciliary care organisers if they always talked with carers before taking any action over services for the elderly person. Views were split: 17 of the 40 social workers (five from the London borough; 10 from the south and two from the north) said that they always spoke to carers, whereas this was true of only three of the 11 domiciliary care organisers.

Various reasons were given for involving carers. This social worker from the London borough felt that it helped give a better picture of the situation, including an understanding of the needs of carers, and that the involvement of carers was to be valued: ‘They (carers) are precious, in the sense that if they were not there there would be far more problems for the elderly person and us. We would involve them in meetings about care plans.’

Another social worker from the south felt that carers should be consulted particularly when the old person suffered from mental health problems: ‘I like to see the whole picture of what’s going on. If you get someone who is mentally confused, then it’s crucial. If someone can talk for themselves, then it’s not so crucial. It’s about getting to know people. You can get your job done easier. There’s a mentally confused couple I’m working with at present where I only met the carer by chance. They could not tell me who she was.’

The 30 respondents (22 social workers and eight domiciliary care organisers) who did not always make a point of talking to carers commented that it was their job to talk to the client, that it would depend on the carer’s level of involvement with the elderly person, and that they did so only if the elderly person wished them to be involved. If the elderly person was mentally able, this group of care workers felt that it was the elderly person who should be doing the decision-making, as this comment from a social worker from the north shows: ‘I look at it two ways. Carers can be an encumbrance. The old person doesn’t say a word and has a whole pile of services dumped on them that they don’t want. I generally prefer to visit the old person alone but will often make the carers aware of what’s going on’.

However, even if these workers did not routinely consult informal carers, there were particular circumstances when most of them did so, particularly if the carers lived with the elderly person, or if the elderly person suffered from mental infirmity, or if the care plan depended on the carers’ involvement. But these were mainly cases involving intensive packages of care to support an often delicate situation, as this social worker from the south explained: ‘In the more intensive cases you talk to everyone so you can see if you can fit services in around them. Also if they are confused you try to talk to more people.’

The importance attached to the autonomy of the old person was seen again when these same respondents were asked under what circumstances they would
not talk to informal carers. A number of respondents (ten social workers and one domiciliary care organiser) said that they would not talk with carers if the old person did not want them involved. A social worker from London stressed confidentiality: ‘If the client had requested that they not be involved then I respect their wishes. The client is the client. If they don’t want me to talk to relatives, I wouldn’t. I wouldn’t divulge anything even if I met them by accident.’

Informal carers who either lived at a distance or were not intimately involved with the elderly person were not likely to be consulted. And for some this was also true of neighbours as this social worker from the south pointed out: ‘Where a neighbour is just coming in, then I won’t involve them unless it’s OK with the client. Some neighbours can be closer than children, but others are not.’

So while some workers would always involve informal carers in their decisions, others felt strongly that if the elderly person was mentally able then they should make the decisions about their future. In such cases carers would only be consulted if they were involved in the elderly person’s care on a regular basis.

The diverse responses to these questions reflect a dilemma which many professional care workers have to face; of ‘Who is the client?’. The important contribution made by informal carers to the care of elderly people is well-documented (for example see Equal Opportunities Commission, 1980, 1982; Finch & Groves, 1983; Charlesworth et al, 1984; Qureshi & Walker, 1989; Arber et al, 1989) and, as we have noted in this study, they are usually easily identified, often having been involved in the initial referral. But, given the desire on the part of many workers to maintain the autonomy of the client within the decision-making process, how is the balance maintained between the needs of the client and the carer?

Who is the client?

We asked all respondents for their views on whether or not carers become more the clients than the elderly people themselves. Whereas eight of the 11 domiciliary care organisers felt that the client should be the old person, this was true of only five of the 11 team managers (three of whom were also from the northern authority) and only nine of the 40 social workers. The domiciliary care organisers held this view very strongly and again this relates to their role as direct service providers. Home help or home care was seen to be of greatest benefit to the old person, whereas the sitting service, run by some of the domiciliary care organisers, was of direct benefit to carers.

However, while the domiciliary care organisers saw their service as geared to the needs of the elderly person who was their client, they recognised the secondary benefits for carers. One said: ‘We see the client as the client but we can never see them in isolation, and we always try and take the carers’ circumstances into account.’

The social workers in all authorities held more divergent views; over a quarter felt that both carer and elderly person became clients in cases where the
carer needed a lot of support and where the elderly person was suffering from mental infirmity. As this social worker explained, this was especially true where the carer was an elderly spouse: ‘I’ve got a classic case, an elderly couple. He’s very confused and driving his wife around the bend. He’s very independent and won’t have any services. She wanted advice and support and a break from her husband. But it didn’t work. I had to get them both into day care in order to get him out. They both became clients. She’s more the client really, as he’s only happy when his wife’s around.’

And younger carers could also become clients particularly where care-giving was disrupting family life. A social worker from the south gave this example: ‘I have a case in point at the very moment. I am counselling a daughter. The husband has a drink problem and she’s looking after her mother. She had a fall and injured both legs trying to get a suitcase out for her mother’s hospital stay. I’ve now planned regular respite short stay for the mother, and I want her to come two days a week for day care. I think she’ll come.’

Some felt that the only way to tackle this difficult aspect of putting together a package of support and services was by treating each case separately with the aim of achieving a balanced approach. A social worker from the south explained: ‘They are often both clients, but each case is different. I had a 90 year-old confused lady. The carer was 40 years old and had a family. There I made a conscious decision that the carer needed my help. You could see that she would end up with psychiatric problems. You judge each case individually. Here the elderly person gets the physical care and the carer gets the counselling and support to carry on. That might be the thing that tips the balance between coping and not coping.’

There was a recognition that in some cases they had to support carers, as without them there could be a breakdown in support leading to a crisis. All respondents had a view on how best to achieve this balancing act. A team manager commented on the level of involvement of different types of carer: ‘We have to meet both sets of needs for it to work. We can fail if we just meet the carer’s needs but we can’t ignore the carer because, if they stop caring, the old person may need long-term care. We do have difficulties with informal carers who are not intensive carers – for example a daughter visiting twice a week says mother needs more and puts pressure on the elderly person. We tend to ignore them. Sometimes if people live around the corner the social pressures are very intense. Long distance carers can be more measured.’

Another team manager from the south felt that the task was to support the carer in the community and then help them through the transition to residential care. She said: ‘The carer is as much the consumer as the client. If you can’t give them enough relief they won’t go on. And sometimes they need relief to let go of the caring and that needs the help of an outsider. This is particularly true where the old person is confused. You see that with Part III. There’s a right time for them to come in. They have to be able to retain enough to make that adjustment. If the carer struggles on the old person may get beyond that point. It’s important to get that right.’
A recognition of the value of informal support was clear from all comments and the importance in relation to provision of statutory services was summed up by this team manager from the north: ‘Without the carers you’re talking about an increase in resources. We couldn’t possibly cope without the carers. We’d have massive difficulties in providing care if the carers’ services were withdrawn.’

**Intensive packages of care**

The complex needs of some elderly people and their carers may mean that they require ‘intensive’ packages of care. But what exactly does this mean? In this study the vast majority of the workers interviewed defined ‘intensive’ as the provision of a number of services within the home seven days a week. Three-quarters of the social workers, nine of the eleven team managers and ten of the eleven domiciliary care organisers defined ‘intensive’ in this way.

A social worker from the London borough explained: ‘I think a client who is bed or wheelchair bound and in need of home care two, three or four days a week needs intensive support. One who needs washing, getting up, toileting and has to have meals on wheels every day. Someone who is continually needing different services – the OT for aids, the district nurse to give injections and change dressings, plus the need for social work support.’

Others, such as this domiciliary care organiser from the north, extended the definition to include clients who regularly attended day care and received domiciliary services, and those where respite care was routinely provided for a carer: ‘We classify intensive care as those who receive care every day through home help and meals on wheels. Some go to a day centre every day or four days and we provide a home help on the other days. Also those people who get a service every day plus respite care every six weeks for a fortnight.’

Another domiciliary care organiser gave her definition in terms of those clients supported by a rapid response home care team operating in her area: ‘People who need seven days a week support get the rapid response team which includes the home help, sitter and the DCO. The team works on its own initiative and goes in as often as the client requires it.’

The circumstances of the case determined the definition of intensive for this social worker: ‘Maybe following a crisis situation we get an intensive case. Say someone was determined to return home from hospital, then we would have to develop an intensive package of care. There would be home care daily for the first week or fortnight plus an OT assessment, nursing services and support from family and friends.’ In these kinds of cases the intense intervention was seen to be short lived, but this was not always the case.

A social worker from the south talked of how informal and formal care were brought together on a regular basis: ‘I would say an intensive package was where someone needs attention seven days a week, two or three times a day. This is mainly through the home help (though not always the same person) plus nurses going in or neighbours. We work some around the family. For example if a son
does shift work, then we make sure that mother is covered when he is not there. Day care has to be brought in then.’

A team manager from the London borough made a further distinction between practical and emotional support. He explained: ‘I think one definition would be a whole range of services for seven days – OT, home care and social work. But other cases involve care management problems and the intensity will be a lot of social work intervention – work with the family; guardianship orders; preparation for residential care. So there are different ways of defining it. We have people with severe senile dementia who are very fit and those who are severely physically disabled but fine mentally. They present different problems.’

The social workers involved in this study had relatively few intensive cases currently included on their caseloads. In the London borough and the southern authority two-thirds of those interviewed reported that intensive cases formed less than a quarter of their caseload. In the northern authority, where social workers were generic, four of the five interviewed reported no cases of this kind.

The average number of clients with ‘intensive packages’ for social workers was three cases, with those in the south being slightly above average, primarily due to two workers reporting more than ten intensive cases. Of course to some degree the reporting of more than ten cases was due to the different definitions used by workers in assessing their own caseload. However, in spite of this inbuilt variation, the demands made by such cases has to be set against the demands of the individual workers’ remaining caseload, and, as we have seen, differences existed between and within the authorities. For example, in the London borough, one trained full-time social worker reported that ten of her 25 cases were ‘intensive’, whereas a part time welfare assistant in the same team defined two of her 16 clients in this way. The heavy load of the full-time worker was confirmed by the team manager who reported that this social worker specialised in such cases. There was some evidence to suggest that qualified social workers managed more of these cases than unqualified welfare officers or social work assistants.

While the domiciliary care organisers were not able to report actual numbers of intensive cases, they were able to give rough proportions. Six of the 11 domiciliary care organisers reported that less than 5 per cent or between one and ten of their cases were intensive, while two felt that they had no such cases.

But even if the number of such complex cases appears relatively small, can they be supported indefinitely in this way? Approximately half of the social workers, domiciliary care organisers and team managers said they could support people indefinitely and the other half were less certain.

The spread of responses was fairly consistent across the various authorities and, in many cases, those saying ‘yes, indefinitely’, qualified their view by making the comment that indefinitely was usually defined by a crisis or change in circumstances. One such respondent, a social worker from the south said: ‘You can support an old person with an intensive package indefinitely but in practice something changes. You can keep things like that going if you’ve got resources and energy. You use short-term care and day care, but very often they decide to
move into a home or their health breaks down. In practice not too many people keep going for too long’.

Another social worker felt that the old person’s mental health was the key to maintaining the situation: ‘As long as they are mentally able. If you get a person who is physically disabled then they can cope as long as they are mentally able. I think I use mental ability as a criteria of whether we can cope indefinitely.’

Those who did not feel that support could be maintained often thought that most intensive packages of care were destined to break down due to the old person’s increasing frailty. One social worker from the south put it this way: ‘Normally that intensive care package comes just before a person moves to a home or hospital. So in practice it’s not long.’

A social worker from the London borough felt that they were only just holding the situation together: ‘We’re only papering over the cracks. Only two and a half hours of home care a day is not enough – we have to because there’s nothing else. But you wait for a crisis.’

Some respondents felt that six months was the maximum period of time during which intensive support could be provided. As this social worker explained, any longer would put a severe strain on resources: ‘Things would be tricky if it went on for more than six months. We’d be looking at doing something else. It could be done but if I went to the Home Care Organiser and said, “I want home care for six months,” she’d have a heart attack.’

Team managers in particular commented on the availability of resources and the pressures to provide services for other people. A team manager from the north said: ‘We just don’t have the resources to do this. We’re hard pressed to do it all. In terms of money it is cheaper in residential care. Intensive community care is not a cheap option and with a limited budget we are spreading resources thinner and thinner which makes it less and less viable.’ And the domiciliary care organisers were obviously conscious that they could only provide intensive support to a small number of people without jeopardising the whole service.

A social worker from the southern authority felt that intensive support was only viable if the old person contributed financially to the cost of care: ‘It all depends on the economics. If the old person didn’t have private means I would have doubts that we could maintain our support. There’s too much money leaving this department. A lot of elderly people today have some money in terms of property which they could tap in to.’

In the future the maintenance of intensive support for very frail elderly people who wish to remain at home may depend far more on their ability to pay for private services in the home. The coordination of these intensive packages of care will become the responsibility of care managers who may find that the majority of their time is spent dealing with such cases rather than more routine, less intense cases. At the time of this study the number of intensive cases managed by each worker was relatively small, although some social workers were already seen to specialise in this kind of work.
Liaison with other professionals
Most older people either living alone or with their carers come into contact with the social services department because of a number of interrelated social and health needs. Some people will have contacted the authority themselves or through their family, but others will have arrived at the social services department through another route, most commonly through their GP and the primary health care team, their local hospital or the housing department. In other cases, social services staff may decide at a later stage that the involvement of other agencies is essential. But how open are the channels of communication between different groups of professionals and whose job is it to liaise between them?

The overwhelming majority of social workers, team managers and domiciliary care organisers who took part in this study said that it was not always their practice to talk to the old person’s GP before taking any action on what services to offer. Only five of the 62 respondents (two social workers from the south and three team managers) said that it was common practice. One team manager from the London borough felt that GPs should always be part of the care planning process: ‘We have a good system with two or three big practices. We feel that GPs opt out too early and transfer responsibility to the social services department. We think that GPs ought to be part of the wider care plan and our working relationship is getting better.’ In this area a system was being developed to bring social workers and GPs together on a regular basis.

However, of those 55 respondents who said that it was not always their practice to contact the GP, the majority felt that there was often no need for medical involvement. A social worker from London put it this way: ‘It depends on the circumstances. If there is a medical or clinical problem then you would talk to the GP, a psychiatrist or the district nurse. But not for social problems.’ Other factors which impinged on this decision included the origin of the referral, their relationship with GPs and the fact that sometimes the old person did not want the respondents to consult the GP.

Poor relationships between social workers and some GPs were reported in all authorities. A social worker from the south said: ‘We try – no, we don’t always try. If there’s a health problem we try. It depends on the GP really. Some will not be very helpful at all and it’s best not to approach them.’ And a social worker from the London borough commented that sometimes GPs did not know about services and gave misleading information: ‘Our relations with GPs are a bit scanty really. I think it boils down to their training. They give very inaccurate information to elderly people, for example about procedures for getting into sheltered housing.’

Of course GPs were not always available to speak directly to social workers, and another social worker from the south who tried to pass on routine information about elderly clients was not sure whether it reached the GP: ‘I try to talk to the GP. If it’s a normal case I just say, “We’re involved with Mrs P and I’m just letting you know.” I may talk to a secretary. Some will pass it on, some won’t.’

A social worker from the south also tried to liaise with the GP over intensive cases: ‘In those packages of intensive help I would go and discuss it personally,
not over the phone. I’m very bad at writing letters. Also if they were just starting
day care I would ring. Sometimes it’s just courtesy. The response you get tends
to go in practices. If the senior partner is a problem, they tend to attract
like-minded others.’

There were circumstances when most workers would consult a GP. These
mainly related to specific medical problems, including the old person’s mental
health and the need for medical expertise regarding medication. One domiciliary
care organiser would always contact a GP if worried about a person’s health: ‘If
I’m in doubt about a person’s medical or physical condition and I’m not sure
what to do for the best, I’ll contact them. Often we meet at the old person’s house,
sit down and have a chat.’

Some of the domiciliary care organisers in this study were also responsible
for organising aids and adaptation and asked the GPs to carry out assessments.
This comment from one domiciliary care organiser highlights the lack of
occupational therapy involvement and the dangers of untrained staff taking on
too much responsibility: ‘If I get a request for aids to daily living I contact the
GP to see if it will be beneficial. I gave one chap a frame and the GP went mad.
He said,”What are you doing? You shouldn’t be making him bend over.” So it
can do more harm.’

Other workers contacted GPs to arrange assessments for other services or
benefits such as domiciliary chiropody or mobility allowance. Nine of the 36
social workers said they informed the GP if the person was going for short-stay,
as there was a need to arrange medical cover in the residential home.

Respondents were also asked whether there were any circumstances when
they would not talk to a GP. The majority of the domiciliary care organisers (eight
out of 11) said that in most cases they did not consult GPs. However, responses
from all groups reflected the sharp division of responsibility which appeared in
all these authorities between medical and social expertise. Social workers and
domiciliary care organisers did not consult where they felt there was no need,
that is where they felt the issue was purely social, including problems relating to
the family and finances.

Once again the quality of the relationship with the GP was important in
developing lines of communication. A social worker from London said: ‘I
hesitate at involving GPs because they are not always readily approachable.
Many GPs refer people to us and then want no further involvement in the care
plan. They tie up parcels and send them off to the social worker and the
consultant. Their expectations are unrealistic. They dispatch them to us when
they can’t do any more and say,”I want this person in a home”.’

While liaison with GPs was clearly very limited, contact with other workers
proved more productive. Nine of the eleven domiciliary care organisers and 22
of the 40 social workers reported that it was their practice always to talk to other
workers involved with an elderly person before taking any action on what
services to offer. Eight of the eleven team managers also thought it was good
practice.
Those who did liaise felt that it prevented the duplication of services, and allowed people to share information and experiences of working with particular clients and to discuss the type of services that were being offered. In the London borough social workers benefited from sharing large open plan offices with occupational therapists and domiciliary care organisers which made liaison easier, as this social worker commented: ‘I think talking to others is good practice. We all work together and there is a combined file for DCOs, Volunteer Services Liaison Staff and OTs. We share experiences. If one of us is not around then there’s always somebody who knows what’s happening at a particular time.’

And a team manager from the south spoke of the good relations between social workers, district nurses and health visitors: ‘We’re fortunate as we’re next door to the district nurses and health visitors. They are in and out of each others places like yoyos. The social workers tend to deal with the district nurses rather than the GPs as they are not next door to us. It is much more convenient for us to ask the district nurse what they are providing.’

Liaising with other workers could be time-consuming at first but it usually benefited all concerned and prevented unnecessary work in the end. This team manager also from the south felt it might be easier to organise in rural areas: ‘If a district nurse turns up when you’ve arranged day care then that’s not good practice. Liaising with others is the bit of community care which is very hard work and time-consuming. It’s much easier in small areas like villages, where you know the health visitors, district nurses, wardens, as a lot of the people have been around a long time.’

Five social workers (four from the London borough) commented on the value of joint assessments and joint visits, although as this comment from a social worker in London shows, different types of worker sometimes did things in different ways: ‘The DCOs think we talk too much but that’s our stock in trade. We see the elderly people, the DCOs don’t. The home carers do. I need to voice my problems. We have a totally different culture. But we do share things, check things out and talk to each other.’

For those who did not see liaison with other workers as a part of routine work (16 social workers, two domiciliary care organisers and three team managers), the circumstances of individual cases usually dictated the level of involvement.

A few commented on poor communication between different professionals. A team manager from the London borough commented on the lack of understanding concerning the role of community psychiatric nurses: ‘I’m not that clear about the CPN role with elderly people. Although there is a lot of talk about more work with the elderly they have never approached us and said we are doing work with old people. We have to work very hard to get a CPN involved.’

Some social workers felt that they needed to make their own assessment, as this worker from the south commented: ‘It is important that I make my own assessment. You’ve already got a referral which has given an opinion. I like to make my own mind up.’

For this group of respondents, liaising with other workers was a priority when a person was at risk or when there was particular information which needed to
be passed on, as this social worker from the south indicated: ‘If we were talking about someone who is mentally frail then I’d talk to the senior psychiatric social worker in the area who is informally very supportive.’

There was also concern that they should not duplicate the work of other professionals and that they should liaise where complex packages of care were being put together. A social worker from London commented: ‘If I’m going in often I ask, "Am I going to duplicate someone’s work?" There is no point in putting two packages together. You need to ask who should be the key worker in each case.’

We were interested to know whether there was a particular group of professionals to whom most respondents always aimed to talk. This appeared to be a matter which was left completely to the individual social worker. Respondents mentioned talking to the GP, a psychiatrist, the domiciliary care or home care organiser and other social workers on a routine basis – but liaison mainly depended very much on the specific circumstances of the case and who was involved. There was no evidence of guidance being given or of good practice being encouraged. The extent to which social workers saw it as their job to liaise with other professionals or agencies varied, and the extent to which they actually involved others varied even more. There seemed to be an urgent need for guidelines on liaison if coherent packages of care were to be provided and social workers were to be able to take on the role of care managers.

**Implementing community care**

In the last two chapters we have been concerned with how social workers and domiciliary care organisers work with old people and their families within the community. In the light of current discussions concerning the implementation of community care policy it is worth reflecting on their experiences.

In the first place, we have noted that provision of basic services such as home care and home help are still inadequate and that many workers feel that they are ‘papering over the cracks’, putting in a minimum service which only postpones a crisis. However we have also seen how a multiplicity of service providers requires those who are coordinating care to have access to an up-to-date information base concerning provision within their area. We found that social workers and domiciliary care organisers did not have comprehensive information. Indeed, the information held by one individual can only be partial and with the growth of new services it is too much to expect workers to hold all the information in their heads, suggesting that a local database of services needs to be developed which workers can tap into and which they can share with old people and their carers.

A second area of concern is the practice of assessment. This study showed a wide variation in the type of assessment carried out and the means by which workers recorded information. There is a need to look carefully at what information is being collected and for what purpose. Are there better ways of recording information? Do workers need new skills to help them make better judgements? What form should multi-disciplinary assessment take and what are
the circumstances in which it is most appropriate? The need for a more open discussion of what financial information old people and their families need to disclose to professionals in order for them to offer appropriate advice concerning services also needs to be addressed. This leads us to ask what are the responsibilities of social workers where financial disclosures are concerned?

The experience of social workers in the London borough and the southern authority shows the value of specialist workers for the elderly in cases where long-term care needs to be coordinated. While the domiciliary care organisers from the northern authority carried out most of this work, the division of responsibility between domiciliary care organisers and social workers with little experience of working with older people seemed cumbersome and inefficient. In most cases the fact that an elderly person is in need of a home help or home carer is an indication of a need for long-term support not short-term intervention. Such cases demand ongoing monitoring and review if the elderly person and their carer are to gain maximum benefit from services which need to change as their needs change.

We have seen that many workers were very much aware of the need to encourage the old person to participate actively in the decisions made about their futures. Finding ways to establish relationships between elderly people, carers, service coordinators and service providers which are based on frank and honest discussions of what is possible in each case is to be encouraged.

In our discussion of how social workers and domiciliary care organisers assess needs and then arrive at the best solution to meet individual and family circumstances, we have seen that four factors are of particular importance: the mental and physical health of the elderly person; the health and well-being of carers, especially elderly spouses; the relationship between carer and cared-for, and the impact of caring upon other family members.

The carers’ involvement in decision making is obviously vital where they are providing ongoing support, especially where the elderly person suffers from mental health problems, although there is always a danger that those elderly people who could speak for themselves, in however limited a way, may be overlooked. Particular skills are needed to deal with the complex relationships which exist between carer and cared-for, often built on a life-time of sharing and caring for one another. The complexity of such relationships begs the question, ‘Who is the client?’, and as we have seen there are many cases where both parties qualify. Here social work skills in family casework and counselling, where the dynamics of the situation are explored, may help a compromise to be reached. Finally, we should also add that in a future where paying for care may become a commonplace, family members and carers may have a role in dealing with financial arrangements or providing financial support for their elderly relative.

This study showed that most workers had few cases where ‘intensive’ packages of care (ie. seven days a week support) were necessary, although a small number of such cases could make great demands on time. In future, when there may be a greater range of service providers, the coordination of an ‘intensive’ package of care could be more demanding. Consequently, it will be even more
important that someone has the responsibility for monitoring and reviewing needs, for ensuring quality of service, and for championing the cause of the elderly person. We should also note the importance of training here, in that it was qualified social workers who dealt with the majority of elderly people with ‘intensive’ packages of care.

If social workers are to be keyworkers with elderly people, they need to find better ways of liaising with their colleagues in other professions, particularly in the health service. The relationship between social services staff and the primary health care team needs to be reviewed. We found that links with GPs were especially poor. There were still misunderstandings over roles and examples of different workers ‘speaking different languages’. Good liaison between workers from different disciplines and agencies is to be encouraged in order to establish the appropriate keyworker for an individual case and to avoid duplication of roles. And the benefits of multidisciplinary assessments and reviews should be examined further in order to see where such an approach is most beneficial and how it is best organised. The obvious example is where the elderly person suffers from mental health problems, but other situations demand the involvement of agencies, such as the housing department, which are often overlooked.