Chapter 13

Views on the future of social work with elderly people

As we saw in Chapter 10, the three authorities taking part in this study delivered their services for elderly people through a mixture of generic and specialist workers. In the London borough, specialist social work teams for elderly people were found throughout the authority, whereas the northern authority devolved a great deal of responsibility to their domiciliary care organisers for the organisation and delivery of home care services, with generic social workers referred to mainly in cases where the elderly person was in need of residential care. In the southern area, a mixture of generic and specialist social work teams were operating in different parts of the county, although there was a gradual shift towards specialist social work teams for elderly people and the use of local authority old people’s homes as resource centres from which all residential and domiciliary services could be coordinated.

It is against this background that respondents were asked to consider current practices and future policy with regard to their work with elderly people. Fieldwork for the study was undertaken at a time when Sir Roy Griffiths’ report *Community Care: an Agenda for Action* (Griffiths, 1988) had been published and when a range of ideas, particularly in relation to case management and the devolution of budgetary responsibility, were beginning to be debated.

Community care policies

For some years there has been a policy of community care relating to frail elderly people which recommends that they should be encouraged and helped to live in their own homes for as long as possible rather than go into residential care. But this view may now be oversimplified and outdated, with residential care becoming an increasingly important part of community care. Although most of the workers interviewed in this study supported the more traditional view of community care, they felt that such decisions had to be made by the old person. Social workers in particular said that people should make their own choices and saw their role as enabling elderly people to make those choices.

One social worker thought that elderly people’s choices might not always be in line with community care policy: ‘We sometimes get people who appear very
physically fit and are not eligible for part III, but they have made the decision that they have reached the time where they want to go into residential care and they should be allowed that choice.’ And the view was also voiced that the stress on community care had gone too far, as this social worker from the London borough explained: ‘I agree with that, but there has been a great emphasis on community care and I think the balance has been tipped too far that way so that people are denied the right to go into residential care. Possibly people have been discouraged from residential care when they no longer wish to live independently in the community.’

The domiciliary care organisers, whose work formed a vital part of the community care provision, recognised that domiciliary care was not always the answer and that residential care sometimes provided greater security. A thoughtful domiciliary care organiser pointed out that community care, even if it was well-resourced and harnessing as many sources of support as possible, was not necessarily what an elderly person wanted: ‘I think that’s fine as long as you recognise that it’s not always the wish of every elderly person to stay at home even with all the services. Sometimes they don’t want lots of people coming in at different times. They want to know that someone is there 24 hours a day. Some people are very frightened at home.’

While many respondents felt that most older people wished to stay at home as long as possible, they recognised that this meant that some extremely frail people were now living in the community and consequently there was a need for more community care services in order to offer a full range of supportive services. The policy of community care was not workable without the support of informal carers, or, as one social worker put it: ‘Sometimes I think community care means the care is handed back to the family.’

Team managers often commented that they felt ambivalent about statements concerning community care, being ever conscious of the resource implications involved. One team manager in the north said: ‘I agree with it although it’s a very glib statement and I think it’s meaningless unless the money is where a lot of mouths are.’

A team manager from the south made a comparison of the cost of community care and the value of residential care: ‘I agree with that in principle as long as the elderly person wants it and as long as funds are available. Community care at its best is hard work and costly. Reviewing a person’s needs and keeping them going is not a cheap or easy option. Residential care is a very valuable resource and you shouldn’t look at it as failure or a last resort.’

Another team manager felt that policy statements were just political rhetoric and that the important point was to recognise the diversity of individual needs: ‘I just think that’s to do with politics both from the right wing and the left wing. The right wing for economic reasons think it’s cheaper and the left wing have old-fashioned ideas about the community which are not true any more. I believe that for some people it is what they want, but some people don’t want to participate and just want to go to an old people’s home. The politicians say that community care is what everybody wants. I would say that for the young elderly
that’s probably true, but the older elderly, in their 80s and 90s, would tend to want more protection. The politicians just talk about elderly people but they are very diverse and their needs are very different.’

This important reminder of the diversity of older people and their needs comes at a time when the range of options open to people regarding community or residential provision may be becoming narrower. Following a period when government policy has actively encouraged the development of private residential and nursing home care, which has enabled some people to make choices over accommodation and care, we are faced with a period when some privately owned companies are ‘going to the wall’, and when the future for some older people within residential care is becoming increasingly insecure because of rising costs.

While few would deny that staying at home is the first choice for the majority of older people, research has shown that the picture is more complex when the elderly person is faced with being increasingly dependent upon others. In the study by Qureshi and Walker of caring relationships between elderly people and their families, elderly respondents were slightly less likely to reject the idea of residential care than the idea of sharing a house with relatives (Qureshi and Walker 1989, p194). It cannot be assumed therefore that residential care is an anathema to everyone, as has been shown clearly in our interviews with elderly people in residential care. It is an option that should be available and at a standard that enables real choices to be made.

Local policy
But if community care policy lies with the politicians, how does local policy filter down to team managers and fieldworkers? The majority of the team managers as well as the domiciliary care organisers from the northern area felt their local authority gave them guidance on the policy of community care for elderly people in their authority, but only 50 per cent of the social workers were aware of any guidance. A generic social worker from the northern authority said: ‘I suppose we have an elderly policy but I can’t tell you what it is. I could tell you about child care. I went on a course’, and a social worker from the south area said: ‘They don’t tend to tell us things like that’.

At the time of the study, such guidance as there was was said to be unwritten policy, part of ‘unwritten law’ or a ‘social work ethic’. Respondents commented that issues were often discussed locally and became part of the policy and philosophy of the team. A social worker commented: ‘We have regular supervision and would discuss these issues with our team leader – it evolves.’

Given their managerial responsibilities, team managers were sometimes involved in authority-wide discussions and committees, particularly in the London borough. A team manager said: ‘As a team manager I’m on an Elderly Care Planning Group which is constantly looking at resources. Community care is obviously part of the overall strategy.’
In some senses community care was felt to be an ‘indirect’ policy in that it manifested itself through services which were aimed at keeping people at home and through discussions around service funding. One team manager said: ‘The way they give you guidance is on how to use the money.’

Only four social workers said that there was a written policy statement, and only five respondents, from all the groups, mentioned written material, such as handbooks. One team manager said: ‘We have a practice handbook – it is perceived policy, I’m quite sure.’

These comments confirm what others have already indicated (see Kubisa, 1990) that community care as it exists at present depends on a series of ad hoc arrangements which are made in the spirit of helping people to remain in the community if that is their wish. Policy is largely unwritten and consequently allows social services departments the opportunity to shift resources and change priorities. When community care plans become written policy then authorities may find that they are committed to providing certain levels of provision through contracting out to a range of agencies. If these agencies fail to meet their commitments then it is the authorities that will have to ‘carry the can’ for the unmet expectations of the general public.

Changes in community care policy

Many of the workers we interviewed, especially social workers and domiciliary care organisers, did not have a clear sense of the complex decisions that were being taken within their authority regarding how services should be provided, funded and coordinated. Whilst developments such as the Kent Community Care project had been taking place since the late 1970s and had been replicated in other parts of the country (Challis and Davies, 1986; Davies and Challis, 1986), discussions about and experiments with case management and devolved budgetary control appeared piecemeal. Within our three authorities, the London borough had devolved budgetary responsibility to team managers who were managing social workers, home care organisers and occupational therapists and budgets of approximately £1.5 million; the southern county operated a variety of systems in different areas, including the management of residential and domiciliary services from residential care homes which were being developed as resource centres. In this authority, devolved financial control had only extended to a small budget of approximately £500 per team to be used to pay for informal care. In the northern authority, the DCOs had greater managerial responsibility than social workers as they were coordinating teams of home carers. Here the social workers were not involved at all in financial management or the coordination of a range of services.

It is against this background that we explored some of the ideas raised by Griffiths in Community Care: an Agenda for Action, concerning the development of care management and budgeting. We began with Griffiths’ definition of a care manager. He recommended that: ‘In cases where a significant level of resources are involved a "care manager" should be nominated from within the social
services authority’s staff to oversee the assessment and reassessment function and manage the resulting action’ (Griffiths, 1988, para 6.6). We asked respondents how they would feel about social workers managing packages of care for individual clients in this way, and how they would go about buying in care for very frail elderly people living at home from a range of service providers from the statutory, voluntary and private sectors – if that became part of their job. Given the radical changes in working practice that could result from such developments, we were keen to understand how these workers felt it would affect their jobs and what they felt about doing it.

The views expressed on these topics revealed respondents’ hopes and fears. Some were well informed and had definite views on how they would handle change; others were confused and could not envisage their future role. However the main comments could be grouped into three key areas: organisational or structural change; the future role of social work with elderly people and a number of important issues concerning individual need and financial resources (see Figure 13.1).

**Figure 13.1** Summary of key themes concerning changes in practice with regards to future developments in case/care management and budgetary control

**ORGANISATIONAL/STRUCTURAL**
- need for specialised co-ordinators
- need more training
- need more time
- need smaller caseloads
- need increased decentralisation

**FUTURE ROLE OF SOCIAL WORK WITH THE ELDERLY**
- elderly people don’t just need practical assistance
- social workers don’t want to do DCO’s job
- danger of losing contact with client
- traditional social work skills no longer needed
- social workers don’t want to/not paid to manage
- too much time on administration/form-filling

**CONFLICT/ISSUES**
- conflict/danger in managing budget and assessing individual needs
- will involve prioritising people/rationing resources
- will involve competing with other workers for services
- will all depend on the size of the budget
- services will be based on value for money
- need to control quality of services
- need to provide a level of services
Organisational and structural change

Case managers or care managers
There was some confusion amongst respondents in this study about who would be responsible for putting together packages of care for individuals and who would have management control for a range of workers and for an overall budget. While Griffiths (1988) had defined those responsible for assessment, reassessment and managing the resulting action as care managers, the task as he described it was really one of working with individual cases.

In a paper on the problems and possibilities of case management, David Challis makes this useful distinction between case and care management:

...I take the definition of case management to be the coordination of care through an identified responsible individual or key worker whose role is to ensure the performance of the core tasks of case management. Care management I take to be ‘the management of case management’. It is, therefore, more systematically focused at a higher tier in the organisation than concern with the coordination and organisation of care for individual clients (Challis, 1990, p10).

By splitting these two functions, the lines of responsibility become clearer. A social worker from the south put it this way: ‘I think social workers will be managing the packages, but a community care manager will have an overall picture of facilities’.

Many of the social workers felt that the advantages of case management lay in one person being able to have the coordinating role – a view voiced by this social worker from the south: ‘Do you mean one person responsible for all services? I think it’s a good idea – less frustration on the person involved. At the moment you know what’s wanted but our hands are tied. We have to rely on others. However, we can’t do it if the services aren’t there’.

A social worker from the London borough explained how she would go about it: ‘You start from the point of view of the client. What sort of thing would you buy in? A home care service, a sitting service? I would try to give the client as wide a choice as possible. Personally, I think it’s challenging. We’re given small budgets to manage now. I would see a trained social worker given more training being able to do it quite competently’.

A team manager from the south felt that social workers were already encouraging people to buy in a range of services and that this would be an extension of their role: ‘That’s what they do now. Social workers are encouraging elderly people to use their attendance allowance to buy in services. So you’re into it in a small way without knowing it’.

And another manager from London felt that although many of those working with elderly people were untrained welfare officers or social work assistants, they could cope with the new role: ‘Would the welfare officers be able to handle the case manager role? Yes, because they are used to working with elderly people. They are already managing a lot, not like child care.’ There was some evidence, however, of a greater willingness among the qualified social workers from the
southern authority to take on the responsibility of care management that was not so apparent in the London borough.

The domiciliary care organisers from the northern area felt that they were carrying out much of the case management work although their interpretation of ‘managing packages of care’ might not have been quite what policy-makers had in mind. They thought that any change would see an enhancement of their role which already included budgetary control and managing resources. One commented on the practicalities of managing staff: ‘(Managing packages of care) I suppose that’s basically what we are trying to do anyway. We are very aware that it’s a constantly changing programme. This morning I was rushing around trying to reorganise people because a home help let us down. You have to withdraw it from one client and give to another. It’s constant management.’

However one domiciliary care organiser felt that such changes were bound to rationalise jobs in the local authority: ‘...it would be the end of it. I’d be redeployed licking stamps. They wouldn’t need as many DCOs.’

On the whole team managers saw their role as one of coordinating other workers and managing the budget for an area. They had already assumed the care manager role. Given the complexity of the job, a team manager from the southern authority felt that there would have to be some separation of roles as their job might become too big: ‘The whole thing would have to be coordinated. It depends on how you read the job. If you’re buying in services, you couldn’t do that and supervise social workers and other staff. It’s going to make the role of social services much larger.’

A team manager from the north highlighted the difficulties of developing the care and case management approach within a generic team: ‘You’d have to have specialist managers and that has massive implications for neighbourhood teams. In this team there is no way I could oversee that function because of the nature of the workload. Most of our work is about child protection. You’d need someone to oversee that. You may get beefed-up DCOs, as social workers are not involved here. So in this authority there are massive implications for the neighbourhood teams’.

Other team managers were more concerned with the implications of managing a finite budget. This team manager from the north queried how this would be managed and monitored: ‘The question I have is where do the managers fit in. I expect there will be budgets devolved in some way to a manager level – either to an area or district. We may have to ask our district manager for approval. If we play a lead role and have financial control it will be a finite budget which has to be managed, and we’d have to approve spending. It would have to be monitored – a bit like the DSS Community Charge budget – divided into 12 monthly instalments.’

A manager from the London borough had thought through the implications of competitive tendering and saw herself operating as a contracts manager, making decisions as to which services were used in his area. She outlined the implications for the local authority: ‘You’d have to reorganise social services – we don’t cost our own services properly. £1.75 a week for home care, a flat-rate.
You’d have to get a proper costing, it might be £5. A lot of alternatives can’t spring up in this area because they can’t compete with us because we’re not properly costed. It would end up with someone like me as team manager. I’d be the contracts manager for a group of social workers. I’d decide who to give that contract to or the social services department may privatise their services and give me a budget – say £1.5 million per annum, and say, what services can you provide for that? I’d put it out to tender to both the local authority and a private company.’

Another was concerned about providing a full range of services and co-ordinating health and social services: ‘I’d start by finding ways to fill in service gaps at the moment. We must include those needing nursing – private nursing is needed. It would be difficult to dovetail with the health side. We may need to increase the range of live-in carers. I’d look for resources within the community. It would mean setting up new services. The split between social services and health is difficult and we must look at the real cost of providing services.’

Such comments show that at the level of both case management and care management, most care workers, even if somewhat daunted by the prospect of change, were prepared to think creatively and constructively about new ways of working. However, doubts were raised about the management of community care where social work was predominantly generic, resourcing issues and the realistic costing of public services, and the dividing line between health and social services in relation to community care.

Changes in working patterns
Given their current patterns of working it was understandable that social workers were more likely than team managers and domiciliary care organisers to comment on how a move towards case management would change their working patterns. Some felt strongly that they would need more training in order to understand how other workers such as occupational therapists or home carers worked with elderly people. A social worker from the south commented: ‘It’s going to mean another job. Each spectrum of care has their own managers. If we are going to manage these services we will have to have a knowledge of OT and home care. It will need much more training.’

A generic social worker from the north felt that specialisation was the only answer: ‘Like most things which are new it’s extremely difficult. You would need to be a specialist worker with the elderly. It couldn’t be done otherwise’.

Team managers also saw a need for further training for themselves, particularly in financial management, like this manager from the south: ‘It would mean far more managerial and financial responsibility. You’d have to be much better trained than team leaders are. The only resource management we’ve had is beds in Part III homes. We need resource and financial management skills rather than just muddling along.’

Another manager from the London borough felt they needed an accountant to advise them: ‘We’ve still had no training on local authority budgets; we’ve
had to learn on the job. We would need an accountant to help us, guide us. We are managers, not accountants.’ However she saw this advantage: ‘...it would give me skills that I could take elsewhere.’

If case management was to include assessment, coordination of services and ongoing monitoring and reassessment, then many social workers felt that their caseloads were far too large. A social worker from the London borough said: ‘...are they going to double the number of social workers? With my caseload it would be impossible.’

Respondents though that putting together packages of care would be time-consuming. There was a need for an information base of services available in each area, and for workers to develop a network of contacts. One social worker from the south thought it might work this way: ‘I suppose some services would have to be found by advertising and using the individual’s private resources or perhaps you’d have the same amount of money to spend as the DSS gives for a private residential home. You’d have to start patch-working services. It would be very time-consuming to do it for all my clients... You’d develop links within the community and you’d find people to "patch it" with. I suppose you’d develop a number of resources, but you’d have to vet them and check them out.’

There was a view emerging that social work time would be spent only with those people who were very frail and without support. A social worker from the south felt that the only way that some old people would be helped would be if their relatives did much of the work: ‘It would be very time-consuming. If the elderly person had relatives you’d have to get them to do it, we haven’t got the time. We’d have to give them the information.’

The future role of social work with elderly people
The second main area of concern to emerge from these discussions focused on the future role of social work with elderly people. In Chapter 10 we discussed the range of social work tasks which includes both short-term intervention involving the provision of particular services, and long-term care management which can draw upon a number of social work skills – assessment, mobilising resources, gatekeeping, casework, coordinating and monitoring, acting as a resource person and community work.

Maintaining social work skills
Social workers in particular voiced their opinions on how their job might change in the future. There was a widely held view that elderly people needed more than just practical assistance and that social workers did not wish to take on the domiciliary care organisers’ role. An attempt had been made in the London borough to get the social workers to manage home care, but this had been resisted. One social worker felt very strongly: ‘I don’t see myself as the manager of a practical package. We’d lose personal contact and those things that are hard to define. We’re almost like an ombudsman. We’re the one they can be totally honest with. We’ve rejected managing the home care service which we were
asked to do on reorganisation. I don’t think the government realises that elderly
people are the same as young people. They suffer from loss of their identity, of
their role, of their home. There is a need for social workers with elderly people.
I think some people think elderly people only need practical help. It’s not so.’

Another worker from the same authority also discussed the problems of
social workers managing home care services: ‘The Director wanted us to be
social services officers and it was not well taken. The idea was to work in a small
patch of three or four roads and assess for home help. It was not well received.
It was nice in theory but you get bogged down with the organisation of home
care. Elderly people need home helps, social work input, financial assistance,
someone to work with other family members – a whole range of knowledge and
experience.’

**Maintaining relationships**

Social workers were also very concerned about losing contact with their clients
and how this could affect relationships which had been built up over time. One
commented on the consequences of coordinating a range of services: ‘You’d lose
a lot by doing that. You lose the personal contact. You don’t have the same
relationship with people because you’re not involved with them in the same way.’

A social worker from the London borough felt there were dangers for
everyone if the contact with clients diminished: ‘I see my job as going out and
seeing the client, providing support and services. I wasn’t trained to be an
accountant or what have you. People at the top, who are managing the budget,
are not aware of what’s going on in the street, especially if the middle manager
is not feeding through information.’

The feeling that traditional social work skills would no longer be needed was
not only felt by the social workers. A team manager from London said: ‘...a lot
of the heart will go out of the social worker’s job. Yes, they would be coordinating
and care managing, but they wouldn’t be doing the counselling because they
would be buying in the counselling.’

**More administration, more management**

There was a fear that the social worker’s job would become more administrative
and managerial, and many felt that this was not what they came into the job for.
A social worker from the south felt it would be a different job: ‘It would be quite
a different ball-game because in a way you’d become an employer and a
recruiting agency.’

Another social worker from the London borough stressed the greater
administrative role: ‘You would be much more of an administrator and do much
less counselling. More like a mini-manager, a clerk, a pen-pusher, an accountant.
I wonder if my social work skills are going to be buried.’ And a social worker
from the south felt that her current salary did not compensate for the additional
responsibility: ‘I’d want an increase in money and a decrease in the number of
people I deal with. We’d need more social work hours – but not for me. I don’t want to work a 50-hour week.’

The domiciliary care organisers had far less to say about how the future changes in practice might affect their job. In fact many were very unsure. However, like the social workers, some felt that administrative work would probably increase. This domiciliary care organiser said that it would mean that she would be even more office bound than she was now: ‘You’d spend more time at your desk. I think you spend too much time now at your desk.’

Another was far more positive and saw her role expanding: ‘You’ve got to move with the times, especially on the cleaning side. I look forward to the day when I can concentrate on care rather than cleaning. I want care in the community. I would get more job satisfaction. It wouldn’t matter where the service was from, as long as people had a better service.’

**Individual need versus financial resources**

*Prioritising and rationing*

Finally, a great deal of concern was expressed over the conflicts which arise when the needs of individuals have to be weighed against finite financial resources. Many workers commented that this balancing act could only be done by prioritising or rationing, so that resources became concentrated on those seen to be ‘most in need’. The assessment of who would be ‘most in need’ might lead to the development of rigid criteria. While rationing of resources was already the case in many authorities, some respondents felt that this was morally wrong and that each case should be considered separately. A social worker from the north said: ‘Bringing in a budget – I don’t mind that. It wouldn’t change the need. It would change where you placed that person. It forces you into prioritising – what happens to the rest of the people? You will get rationing whereas at present you have the ability to spread resources.’

The conflict between needs and costs was raised time and time again. One worker felt that she would have to change her attitudes: ‘I’d have to have a more balanced view. I tend to be very client-orientated at the moment.’ Others stressed that the roles of assessment and budgeting should be kept at a distance: ‘You’d be making choices and decisions for people based on money. The people who are responding to need should not be managing the money. You end up with a conflict within yourself.’

*Relationship with clients*

The relationship with the client was the concern of this social worker: ‘If the client knew that I was the person in charge of finances to do with care they could try and manipulate me. Now I don’t bring the goodies, I’m always going away and referring to someone else. I’m regarded as a friend. If I controlled the money, I’d be put in a position of power and then they would try and manipulate me.’

How relationships with clients might be affected by changes in the role of the social worker was also explored by this social worker from the south, who
gave this example from her caseload: ‘...sometimes if you’re too wrapped up in finances it’s a problem. I’ve got an old boy who came into [residential home], who would not disclose any finances, and this business about filling in forms and money is ruining our relationship, which I’ve developed over a number of years. If you get too involved with finances then the balance between the service you are providing and the budget gets confused.’

While some social workers saw these conflicts as the key to whether they would stay in social work in the future, others were more enthusiastic and pragmatic about the changes. One from the London borough saw positive benefits in handling the budget as it would offer flexibility in the type of services which could be offered: ‘I’d look at getting value for money in getting the services to suit the client’s needs. You might need extra hours of home help and you could buy in extra. You could buy in care from the private sector – nursing auxiliaries or private help, and they would supplement our resources.’

A social worker from the north accepted that he would have to make some difficult decisions over who had the greatest need and described how he would go about it: ‘I’d look at all the services they felt they needed and then I’d look at all the services that were available. I’d try to explain to them how much each service cost. I don’t think everybody should have the same budget. I’d say what they had available. It would have to be the social worker making that decision. That would be the hardest part. You’d be restricting the services, but then we’re restricting them now.’

While this social worker felt that he could make these difficult decisions another social worker from the north drew upon her experience of working in Australia, where a similar system operated. She described some of the problems of assessment and buying in services and, in particular, drew attention to the variation which can occur when social workers adopt different criteria for assessing need and to the difficulties which can occur when contracting out services: ‘When I lived in Australia we called that the brokerage system. I don’t like it because what I perceived as being someone in great need and worth $20 a month, another social worker could say was worth $300 per month. It is not a fair assessment. I found it fragmented and open to abuse. Also we were told that there were five establishments we could use to provide services, but in fact there were 105 others. The rules were laid down from above. I understood that we could buy in units of care from anywhere, but when the money was handed over only certain establishments could be used. We were only allowed to provide care for twenty clients out of two hundred. We had to prioritise. They were much worse off but it didn’t become evident until the money was handed over.’

The availability and quality of services
Of course buying in services presupposes that there are services to buy in. In rural areas there was a feeling that the private sector would not meet this need: ‘You would need to know all the private agencies. What would come first? If you had money and it became known, would private agencies spring up? In a
rural area like this would people offer services? It’s very different in the country. There are areas where meals-on-wheels won’t go.’

And a team manager from the same southern authority was concerned that the provision of services could not always be left to market forces: ‘There would have to be a very high degree of knowledge of what resources there were, and this would have to be backed up by some kind of legislative system that dictates that those resources are there. There is no point in being a case manager with only one thing to choose from. If you had a situation, particularly in rural areas, where services are not available then the onus is on the health authority and the local authority to be service providers where there are obvious gaps in provision.’

A London social worker who felt that buying in home care would be her main priority, was more concerned about the quality of the service she might be buying than its availability: ‘The quality of this work stands and falls with the quality of the home carers. I can’t work without them. They have to be good people and well-trained. I’ve no idea if you advertised for a service what you’d get. I know what I want and if you are paying for it you might have some control. It might produce some amazing results, but it might be variable. It might work in a London suburb but not in a rural area.’

The need for quality control and monitoring of services was another crucial issue raised by respondents, especially the domiciliary care organisers. One was concerned about the reliability and accountability of the independent sector, and the insecurity it would cause her as she would not be in control of the workforce. She said: ‘It would make my job more difficult. If you bought in a home help and they didn’t turn up, how would you know? How would you provide cover? How would they let you know? They would let their bosses know, but not you.’

Another commented on the standards met by her own staff which she felt would be difficult to enforce within the independent sector: ‘If we put in a home help they go through training, police checks, how to handle money. You know who you are dealing with. We scrutinise our staff. You don’t know who you are dealing with otherwise.’

Feelings and attitudes
The views expressed above demonstrate something of the wide range of anxieties and concerns of workers in social services departments during this period of change over community care policy and practice. It will come as no surprise then to learn that 19 of the 40 social workers interviewed said that they would not like these changes in their role and only 11 said they would find it interesting or enjoy it. One social worker from the southern authority felt very strongly, saying: ‘It’s all to do with the present government’s policy of value for money. Services would have to be costed and you’d need to know how much things cost. I’d find it difficult. I would probably leave and do something else. You can’t cost care.’

However a colleague felt differently: ‘I’d be quite happy because I feel you would be able to work out an appropriate package for people. I’m not frightened of money. I’d probably overspend but many local government departments
overspend... There is an argument that money gets in the way, but money gets in the way anyway with residential care’.

Domiciliary care organisers were also less sure about these changes, with seven of the 11 domiciliary care organisers giving negative responses. Many voiced strong support for the local services in their area. One said: ‘It’s very difficult to approach the private sector. Anyway we should provide, I believe that very strongly. We should provide the service and if we are going to do it, we should do it properly.’

Others felt that their job would change. One commented: ‘I think it would make life very complicated. It would be time-consuming and expensive. I wouldn’t like it.’ And another felt she would have to leave: ‘We appreciate that it’s going to come to that – buying in, privatisation, but I’ll be gone.’

Not surprisingly perhaps the team managers were more positive. Five of the 11 team managers were very enthusiastic about the changes in responsibility and a further three said they would find it interesting. A manager from the south said: ‘I’d love it. I’d be really pleased. It would be real community care. A lot of real choice so that they could stay at home.’

Others were more cautious: ‘I think it would be a possible step forward. We would be able to look at all the resources available to elderly people and how they would fit together in a matrix of care.’

**Conclusions**

Within this chapter professional care workers expressed their feelings about the future development of community care and how it would affect their working practices. Their reactions were mixed: anxiety about change mixed with a desire to offer elderly people and their carers a better service – one more attuned to individual needs. Some anxieties were personal and there were definite fears concerning the loss of counselling skills in work with older people. But other fears related to the emphasis within the political rhetoric of community care policy of matching individual needs against constrained financial resources – policies which would inevitably lead to further prioritising and rationing of services. There was a general feeling expressed by one worker that ‘You can’t cost care’.

It was apparent from this study that current services were only able to meet needs because the bulk of care was provided by informal carers. In future it is hoped that a diversity of service providers will enable greater choice for elderly people and their families, but will the diversity of services be available in all areas, and how can quality be assured? These questions trouble care workers.

For most of them community care was about providing people with choices over how best to live their lives in later life and this meant both care at home and in residential settings. If community care was to encourage care at home for extremely frail elderly people then more resources would be needed. And there was a recognition that residential care had to be brought within the realm of community care. It should no longer be seen as a dreaded alternative, but an
option that some elderly people positively choose in later life. Because of this fieldworkers needed better information about the whole range of alternatives open to older people across the range of sectors. Without resources in terms of manpower, information systems and direct services – these care workers felt that they were in danger of having to develop strict criteria for rationing their services, meaning that they would only be able to concentrate on the few at the expense of the majority who would continue to have to rely on informal support.