Discussion of findings
Chapter 14

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This study was designed to explore the ways in which elderly people actively participate in decisions about their receipt of services, with special attention to those elderly people ‘at the margin’ of community and residential care. The main questions posed were the extent to which elderly people had a choice in the care services which they received from all sources, how they were helped to make choices by means of information, advice and counselling and the extent to which they felt satisfied that these were the most appropriate services for their real needs.

We were particularly interested in the move into residential care from the community and our aim was to examine the experience of equal numbers of elderly people on either side of the divide. There can be no doubt that moving into residential care is one of the most critical decisions a person may ever make. It is a decision which ought only to be made after all the options have been presented and fully considered. Once the move has been made there is usually no way back. How much choice did elderly people have in this decision? What options had they had? At what stage? Who else was involved and what roles did they play?

In this report we have presented evidence from a variety of sources – from elderly people living in the community and in residential care, from their carers, from their social workers, from heads of private and local authority residential homes for the elderly, from social work team leaders and from domiciliary care organisers. Our main aim has been to let people speak for themselves, while putting their remarks and reflections into the policy context. This discussion of findings brings together some of the key issues and analyses the extent to which the reality matches the aspirations of those who wish to ‘promote choice as well as independence’ among people who need care in the community.

This report comes at an important time in the development of policy and practice in community and residential care for elderly people. The research was carried out during a period of considerable debate and discussion about the future of community care. The Griffiths Report, giving an ‘agenda for action’ on the organisation of community care services, and the Wagner Report on residential care, had been published before the study began, and the Government White Paper, Caring for People, was issued as the fieldwork was being completed. The
NHS and Community Care Act, 1990, and Policy Guidance on Community Care in the Next Decade and Beyond were published during the writing of the report. There has therefore been no lack of written material over the past two or three years indicating the policy of the Government on the future organisation of community care. The key components of community care, spelt out clearly in Caring for People, are (i) services that respond flexibly and sensitively to the needs of individuals and their carers; (ii) services that allow a range of options for consumers; (iii) services that intervene no more than is necessary to foster independence and (iv) services that concentrate on those with the greatest needs. At the heart of the Government’s policy are two statements in Caring for People – ‘Promoting choice and independence underlies all the Government’s proposals...’ and ‘Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives...’

It is with the issues of choice, participation and satisfaction that this report is concerned. Few people would disagree with the idea that elderly people should maintain control over their own lives and should live as independently as possible, however old they are and whatever their level of disability or handicap. But providing choice and maintaining independence and control for elderly people are not always easy. There are other characters in the drama, like informal carers, who are acknowledged to provide the bulk of community care, and professional workers, who are the traditional ‘gatekeepers’ to the community health and social care services which can help to keep people living at home for as long as possible.

There is also the fundamental question of resources. Most services can only be provided if they can be paid for. An increasing number of dependent, elderly people means that more demands are made on public funds, and the Government has made it clear that increasing use should be made of the independent sector of care, even if public money helps to develop services in this sector. How services are provided, who pays for them and who runs them are all key elements in the provision of the ‘packages of care’ which are so central to the question of maintaining choice and independence.

The Government has stated that it wishes to see community care services which are ‘needs-led’ rather than ‘service-led’. The emphasis is on the choice of the individual to make demands on the services and to be provided with a series of options, rather than for the service providers to state what can be provided, and to ration access to the services to suit their needs rather than those of the users.

This was the policy context in which this research took place, and it is against this background that we discuss the main findings of a long and complex report. The study was ambitious, in that it was designed to explore a number of key issues from a number of different standpoints. The views of elderly people and their carers, their demands and their wishes, do not always coincide, and they may be at odds with the views of the service providers, let alone with the reality of what can be provided in a society in which resources are finite and, in any
case, are increasingly to be concentrated on those with the greatest needs. How are decisions on care to be made in this context? And how are the twin aims of satisfying the users and supporting the carers to be met when the two may be completely incompatible?

It should be emphasised that our study was restricted to elderly people over the age of 75 who were not suffering from senile dementia or a high degree of mental frailty. We wanted to examine the experience of people who might have been in a position to exercise choice and to participate in decisions about their care, if such choice and participation were made available. It should not be forgotten that one fifth of elderly people over 80 are said to be suffering from senile dementia. Issues of choice and participation may be somewhat academic in such circumstances, but these people constitute an important group of consumers or users of services, and undoubtedly make considerable calls on health and social services. If our findings suggest little choice and participation among the majority of elderly people who are lucid and potentially able to make decisions about their care, what are the implications for those who cannot?

The discussion of findings approaches the research thematically. We look first at the key issues of information, packages of care services in the community and the questions surrounding a move to residential care. We then look at choice, participation and satisfaction – the key concepts around which this research was constructed. How did it all work? And what are the policy implications of our findings?

**Information on community services**

If people are to use services or to exercise choice over whether they might use services or not, they have to be aware that the services exist. Similarly, if they are to choose which services they would like, or if they are to review a series of options, they must know something about the components of the services. This applies as much to community care services as to residential care services. If the aim of policy is to encourage consumer choice, the consumer must know not only what is on offer but also what it consists of. In addition, and perhaps most important, the consumer must know something about the likelihood of whether he or she can gain access to the desired service. There is not a lot of point in raising expectations of choice, when rationing is the order of the day and qualifications are more important than demand.

There was little evidence in this research that elderly people were able to operate as ‘informed consumers’ in their use of care services, either in the community or in the residential sector. We look first at community services. Before they came into contact with the social services department, the elderly people we interviewed in the community had known very little about the services which might be available to help them stay at home, and only half of them thought they knew enough at the time they were interviewed, when the majority of them were receiving at least one service.
Very few elderly people had had any written information about the domiciliary services they received or might receive, and most of this was restricted to those living in sheltered housing. It usually consisted of information about one particular service or was material about commercial aids or alarms, some of which had been pushed through the door. Sometimes the material seemed well-targeted and well-designed, but there was a clear, unmet need for comprehensive booklets describing the health and social care services available from as many sources as possible, with information on how access to them might be gained by elderly people.

It could be argued that elderly people might find it difficult to seek out information about services or to be aware of what was available before they needed care. It should be stressed that few people plan ahead or know how to plan ahead for the services and information they might need in old age. Fears of old age, disability and death tend to combine to militate against active planning for one’s own personal deterioration.

Perhaps elderly people’s carers were in a better position to find out about services, certainly after the need for them had become apparent. But it was quite clear that many carers only found out about community and domiciliary services when they were virtually at breaking point or when they were in despair at their own inability to meet the needs of the elderly people. Most worryingly, the elderly husbands and wives caring for an equally elderly spouse, who was usually very frail and dependent, were the least likely among the carers to have easy access to information about services.

How had the elderly people and their carers learnt about services if they received so little information? The whole system appeared to be very haphazard. It helped if a relative worked in the social services department, and it certainly helped if you were ‘quick on the uptake’ and ‘kept your wits about you’, with your ears skinned for passing bits of gossip in the post office. But many people were not so fortunate or sprightly, and there was evidence that many elderly people and their carers tended to ‘learn as they went along’, reinforcing the impression given in so many interviews in this research that access to services was incremental and often accidental, with little evidence of the care planning envisaged in the Policy Guidance issued by the Department of Health.

Why was access to information about community services so restricted? Was there a deliberate policy afoot among health and social care professionals to restrict information? Was there a fear that passing over the information might open up the floodgates of demand which could only be disappointed? Or was it simply that nobody had thought of designing comprehensive information about services which could be passed to potential or actual users?

Although the conspiracy theory may have its supporters, our evidence suggested that the reasons for the lack of information exchange between the service providers and potential service recipients were often much simpler. Before care workers can inform elderly people and their carers about services, they must be well-informed themselves. Social workers and domiciliary care organisers (DCOs) interviewed for this study usually only had a partial and
selective knowledge of community services in their areas, particularly with regard to the private sector. Links with voluntary community services were often ad hoc and based predominantly on personal contacts and the proximity of services.

There was also the problem of time. It takes time for professionals to find out about services, and it takes time to give information and to discuss the options with potential users. Social workers and domiciliary care organisers were often responding to crisis situations and urgent needs, and tended to rely on their own memories and knowledge rather than refer to other sources. At the same time, they were often faced with situations in which a speedy response was needed to an immediate problem. Information giving and discussion of a range of options, even if they had thought this appropriate, was not always possible in reality.

There was a clear need for local authorities and other service providers to make available effective and reliable information about care services of all kinds, both for the use of the general public and for professionals. It is far too important an issue to be left to individual fieldworkers who may have not enough time, expertise or inclination to develop such an information base.

The traditional oral culture of social work undoubtedly played a large role in perpetuating a system in which information was transmitted by word of mouth. The reluctance many social workers felt for recording information about their clients was reflected in their reliance on passing over information about services by talking about them. The fact that this method might result in suspicions that information as well as services were being rationed simply did not seem to have occurred to many of them, but this was undoubtedly the result.

Elderly people and their carers alike recognised – and mainly accepted – that rationing of information was related to rationing of services. Some social workers and domiciliary care organisers acknowledged that this was precisely what they were doing, and it has important implications for the construction and designing of the packages of care which are discussed in the next section. Social workers and domiciliary care organisers, like most people, want to be liked and do not want to disappoint people. There can be no doubt that some restricted their information-giving role, and did not really welcome the introduction of written information, because they did not want to raise expectations which could not be fulfilled.

The development of a local information base which care workers and others will use will require a change in practice away from an oral culture to one which demands more research, consultation and discussion among all potential care service providers. It remains to be seen how key workers will work with care managers to ensure that access to information is not only a pre-requisite to access to services but also a fundamental right of all elderly people who might potentially be service users.

**Packages of care**

Much has been made in recent years of the importance of ‘packages of care’. This concept of a carefully designed, tailor-made ‘package’, in which services
are put together in a tidy way to meet the individual needs of people requiring care in the community has been around for some years. It is central to the Kent Community Care Scheme (Challis and Davies, 1986), and has received added credence and official blessing in the Griffiths report, the White Paper and the ensuing Policy Guidance.

The idea that a package of services is put together in a planned and coherent way is clearly very attractive to service managers and policy makers alike. It is a rational way of dealing with a problem. But reason is not always the overriding force at work when services for dependent people are being put together, and ‘design’, as we have noted in the report, was rather an ambitious term to describe the way in which the social workers and domiciliary care organisers we interviewed approached the question of the services they suggested or provided for elderly people.

There was little evidence in this research of extensive packages of care being provided to help elderly people stay at home rather than enter residential care. Most help for the elderly people interviewed, whether they were still living in the community or had entered residential care, was being provided or had been provided by relatives, with the bulk of the care being provided by only one person. This was particularly true of personal care, which required help with intimate tasks such as bathing, washing, dressing, getting to bed and so on. Other members of the family might give help with more functional tasks, such as shopping, cleaning, cooking, laundry, transport and so on. Help from friends and neighbours was limited and rarely took the form of personal care.

But it should be stressed that many of those interviewed did not have much help from either informal or formal sources. One third of those interviewed in the community had little or no help from anyone with either personal or functional tasks, even though some of them were very old and becoming increasingly frail. The potential size of the informal care network has to be put into context. Over one fifth of the elderly people living in the community and one third of those living in residential care had never had children or had no living children. Nearly one fifth of the community sample and nearly 30 per cent of the residential sample had neither a living spouse nor living children. Help or care from relatives more distant than a spouse or children was rare and usually only of a functional nature. Seven per cent of the residential sample and 3 per cent of the community sample had no kin at all. Even among those with children there was little evidence of large families fighting over who was to look after mother or father. Most elderly people had only one or two surviving children, who were often elderly themselves and living some distance from their parent. There was usually little choice of informal carer – either for the elderly people or for the carers.

Essentially, the pattern established in so many research reports was repeated in this study: care of both a personal and functional nature for the elderly people mainly devolved on the shoulders of a close female member of the family, if there was such a person available. There was also, in this study, evidence of such help being given by a number of very elderly husbands to their more dependent wives, and we return to the theme of the need to recognise the special needs of
some of these elderly carers. Nearly half our sample of carers in the community were over the age of 60, but a quarter were over 70 and over 10 per cent were over 80. The implications of this for policy on supporting carers cannot be underestimated.

The elderly people we interviewed were all ‘at the margin’ of community and residential care. It might have been thought that they would be more likely than other elderly people to have had fairly extensive packages of formal care, particularly since those living in the community were all known to social services and half of those living in residential care were in local authority homes. Even if none of those living in private homes had had a range of domiciliary services to help them stay in the community, it might have been expected that those in local authority homes, all of whom should have been assessed by a social worker, would have had every imaginable service before they entered residential care, which was still seen very much as a ‘last resort’ by the majority of social workers interviewed.

Our samples of elderly people included a high proportion of people living alone. Over 60 per cent of those living in the community were living alone and 70 per cent of those now living in residential care had been living alone before they entered a home. This is a much higher proportion than that found in the community among over 75 year olds as a whole (General Household Survey, 1986), who are more likely than other groups to receive domiciliary care services of all kinds. In addition, 20 per cent of the community sample were living with an elderly spouse and 10 per cent of the residential sample had been living with an elderly spouse before admission, leaving around 20 per cent of both samples living with younger relatives or other people. It might have been thought that elderly people living alone or with elderly spouses would be more likely than the elderly population as a whole to have received fairly extensive packages of care.

In fact, the level of domiciliary or community-based services received, both by elderly people still in the community and by those who had entered residential care, was low. It was low whether they lived alone, with an elderly spouse or with younger relatives. Over 10 per cent of both samples had or had had no ongoing community or domiciliary services at all, and in the two areas where elderly people in the community were sampled only from those on social workers’ caseloads, nearly 20 per cent of those interviewed had no ongoing community or domiciliary services. Some had aids or alarms or lived in sheltered housing, but some had nothing in their packages at all.

The most common ‘package of care’ was very limited – usually consisting of one or two services and provided only on one or two days a week, even for those with considerable disabilities and little informal care. Three-quarters of those interviewed in the community had less than four items in their packages of care, and a typical package of three items consisted of a couple of hours of home help a week, day care once a week and a bath rail or walking frame. Only a tiny proportion of elderly people, either in the community or in residential care, had packages of services amounting to more than three hours of home help a week, with meals on wheels or day care on some days. Very few had intensive packages
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of care with four or more services covering them on most or all days of the week. Even in these cases, there were or had been long periods when they were not covered, and intensive informal care was needed.

There was little difference in the size of packages of care received by the community sample and the residential sample overall, but the average package of care received by elderly people in private residential care had been rather smaller than that of the elderly people we interviewed in local authority residential care.

There was little evidence of use by either sample of elderly people of private or voluntary sector community services. The organised use of ‘paid neighbours’ or of a recognised variety of helpers aiming to maintain elderly people at home, as found in the Kent Community Care Scheme and other schemes, was not found at all. Perhaps this indicates how difficult such schemes are to replicate without the resources of a ‘demonstration’ model. Private or voluntary help was usually arranged by the elderly people or carers themselves. It rarely appeared to have been recognised as part of a package of care by the social workers or domiciliary care organisers.

In fact, there appeared to have been very few private or voluntary domiciliary services available for elderly people in any of the three areas, apart from private cleaners or very expensive nursing services. There were various voluntary visiting services, and some of the day centres and meals on wheels services were staffed by volunteers. But the social workers and domiciliary care organisers interviewed reported little organised private and voluntary community and domiciliary care, and there was no real evidence to suggest that there was much to know about in any of the areas. There was certainly a lack of any well-developed data base of potential private and voluntary service providers into which care workers could tap, and, again, the oral culture of social work, with data bases kept firmly in the heads of individual workers, militated against the development of such information exchange.

However, even allowing for a restricted information base, there were very real concerns among social workers and domiciliary care organisers about Government exhortations for them to develop and ‘enable’ the independent sector by increasingly building private and voluntary care into the packages they put together for elderly people. The voluntary sector was thought to be contracting, and often unreliable in instances where there was thought to be a great need for voluntary help, like transport or regular sitting or visiting. The private sector was thought to be very expensive, particularly where intensive home care or personal care was needed. There were worries about assessing the quality of private domiciliary care and concern about how and to whom the providers of such care were to be made accountable.

Although some social workers and team leaders recognised that there was likely to be a shift towards more ‘care management’ and greater use of the independent sector, there was little enthusiasm for either, and a great deal of scepticism about how such support could be found or managed. The domiciliary care organisers were generally so concerned with the problems of keeping their
own service going that the idea that they might develop private or voluntary
community care had simply not occurred to them.

There was evidence that a substantial proportion of elderly people in the
community and their carers wanted more services to help them at home – either
more of the same or something different. The additional help required was usually
of a functional nature, and the biggest demands were for more home help and for
gardening help. There were some surprising gaps in the packages of care
received, with only one elderly person in the community sample and only four
in the residential sample receiving a laundry service of any kind. The question
was not one of ‘intensive’ packages of care. It was a question of an hour or two
more home help a week or another day at a day centre.

The social workers and, to a lesser extent, the domiciliary care organisers,
saw part of their role as putting together packages of care for the elderly people,
and described in detail how they went about it. But there was absolutely no doubt
that they were rationing what they saw as scarce resources, and they made this
clear to the elderly people and their carers, either explicitly or implicitly. They
were trying to take account of the needs of the elderly people and their carers,
but their ‘assessment’ of need was clearly constrained by what they knew to be
available. The ideal might be a ‘needs-led’ service: the reality was undoubtedly
a ‘service-led’ service.

There were problems in assessment, recording and provision in all three
areas, but the difficulties were most acute in the northern area, where virtually
all the work with elderly people surrounding packages of care was done by the
domiciliary care organisers, who had caseloads of two to three hundred people.
It was obviously out of the question that they could possibly be expected to
design, discuss, assess and monitor individual care packages for all these people.
They were heavily reliant on home helps feeding back information, and a great
deal of their time was spent in prioritising and moving services from one client
to another whose immediate need was greater, much to the dismay of both elderly
people and their carers. Interestingly, however, some of the warmest comments
about professionals from elderly people and carers were made about some of the
domiciliary care organisers interviewed in the northern area, who were based at
a very local level. There was a clear dilemma here, because, although they could
potentially build good relationships with elderly people and their carers, their
caseloads were huge and most of them were not qualified to offer more than
practical help.

Social workers in particular usually had detailed knowledge of the elderly
people on their caseloads, and painted comprehensive little pictures of the
circumstances in which they were living. The extent to which they were able to
provide a comprehensive package of care was quite a different matter. Some of
the elderly people did not really need many services, if any, but others were
acknowledged to be functioning at a very low level of formal services, only being
maintained in the community by a high level of informal support. There was no
doubt in the minds of most social workers and domiciliary care organisers that
it was only through keeping this informal support going that the elderly people
were being prevented from entering residential care. In some cases the social workers said they were keeping the informal care going by offering regular checking or counselling support on an individual basis, but information on this was difficult to collect, partly because of the ad hoc ‘dropping-in’ nature of some of this support.

Support for carers
One of the Government’s key objectives in the future provision of community care, outlined in *Caring for People*, is ‘to ensure that service providers make practical support for carers a high priority’. The White Paper acknowledges the major responsibilities carried by carers and recognises ‘that many need help to be able to manage what can become a heavy burden. Their lives can be made much easier if the right support is there at the right time, and a key responsibility of statutory service providers should be to do all they can to assist and support carers. Helping carers to maintain their valuable contribution to the spectrum of care is both right and a sound investment...’

There was no doubt that many of the carers, both of the elderly people in the community and those who had entered residential care, had taken on the task willingly and happily. Many carers in the community could not envisage a time when they would cease to look after the elderly person, and there was evidence of great sorrow on the part of some carers of people in residential care that they could no longer continue their caring role. This report is full of examples of very close caring relationships, based on years of love and affection, or illustrating the reciprocity which is the key element in so much care. The very elderly husband who explained his reasons for caring for his increasingly disabled wife – ‘I still enjoy looking after her. It’s called love...’ – was echoed by the daughter who said of her father – ‘He looked after me, and didn’t put me in an orphanage. It’s a chance to repay him, isn’t it?’

But not every relationship between carer and elderly person was so close and loving, even if it had started off that way, and there was plenty of evidence of carers at the end of their tether. Although the carers in the community appeared rather less generally stressed than the carers of people who had entered residential care said they had been when the elderly people were still in the community, there were many indications of strains and unhappiness, leading to tension in the family and in marriages. There was a disquieting incidence of carers having to give up work or change their working patterns, and resentment of lack of support from other members of the family.

The main complaints of carers centred round their loss of freedom and the necessity to plan their lives around the elderly people. Many of the ‘younger’ carers were in late middle age, and there was considerable resentment of the ‘millstones’ that elderly parents had become at a time when freedom through retirement or children leaving home had appeared just around the corner. There was no doubt at all that some relationships between elderly parents and their ageing children were less than harmonious, and were exacerbated by the demands
of the elderly people, some of whom had not become less ‘cantankerous’ as the years had gone by. Unresolved family tensions had certainly become more acute in many cases, and the woman who said, ‘I’ve never been able to do anything right for my mother...’ and the son who said, ‘Some elderly people can be real tyrants, real tigers... It’s a blessing when they go away...’ were by no means alone in their assessment of their lives and the effects of caring for their elderly relatives.

It should be remembered that our samples of elderly people were made up of relatively lucid people who were not suffering from mental infirmity. The strains on carers of elderly mentally frail people may well be much more acute than those found in many of the cases studied in this research. They have been well documented in research reports over the years (Levin, Sinclair and Gorbach 1983) and should not be overlooked.

What did the carers need? There has been much rhetoric in recent years about ‘caring for the carers’ and ‘supporting the supporters’, particularly as the ‘sound investment’ of maintaining their contribution has been recognised by governments. Everyone agrees now that carers need help, but the nature of that help has not always been agreed upon.

Perhaps one of the greatest problems has been the failure to acknowledge that carers do not constitute a homogeneous group, any more than elderly people themselves do, and that the range of needs of carers is as wide, if not wider, than the range of needs of elderly people. Probably of greatest importance is the fact that there is indeed what has been called a ‘hierarchy’ of carers, ranging from those who are prepared and able and ‘chosen’ to carry out the most intimate and arduous of caring tasks through to those whose claim to be ‘carers’ may be rather remote and tenuous, some of whom may only accept the role at a distance and unwillingly.

Given the wide range of potential and actual carers, however, certain generalisations can be made about the needs of carers. Successive research reports over the years have suggested that the greatest need of carers is not so much the provision of more services or support specifically for them but the provision of more services which actually provide care to the elderly people. There is a particular need for respite care, but there is also a considerable need for more home help or home care or other practical help for elderly people. One of the striking features of this research was the anxiety experienced by the carers of elderly people who were living alone. The need for respite in many of these cases was perhaps only secondary to their desire for more ongoing domiciliary support for the elderly people they were looking after at a distance. This was particularly marked among carers of elderly people who had entered residential care, but was also noticeable among many non-resident carers in the community.

Another important feature of this research was the identification of a relatively high proportion of elderly spouses caring for more disabled husbands or wives. Some of them were happy to do so, even if they felt they did not have enough practical services, but others, particularly the elderly wives, complained of enormous fatigue and lack of support. Some of the domestic situations of some
of these elderly couples appeared very precarious, and there is clearly a need for much closer identification and more sensitive monitoring of elderly carers who might appear to reject or not to need help.

Much has been made of the development of carers’ groups, in the wake of so much interest in self-help groups, which have been said to provide great support and mutual aid. It appears that groups of this kind might be more successful among carers looking after younger disabled people. Only one of the carers we interviewed had been to a carers’ group. There was little interest among the carers we interviewed in attending such groups, and evidence that the last thing in the world they wanted to do with such little free time as they had was to talk about elderly people. Social workers were more enthusiastic about carers’ groups, but disappointed in how easily they foundered if not continually supported by a professional. Perhaps they should have explored in greater detail what it was that carers wanted.

Essentially, carers of all types wanted good professional help and support, as well as help and support from relatives, if there were any. Their main need was respite of some kind, combined with practical help in the day-to-day care of the elderly people they were looking after. Information on services and benefits was thought to be essential, and there was undoubtedly a need for what one son called ‘A beginner’s guide to looking after your old mum...’ There was certainly a demand for some coordination of information, help and advice, and some carers felt they had no real idea of whom to call upon. The problem of initial access to services for the elderly people, combined with a strong suspicion that services were strictly rationed and only dealt out incrementally to those who shouted loudest, served to make relationships between some carers and professionals a matter of tiptoeing negotiation. There was not much evidence of an informed consumer movement among the carers.

Many of the carers felt very isolated, and, although most of them thought they had good support from professionals, nearly three-quarters of the carers thought they needed more help. Carers of elderly people who had entered residential care were less likely than carers in the community to say that they had had enough help from professionals, and more than a third of the carers of elderly people who had entered private homes complained about lack of professional support in the community. It should perhaps be emphasised that carers were not asking for a huge increase in services or support. Their requirements were, in fact, very modest in relation to their needs or those of the elderly people they were looking after.

Many social workers were uncertain or ambivalent about the question of who the client was and the relative claims of elderly people and their carers, and, although most of them said they would usually take the carers’ views and preferences into account, there was still no doubt that social workers sometimes found it difficult to make assessments of situations where carers were involved. This was especially true where elderly people had mental health problems and could not ‘speak for themselves’, but it was reflected time and again in the way...
in which social workers spoke about their methods of working in connection with the lucid elderly people who were the subject of this research.

There was often complete incompatibility between the needs and choices of the elderly people and the needs and choices of the carers. Getting the balance right was found very difficult. Some of the social workers felt very strongly that they should be the ‘advocates’ of the elderly people, but they ran into problems when they could not maintain that role, particularly when the carer was also elderly.

There was some evidence that the development of specialist social work teams for elderly people could engender great loyalty to elderly people themselves, in which the needs of the carers might not always appear as ‘legitimate’ as those of the elderly people. Some social workers found it difficult to deal with complex relationships between carers and elderly people, and it is clear that special skills are needed to help ensure that the quality of life of carers is not sacrificed to enhance, perhaps only temporarily, the quality of life of elderly people.

There can be no doubt that the majority of elderly people enter residential care only when the informal caring relationship in the community has broken down for some reason or another. It is therefore all the more important that every attempt should be made to help carers who wish to continue caring to do so. On the other hand, carers who can no longer care should be enabled to relinquish the caring role without experiencing unbearable guilt and recrimination. This report suggests that there is no easy solution to these complex problems, and that more resources should be devoted to training and supporting social workers and other front-line workers in dealing with matters which are by no means as simple as the slogan ‘caring for the carers’ implies.

The move to residential care
The question arises of whether bigger, better-designed, more flexible packages of care could have helped or might help to keep elderly people out of residential care. Four issues have to be examined closely: first, the extent to which any package of care can really maintain an elderly person with a number of disabilities and little or no informal care at home; secondly, the extent to which such intensive packages of care are feasible on a wide scale; thirdly, the extent to which increasing packages of care are in order when the informal caring relationship is under an intolerable strain; and fourthly, the extent to which elderly people themselves wish to remain in the community and not to enter residential care at any price.

The Kent Community Care Scheme and experience from a number of local authorities suggests that it is possible, given a well-organised, well-resourced service, to maintain very dependent people in the community with intensive, flexible packages of care. The question arises of how broadly these intensive packages can be spread and what the implications are for the majority of people
who are not in need of such intensive packages, given limited management resources, leaving aside the potential supply of service providers and finance.

Most social workers said they had only two or three people with intensive packages of care on their case-loads, and there was a general consensus that the provision of such packages was usually only a short-term measure because people in need of such intensive care often deteriorated quickly because they were so mentally or physically frail. There was, however, little doubt that social workers and domiciliary care organisers alike would have found it very difficult to maintain more than a tiny number of elderly people with intensive packages of care, given their other responsibilities and preferences.

One of the most important findings of this research was how small the packages of care were for the majority of elderly people interviewed, whether they were still in the community or had entered residential care. If resources are to be concentrated on those in most need, as indeed they appeared to be in these three areas, how are services to be developed to prevent entry to residential care by those who do not have such an intensive package? There was a strong probability in these three areas that the need was not so much for intensive packages of care but for a general increase in services at all levels to help prevent a deterioration in the home lives of the elderly people leading to a situation where residential care appeared to be the only solution.

It is possible that there has been too much concentration on ‘intensive’ packages of care, and that the real point of community care has been missed. Targeting those ‘most in need’ and providing services for them may, in fact, be easier than caring for those who are less obviously in need. The lessons from this research suggest that more preventative services for more people may perhaps be of greater overall value in keeping elderly people out of residential care than concentrating services on a very few. This may not be a fashionable view, but our findings indicate that much closer attention should be paid to it.

The third question, of the extent to which intensive packages of care are the answer when the informal caring relationship is at breaking point, poses more problems. The majority of elderly people in our residential sample could be said to have entered residential care when there was no further possibility of informal carers continuing to care in the community. Over a quarter of the elderly people, both in residential care and in the community, simply did not have an informal carer in any case, and a substantial minority did not any close relatives who might have taken on the role. Others had reached a point of complete breakdown in the caring relationship. Accounts differed between carers and elderly people, but a total breakdown had certainly occurred in around one fifth of the cases of elderly people we interviewed in residential care, and was a contributory factor in many other cases.

The elderly people who had entered residential care were rather less likely than those living in the community to have had a wide range of services at home, and, indeed, around 40 per cent had had very little help of any kind, either formal or informal, while a further 25 per cent had very little formal help. However, it should be added that in many cases, the question of additional community
services often appeared rather irrelevant by the time the decision to enter residential care was being taken. Only one-fifth of the elderly people interviewed in residential care thought they could have stayed at home with more help, and even fewer of their carers took this view.

The elderly people in residential care were usually very old, with nearly half of them being over 85. Many of them were in poor health. A quarter of them had entered the home from hospital and a further quarter had been in hospital in the previous twelve months. Around 40 per cent of the elderly people we interviewed in residential care had entered the home as a result of a crisis situation following a fall, fracture or acute illness which had precipitated the decision, while in another 25 per cent of cases there had been a general deterioration in health which had severely affected their ability to cope at home. Their carers, if they had any, were often simply unable to continue looking after them, even with considerable formal help, which was by no means always forthcoming.

There was undoubtedly pressure on some elderly people from carers to enter residential care. This was explicitly acknowledged by one in ten of the elderly people and confirmed by a higher proportion of the carers. In around 20 per cent of cases, there was clear pressure on elderly people to enter residential care even without a crisis or deterioration. It often appeared that the pressure had been sanctioned or ‘legitimised’ by professionals who had intervened to support the choice of the carers.

It is possible, in some cases, that earlier intervention or offers of help might have prevented admission to residential care, but, by the time the decision to go into a home had been taken, elderly people and carers alike usually felt that any alternatives were too little and too late or inappropriate.

The fourth question, on whether elderly people only considered residential care as a complete last resort, when they were ‘past caring’, as one man put it, was central to this study. We wanted to know whether there were any elderly people who made a ‘positive choice’ as far as residential care was concerned, and actually opted to enter residential care rather than continue to live in the community.

In general, although relatively few elderly people had felt themselves under pressure to enter residential care, and most felt they had some control over the decision to enter a home, the actual decision over which home to enter was usually taken by others. On the other hand, a substantial minority of our residential sample had made an active ‘positive choice’, and had usually entered private homes while they were still relatively fit and well, even if they were very elderly.

It must be asked whether the constant emphasis in recent years on the benefits of care in the community has not blinded elderly people, carers, policy-makers and professionals alike to the possibility that residential care may, in some cases, be a preferable option to living in increasingly difficult circumstances in the community. There was undoubtedly a strong measure of relief among many of the elderly people we interviewed, who had found residential care much more attractive than they had expected, valuing the security and company it offered. Some of them were old and tired and happy to be looked after, having lived on
their own for many years. For them, the decision to enter residential care might not have been a ‘positive’ choice, but it was not a negative choice. In many cases it had turned out to be a positive solution. There was also considerable relief among many of the carers we interviewed, whose increasing anxiety about the well-being of the elderly people they were looking after had begun to blight the lives of all concerned.

Those who entered residential care usually knew little about the homes they were entering unless they had been there for day care or short stay care. These were mostly local authority homes, since few of the elderly people had been to private homes for day care or short stay care. Written information was usually unheard of in local authority homes. It was more commonly available to elderly people in private homes, but often only after admission. Carers were more likely to have received written information, usually in the form of a list of registered private and voluntary homes supplied by the local authority, although some had sought a number of private home brochures and had shopped around a great deal.

Information from social workers and domiciliary care organisers about private homes was usually very limited. They were reluctant to offer information about the private sector, except the list of homes provided by the local authority registration officer, and knew little about the voluntary residential sector which was very limited in the three areas studied. There was much concern among social workers about the future funding of residential care and the fate of elderly people in the independent sector.

There can be no doubt that the majority of social workers and domiciliary care organisers still felt that residential care was a ‘last resort’, although some thought the boundaries of community care had been pushed too far. Heads of homes were often unhappy about the poor image that residential care had among so many elderly people – an image that was not helped by the lack of contact most of the elderly residents had had with residential homes before they entered them, as well as by negative reports and scandals on television. It does appear that the pendulum may have swung too far in the direction of community care at any cost, and that more attention should be paid, not only to brushing up the image of residential care, but also to making it, in reality, a positive rather than a negative choice for elderly people.

Choice and participation

The issue of consumer choice has been in the forefront of Government policy on community care. The language of the market-place, with its emphasis on a range of options, ‘sound investments’, ‘needs-led’ services, promoting choice as well as independence, has been used in much of the literature on policy development to encourage the idea that health and social care services should be tuned to the demands of informed consumers. The implication has been that, given the information, ‘users’ of services will be able to select the ‘best buy’ from a range of possibilities, all of which are available to them. They should be able to stipulate
what they want, when they want it, how they want it mixed with other services, who will deliver it and how much they receive.

The reality, as illustrated in this report, is that few, if any, elderly people are able to operate in such a way. Most of those interviewed had no choice in what went into their package of services and some did not have anything in their package at all. They certainly had no choice about the time at which the service was delivered, the person who delivered it, or how much they received. The ‘mix’ of services was very limited, and very few elderly people had more than two or three services in their package. Rationing was the order of the day. Services were generally acknowledged to be in very short supply, access to them was usually controlled by professional gate-keepers and, in the absence of considerable financial resources on the part of the consumer, they were not readily available in the form and at the time they were needed.

The question of finance is an important issue in discussing consumer choice. It was generally agreed by elderly people, carers and professionals that private community care, particularly if it involved anything more than a cleaning service, was very expensive. The notion of private domiciliary care was simply dismissed by many of the elderly people, and, even when they were asked to consider the advantages of such care, many carers and elderly people were sceptical of the quality as well as the accountability of those providing private care, which was in short supply in these areas in any case.

But if private domiciliary care was thought to be out of the question for most of those interviewed, who included a substantial minority of elderly people with reasonable incomes or carers who were prepared to pay for care, what was the alternative? There was a general acceptance that elderly people and carers had to put up with a rationing of scarce resources. The idea of exercising choice in such circumstances was reduced to attempting to get in on the network, learning as you went along and presenting a good case to the gatekeepers.

Choice and participation go together. How did the elderly people participate in decisions about their services if they had such little real choice? Social workers described how they tried to ensure the participation of the elderly people in decisions about their care, some of them with more commitment than others. They clearly entered the discussion with a knowledge of what was likely to be available. Their assessment of what was needed was dominated by what could be provided, and they tailored the amount of information they gave on possible options to this assessment. An elderly person or a carer might express desires, but many social workers and domiciliary care organisers had developed skills which helped them to dampen any unrealistic expectations.

Positive choice among consumers was not really encouraged, and, in some cases, was treated as undesirable. Certainly any idea that elderly people might exercise choice over which day they might like to go to the scarce resource of a day centre, or that meals on wheels might come at their usual dinner-time, or that a home help should come at a certain time, was usually discouraged very firmly, even by the most sensitive and considerate social workers. They often regretted the fact that this was how they felt obliged to operate, but saw little alternative.
Although most social workers and domiciliary care organisers were aware that elderly people should participate actively in the decisions made about their services, they found this difficult to facilitate. There were problems in establishing relationships between consumers, care managers and service providers, based on frank and honest discussions of what was possible in the provision of care. Care workers were clearly worried about creating demand for services which they could not guarantee to deliver.

Participation, in effect, usually meant acceptance of what was offered – or not offered. Consumer choice, when it was exercised by elderly people, usually took the form of refusing services that were offered, or discontinuing them if they were found unsatisfactory. The general picture painted was that any participation and choice of the elderly people in the community in the services they received was essentially passive or negative. There was absolutely no sign of an active consumer movement among the elderly people interviewed either. They kept their heads down and tried to keep out of trouble. Complaining, as we shall see, was the last resort, and very much feared by some, in case they were ‘crossed off the list’.

Although, as we have seen, most elderly people felt they had had some control over the decision to enter residential care, the majority of the elderly people had left the actual choice of home to others. With local authority homes, there was usually no choice available, since it depended to a large extent on bed availability and locality. With private homes, the choice was usually made by carers, some of whom had shopped around and visited a number of homes, something which was felt to be beyond the capabilities of most elderly people considering residential care.

The fact was that most of the elderly people entering residential care in our sample were very old and usually in a fairly poor physical condition. They simply did not feel themselves up to behaving as active consumers, and, in most cases, clearly felt happy to leave choice and arrangements to others. The exceptions were the substantial minority of elderly people who had made an active decision to enter residential care because they were lonely or afraid or tired of continuing to live in the community. They had almost invariably entered private homes, for which there had been no assessment, other than a financial assessment if they needed income support. They had often shopped around on their own account, and had made what could be called a ‘positive choice’. There can be little doubt that many, if not all, of them would not have been assessed at the moment as needing local authority residential care. It seems clear that one of the effects of the introduction of assessment for all people seeking residential care and requiring a contribution from public funds, as a result of the NHS and Community Care Act 1990, will be a reduction in the numbers and proportion of elderly people actually exercising choice in their entry to residential care. Just feeling tired and lonely and unable to cope at home will no longer be enough to secure a place in residential care, even if you are 85. Choice, of course, will remain for those with their own financial resources.
Satisfaction and complaints

Reported levels of satisfaction with the domiciliary and residential care services received by elderly people were usually fairly high among the elderly people and carers, although there was a significant minority of dissatisfied customers and strong indications that elderly people and their carers found there were insufficient domiciliary services, particularly of a practical nature.

This report discusses in detail some of the dangers in relying too heavily on standard measurements of ‘satisfaction’ when assessing the quality of health and social care services. Research has indicated that reported satisfaction levels with health and social care services are almost always misleadingly high, since people are often reluctant to appear to criticise services supplied by ‘dedicated’ professionals or poorly paid care staff, which are ‘free’ at the point of delivery, and which are seen to be in short supply and needed by more deserving cases. There is also clearly a fear that any criticism might be construed as a complaint, the result of which might be the withdrawal of a service for which there is no available substitute.

These observations have important implications for authorities who might be designing instruments to assess quality and to measure consumer opinion. Straightforward satisfaction scales, which may be suitable for market research on consumer goods, are usually inappropriate for research on users’ views of health and social services, other than as a very crude measure. The design of appropriate measures, which can be used at a local level by people who are not necessarily trained or skilled in research techniques, is a top priority for health and local authorities alike. It cannot be stressed too strongly that a completely inaccurate picture of satisfaction with services may be presented, leading to inertia in planning and to the provision of inappropriate services which may not meet the real needs of either users or carers.

We explored the question of complaining in some depth, since it is clearly an important tool of the active consumer. Many elderly people were reluctant to complain about services, either in the community or in residential care. Women were more worried about complaining than men, and those living alone were more worried than those living with others. A substantial number of elderly people in the community were anxious about complaining in case the services were taken away, or in case they upset the person providing the services or they were thought to be ‘trouble-makers’. Elderly people were afraid of being ‘crossed off the list’ and thought they should ‘best keep in the good books’ of those in charge. The perceived power of the service providers came through very clearly in answer to questions about complaining, and the lack of power and control felt by many elderly people in the community was summarised by one elderly woman – ‘When you get old, people don’t think of you as a whole person the same as them...’

The carers of elderly people in the community were less reluctant to complain, but many still felt that much more negotiation was needed in complaining about scarce resources supplied by overworked and underpaid care workers than in complaining about any other kind of service or consumer good.
There was a generalised feeling that such services were not supplied as a ‘right’, and that different standards had to be applied to the provision of such services.

The issues surrounding the amount and times of service delivery, not to mention the people actually delivering the service, which were so important in the discussion of choice, were equally important in the discussion of complaints. Most carers, as well as the elderly people, felt that their absence of choice severely limited the extent to which they felt able to complain. There was no doubt that complaining was usually limited to situations where there was a blatant breakdown in the quality of the service. Complaints about quantity were thought to fall on deaf ears, and minor complaints about quality were thought to be counter-productive.

The same was true of elderly people in residential care and their informal carers. Complainers were thought not to be regarded in a favourable light, and elderly people were very careful about the way in which they treated the staff. Again, complaining was seen as something which had to be negotiated very carefully. Elderly people were afraid that they might be thought of as nuisances, and carers were afraid of the repercussions their complaints might have on the treatment of the elderly people by the staff.

It was particularly interesting that elderly people in private homes, and their carers, were as worried about complaining as those in local authority homes. There was certainly no indication of active consumers feeling that ‘money talks’. Paying for services of this kind was not seen as giving the consumer an advantage over those who were in local authority homes. Some elderly people, or their carers, had spoken with their feet and had moved homes, but this solution was considered only in extreme circumstances, and there was every indication that most elderly people would ‘grin and bear it’ rather than face the inevitable upheaval and upset of a change of residential home. Some elderly people were as worried about complaining to their carers as about complaining to the heads of homes.

There was little doubt that elderly people and their carers felt constrained in their assessment of the services by their recognition that resources were limited and services were rationed. One of the overwhelming impressions given in this research, particularly by the elderly people themselves, was that expectations were low. The comment by an elderly woman on her limited package of care – ‘I’m satisfied. I don’t expect a lot in life...’ – was echoed time and again by elderly people, both in the community and in residential care.

Carers might have had higher expectations, but, like the elderly people, often felt themselves outflanked by lack of information, lack of available services and lack of alternatives offered by the professional workers with whom they came in contact. Some carers were becoming increasingly frustrated, and our questions about choice sometimes brought very sharp replies, as this son indicated – ‘If we don’t know enough about services, she hasn’t been able to make a choice, because she hasn’t had the information to do so...’ Many carers were dissatisfied with what they saw as a ‘conspiracy of silence’, in which services had to be dragged out of reluctant professionals and service providers.
Resource and management implications of consumer choice

There are undoubtedly problems in allowing people choice. There is an undeniable contradiction in much of the recent policy literature, with its emphasis on choice for the user and carer on the one hand and care management and assessment on the other hand. There must be a questionmark over whether real choice can be exercised when someone else is assessing your needs and then ‘managing’ your care. The two concepts appear to be completely at odds with one another.

If an elderly person wants five hours of home care a day, or even only another hour a week, but is not assessed as being in need of it, then what happens to the notion of choice? How is the assessment being made? The elderly person might actually ‘need’ that care, by their own standards, and possibly by any objective standards, but the reality of the situation is that such care is not available because of resource constraints. The notion of choice comes up against the reality of availability. Resources have to be rationed and prioritised, and individual choice does not really come into it.

Similarly, why should an elderly person’s care be ‘managed’? The implication is not only that the elderly person is incapable of managing it alone but also that resources have to be managed to allow a fair distribution of available care. Perhaps the elderly person will be allowed more say than at present in who and how and what he or she is offered, but ultimately the question of individual choice may become lost in the reality of what is available and what the competing claims are. There is a clear tension between managing the package to provide ‘seamless’ care for the individual and achieving the best use of available resources at the least cost for most people.

Who is to assess that an elderly person needs or does not need residential care? Who is to restrict that choice if an elderly person chooses to go into residential care, and what are the criteria to be used? What will happen if the carer cannot continue to care in the community but the elderly person is not assessed as ‘needing’ residential care? There are clearly potential conflicts between individual choices and the assessment of the service providers. To what extent can individual choice prevail?

There is also a conflict of a rather different kind between individual and collective responsibility. On the one hand, the individual is encouraged to operate as an informed consumer and to exercise choice, but to do this effectively he or she needs resources, information, and access to the supply of the goods or services needed. There has been plenty of evidence in this report that elderly people and their carers do not have the resources, the information, or the access to services, while considerable doubts have been expressed about the extent of the supply of the services. But how far can informed consumers, with sharp elbows, gain access to services which are in short supply if they have the money. And what are the implications of that for collective responsibility?

Collective responsibility assumes that society should ensure that elderly people have care services. But there is a possibility that these services supplied by ‘society’ may become concentrated on those assessed as being in greatest need.
to such an extent that the majority of frail elderly people are left out altogether, neither having the personal resources to buy care nor the acute needs which would qualify them for ‘intensive’ packages of care.

Other issues around the question of choice must be addressed when looking at services for elderly people. Very often, the needs of elderly people appear to be completely practical, ranging from functional tasks such as cleaning, shopping, cooking and so on, through to more personal and intimate tasks requiring help with washing, bathing, dressing, eating and so on. ‘Assessing’ the needs of elderly people for these tasks can be interpreted as a purely practical operation, asking such questions as ‘Can they do it themselves?’ ‘Who else could do it for them if we don’t supply the service?’ and ‘Do they want someone to do it for them?’ Or it can involve a much more ‘holistic’ approach, exploring family relationships, the elderly person’s psychological needs, their personal history and so on. This approach is particularly important when informal carers are closely involved, especially when there may be potential conflicts between the needs of the elderly people and the needs of the carers.

These issues were central to the discussion with social workers and domiciliary care organisers about the future role of social work with elderly people, but they are also central to discussions of choice. If the needs of elderly people are seen primarily as practical, to the exclusion of everything else, there is a clear danger that the very real emotional needs of older people are never recognised or are completely residualised. Much imaginative work in the last twenty years which has attempted to raise the profile of elderly people among health and social care workers would be lost, and elderly people themselves would undoubtedly suffer.

These questions are of fundamental importance to the future development of community care and the way in which services for elderly people are managed in future. They raise basic issues about the future of social work with elderly people, whether anyone other than a social worker should work with elderly people, and, if so, whether they can combine the roles of key workers and care managers and whether and how they can ‘assess’ elderly people. They also raise issues about the future of social work as a profession.

The future organisation of community care

This research was taking place at a time of extensive debate about the future organisation of community care. We asked the social workers, team leaders and domiciliary care organisers a series of questions about social work with elderly people and how they felt the proposals contained in the Griffiths report would affect both their role and the provision of services for elderly people. The Griffiths proposals have largely been adopted as Government policy, and countless words have rained down on care workers since we asked them these questions. Nevertheless, their views and expectations are of crucial importance to the development of community care policy. Without the active cooperation and endorsement of fieldworkers, no policy can really be put into practice.
Social work with elderly people

There was general support for specialist social workers for elderly people, mainly in order to raise the profile of work with elderly people. Many social workers felt they could only provide inadequate emotional support for elderly people and their carers at present because of the practical demands on their time in putting together packages of care, ensuring their delivery and dealing with crises. And yet social workers placed a premium on their counselling skills which they did not want to lose. In the northern area, social workers rarely or never worked with elderly people at all, and their working lives were dominated by child care issues and problems. Domiciliary care organisers in that area felt there was a limit to what they could do to meet either the emotional or more general practical needs or elderly people because of the complex demands on their time of running a service as well as assessing for care and juggling with scarce resources.

There is clearly a danger, demonstrated in the experience of the social workers in the northern area, that generic neighbourhood teams can lead to a situation where social work with elderly people tends to get squeezed out. On the one hand, social workers may become completely absorbed in child care work, and on the other hand, other practitioners, such as domiciliary care organisers, are put in a position both of assessing the needs of large numbers of elderly people requiring practical services and of managing the delivery and maintenance of these services. The extent to which a ‘person-centred’ approach to social work with elderly people is possible under such circumstances is questionable.

Multidisciplinary collaboration

Multidisciplinary working with other care professionals and agencies was still seen to be in its infancy and very much dependent on personal contacts. There was evidence of a considerable lack of knowledge of health services received by social services clients, particularly community nursing services. A disquieting number of social workers had no idea which of their clients were being visited by district nurses or bath nurses, and many seemed to think it of little relevance to their own work with elderly people. There were, of course, shining exceptions, but much appeared to depend, as we found so often in this study, on proximity, sharing of premises or personal relationships built up over years of acquaintance.

Relationships and links between social workers and GPs were especially poor, with some notable exceptions. There were frequent misunderstandings over respective roles, lack of trust and considerable suspicion. Some GPs were seen as much too eager to bounce elderly people into residential care and to be reluctant to consult social workers on decisions of a far-reaching nature of this kind, or indeed of any kind.

We concluded that if social workers are to act as keyworkers or care managers and there are to be joint assessment procedures, there is an urgent need for the development of structures and practices which facilitate close liaison with colleagues in other professions, particularly those in community nursing and
primary health care teams. This conclusion is not new, but our findings reinforced that there is a long way to go before the links and structures so necessary for the implementation of the community care legislation are in place. We were looking at areas where there was much good practice and a commitment at the highest levels in the social services departments to fostering the introduction of imaginative ways of collaborative working and the development of community care. Not all areas have such well-supported staff or such enlightened management.

**Areas for concern among professionals**

There were considerable concerns among social workers, team leaders and domiciliary care organisers about future developments in the care of elderly people. The first concern centred round the organisation of the new system. There was confusion over the precise meaning of such terms as care management and case management, as well as the respective roles of care managers and key workers. There were questionmarks over who would manage or hold the budget, who would organise assessments, and which professionals would act as case managers (as they were termed in the Griffiths report). This led to concerns over caseloads, training and increased decentralisation. The purchaser/provider split was not understood at all, and social workers and domiciliary care organisers alike were not clear about which side of the divide they might find themselves on. Even team leaders, some of whom were keen on the idea of holding budgets and managing resources to a much greater extent than at present, were confused about the implications of a move to care management. It is to be hoped that the Policy Guidance issued by the Department of Health has made things clearer for them.

The second main concern centred round the future of social work with elderly people. There were very real anxieties that social work skills would become devalued and would be submerged in the demands of administration, budgeting and management of the delivery of services. Many workers were concerned that they might lose contact with elderly people and would no longer be able to provide the counselling which they considered so essential, for example in connection with bereavement and the transition to residential care. Many stressed that they had not entered social work to become managers or administrators or ‘pen-pushers’. Most did not want to manage or employ staff or to ‘enable’ and recruit private or voluntary help to augment packages of care, and certainly did not want to lose the fairly wide range of work they had at present to concentrate only on those in greatest need. This marked reluctance to get involved in issues divorced from traditional social work skills have far-reaching implications for the introduction of care management. If social workers are unhappy about taking on this role, who is going to perform this function? How can social workers be persuaded that their skills will not be lost in a role they do not wish to take on?

The third area for concern was centred around ‘conflicts’ which social workers saw arising from the new policies. They were worried about managing
budgets and assessing individual needs, whether these functions were combined in one person or in a number of individuals. They were particularly concerned that their role of prioritising and rationing resources would become explicit. They knew that this was what they did at the moment, but felt that they could disguise the extent to which they did it by rationing information and blaming the inadequacy of provision on the service providers. They feared that their relationships with elderly people and carers would be affected by the recognition that they were actually making an assessment and ensuring the delivery, or non-delivery, of services in a much more formal way than had hitherto been the case. They were concerned that they would be competing with colleagues for scarce resources in a much more open way than at present, and they did not welcome the idea of the conflict which this could potentially cause.

And finally, they were particularly concerned about purchasing services without being able to control the quality of those services. Many could see a situation in which much of their time would be taken up in managing, inspecting and regulating domiciliary services supplied by individuals or organisations in the private or voluntary sector to their elderly clients. They were not keen on this type of responsibility and many stressed that this was not why they had entered social work. These comments underline the need for local authorities to develop regulatory or quality assurance mechanisms to maintain standards of community and domiciliary care supplied by the independent sector.

Many of the social workers, team leaders and domiciliary care organisers were struggling with the move from a service-led to a needs-led culture. Most of them felt they had been trying to satisfy people’s needs for years, and felt resentful of the idea that a brave new world of sensitive caring services was about to be opened up to elderly people and their carers, replacing the work to which they had dedicated their lives. They wanted to offer a person-centred approach to their delivery of care, but this seemed to slip from their grasp as they recognised the overwhelming pressure to ration and prioritise services.

There was general scepticism that the introduction of the community care legislation would solve the problem inherent in these three areas, as well as in many others, of a limited range of domiciliary and community services from the public sector, and little sign of an emerging independent sector to supplement and complement the statutory services. Indeed, there was every indication that voluntary services were contracting, for a variety of reasons. It is likely that the move towards contracts and more formal service agreements, combined with a sharp cut in local authority funding of voluntary organisations, can only have accelerated this decline. Similarly, there was little sign of burgeoning private domiciliary services, except at the more expensive end of the spectrum in some districts, and there were considerable doubts about the ability of social workers or care managers to recruit local paid help on anything other than a very minor scale and certainly doubts about how they would exercise quality control.
Conclusions

It remains to be seen what the changes brought about by the introduction of care management and assessment will bring. The evidence presented in this report suggests that care managers and key workers are going to have to dust off their combat gear if they are going to satisfy the needs of elderly people and the demands of their increasingly worried carers. But is this the role that front-line workers should have to play? Should they be the only ones in the firing-line? There is every argument that they should have a right to look for a lead from their employers to get the organisation right and to offer them the back-up they are going to need. Social workers and domiciliary care organisers are not the only ones who do not understand the implications of the purchaser/provider split or what care management and assessment will really mean to them and the users of the services. There are profound organisational issues which need to be resolved before the policy can be implemented.

But it is not only a question of getting the organisation right. If the aim is really to provide a ‘needs-led’ service, which is going to be well publicised, with well-designed and comprehensive information available on the full range of services which might be available, combined with a discussion of the range of options, proper assessment and sophisticated care management, there can be little doubt that fundamental changes are needed, not only in the way social workers and other key workers operate at the moment, but also in the amount of resources put into providing components of the ‘packages of care’, so central to the future of community care as envisaged by the policy-makers. Explicit information may encourage explicit requests from potential consumers and their carers, who might not understand why their choice and needs cannot be satisfied.

There is a danger that the rhetoric has overtaken the reality. The ideal might be a needs-led service, but the reality is that a needs-led service is operating within an organisational framework where resources govern availability. Of course, social workers, care managers and others in health and local authorities can attempt to ‘enable’ the independent sector, and of course they can try to design more flexible packages of care, using the given resources in a more imaginative way. But ultimately, real choice assumes that there is a wide range of available goods and services at a price which can be afforded and which are accessible to anyone who wants them. Services for elderly people do not fall into that category.

There is also a danger that the enthusiasm for community care has become overblown. It should be recognised that there is a very real need for good quality residential care for very elderly people with no informal caring networks, for those who are mentally and physically frail, and perhaps for others who wish to make a ‘positive choice’ to enter residential care because they feel they can no longer cope in the community, even with a full complement of community services.

One of the major problems in the future of community care is how to ensure consumer choice at a time of scarce resources. The emphasis on consumer choice
in Government statements is at odds with a resource-constrained supply of care with access to it controlled by ‘assessment’ and continuing participation in it controlled by ‘care management’. The challenge of the future is how local authorities and others will tackle the problem of targeting those in most need while attempting to satisfy the needs of those users and carers who are not thought to be in greatest need. An expansion of user involvement, participation and choice is unlikely if services cannot be provided to meet the expectations raised by an open discussion of possible services. The role of social workers and others in attempting to implement a ‘needs-led’ services instead of a ‘service-led’ service in the absence of an increase in resources should be examined.