

**STRANGERS IN THE HOUSE: THE IMPACT OF DOMICILIARY CARE  
FOR OLDER PEOPLE**

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## **Abstract**

This thesis critically examines the operation of domiciliary care for older people, applying a realist evaluation framework to the open system of provision and receipt of care in home settings. It thereby scrutinises conditions that enable or constrain good quality care in the home, from the perspectives of key agents within an inner city Local Authority Social Services Department. The provision of domiciliary care is placed within its historical context, from the period following implementation of care management to current models of personalisation and citizenship.

A multi-method case study approach is adopted to analyse qualitative and quantitative sources of data from semi-structured individual interviews, group interviews and content analysis of written and electronic case recording. Older people (n=24) are interviewed for their views of receiving services from the Local Authority, managers of domiciliary care agencies (n=10) to provide their perspectives on the local market contexts, and the three locality care manager staff teams on their roles as assessors and commissioners of services. Drawing on models of professional discretion, distinct practice contexts across the constituent care management locality teams and associated provider agencies are compared. From this, mechanisms leading to discrepancies between policy production and practice implementation are proposed.

To conclude, the thesis critically appraises interactions between negotiation and exercise of control and choice by the core triad of older people using domiciliary services, care management staff, and provider agencies. Methodological issues of empirical research on routine delivery of services are examined, tracing development from effectiveness paradigms and forging a synthesis between empirical welfare service evaluation and the interpretation of interlocking mechanisms in the complex construction of care services in the home.

*Keywords:* Older people; community care; domiciliary care; realist evaluation

## **Declaration Of Authorship**

I, Michele Raithby, hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

Signed: \_\_\_\_\_

Date: \_\_2/11/2015\_\_\_\_\_

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## **List Of Abbreviations**

ADASS	Association of Directors of Social Services
CCETSW	Central Council for Education and Training in Social Work
CCW	Care Council for Wales
CM	Care Manager
CSCI	Commission for Social Care Inspection
CSDPA 1970	Chronically Sick & Disabled Persons Act 1970
CQC	Care Quality Commission
ECIS	Pseudonym for Social Services Information database
EMI	Elderly Mentally Infirm
ESRC	Economic & Social Research Council
GP	General Practitioner
DSO	Direct Service Organisation
GMS	Geriatric Morale Scale
GSCC	General Social Care Council
HCPC	Health & Care Professions Council
LDS	Lambeth Disability Schedule
MSQ	Mental Status Questionnaire
NHSCCA 1990	NHS & Community Care Act 1990
NSF	National Service Framework
OT	Occupational Therapist
PI	Performance Indicator
SSI	Social Services Inspectorate
SSD	Social Services Department
STG	Special Transitional Grant
UKHCA	United Kingdom Home Care Association
UES	User Experience Survey
WAG	Welsh Assembly Government

## **Chapter 1**

### **The Problem with Domiciliary Care: Rationale and Context for the Research**

#### **Introduction**

This thesis explores how care in the home for older people is assessed for, commissioned, delivered and received from the perspectives of three key participants; care managers as assessors and commissioners of services, home care agencies as the providers, and older people themselves as recipients of these services. This thesis thereby contributes to current debates on the continuing relevance of domiciliary care models, and examines what may be the conditions that enable or constrain good quality home care from a synoptic perspective. This is operationalised through an empirical case study in one inner city local authority, pseudonymised as Parkside.

In this chapter, I first address the rationale, focus and context of the research, and why the provision of domiciliary care for older people remains problematic. I go on to discuss how the research was commissioned, and the organisational and demographic background to Parkside Social Services Department (SSD) both as the site of the case study, and as joint commissioners of the thesis. Next, I discuss the ontological and epistemological frameworks for the case study, leading to the research question and argument for the distinctive contribution of the research and continuing relevance. Finally, I provide a preview of the chapter structure of the thesis.

## **The problem(s) with Domiciliary Care, and their continued importance**

The focus of this thesis is the operation and impact of domiciliary care in a case study of service provision for older people in Parkside, and the implications for social workers and providers. Before discussing how the research was commissioned, and the characteristics of Parkside, I will outline why home care was, and remains, a crucial but often fragile area of care.

Domiciliary<sup>1</sup> (or 'home') care is a deceptively simple model of provision, yet appears freighted with intractable difficulties in delivering a quality service. The interactions of personal care within domestic spaces occur mainly in private, are often privatised commercially, and are predominantly unobserved. Nevertheless, despite these difficulties, care in the home continues to be more than a commodified conveyance of goods. At its best, it is a valued service that makes a significant difference to older peoples' lives, as seen in numerous studies, across the devolved nations of the United Kingdom, including the Commission for Social Care Inspection (CSCI, 2006) and its successor in England, the Care Quality Commission (CQC, 2013); Northern Ireland Audit Office (2007), Office of the Older People's Commissioner for Wales (2012) and the Care Inspectorate in Scotland (Care Inspectorate, 2014). However, despite evidence of positive impacts, all of these reports are also equivocal, highlighting areas of unsatisfactory quality in domiciliary care. This has shown stubborn persistence, despite policy rhetoric of person-centred care, from the White Paper *Caring for People* (DH, 1989) underpinning the implementation of community care in the United Kingdom under the NHS & Community care Act 1990 (henceforth abbreviated to NHSCCA

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<sup>1</sup> Domiciliary' and 'home' care are used interchangeably in the literature. Domiciliary

1990), to the more recent incarnation within personalisation in England (Social Care Institute for Excellence (SCIE), 2010), culminating in the Care Act 2014. Nevertheless, a continuing crisis is indicated by the Equality and Human Rights Commission (EHRC) Inquiry into the home care of older people, which frames domiciliary care as a human rights issue (EHRC, 2011:7), and uncovers:

(...) serious, systemic threats to the basic human rights of older people who are getting home care services.

These findings suggest embedded and recalcitrant difficulties, indicating an experience that can be degrading for some recipients. The EHRC in particular highlighted areas of physical and financial abuse, neglect of personal care, lack of attention to autonomy, choice and diverse needs, and an inflexibility in services that did not address social participation. This report led to the EHRC publishing further guidance on human rights for home care commissioners (EHRC, 2013), emphasising local authorities' need to take into account their 'positive obligations' to actively promote and protect the rights in the European Convention on Human Rights incorporated into the Human Rights Act 1998.

The later CQC (2014) regulatory report into home care inspections in England identified areas of good and improving practice, with 74% of services inspected meeting all five standards measured. In particular, written information on services, involvement of relatives and carers, encouragement of the expression of views on services, and the personal qualities of kindness, friendliness, gentleness and respect found in care staff were highlighted as characteristics of good care. However, it also repeated many of the concerns found in earlier reports, such as missed calls, lack of staff knowledge and skill, inadequate assessment of need, lack of detailed care plans including



choices, needs and preferences. The state of the workforce in home care has been a source of concern for decades. Within the space of a year after the CQC report, the Labour Party (in opposition under the leadership of Ed Miliband) commissioned a policy review on working conditions in the care sector, finding care workers to be '(...) undervalued, under-paid and undertrained' (Kingsmill, 2014:3), with increasing use of zero-hours contracts and non-payment of travel time leading to workers earning below the minimum wage. Eleven months later, the report of the Burstow Commission on the future of the home care workforce (Koehler, 2014) also identified responsibilities for both commissioners and providers of services that would result in a living wage for care workers and a move towards outcomes-focussed commissioning that would avoid services based on tasks and restricted time slots. Although such evaluations are not lacking in the United Kingdom and in Europe overall (World Health Organisation (WHO), 2008); in Norway (Vabø, 2012); in Italy (Gori, 2012); and in France (Le Bihan, 2012), home care itself is an under-theorised area (Ceci, 2012). In other words, it is recognisable from repeated evaluations and satisfaction surveys what the end products of 'good' and 'poor' care look like. However, how to constitute good care in practice from the multiple dimensions of the micro-interactions that take place within the home to the organisational issues of funding, assessment, commissioning, and provision are less clear.

### **How the research was commissioned**

Contextual information on how the research was commissioned is important for an understanding of its initial framing. I was awarded one of four ESRC CASE collaborative studentships between Royal Holloway University of London as the academic partner and Parkside, an English inner city local authority. This continued an established working relationship between the two agencies. Within such awards,

originating in industrial contexts, there was an expectation of a research partnership between the academic institution and the local authority. In return for dissemination of findings, permission was facilitated for access to both staff and service user details. The initial parameters of the CASE studentship were to investigate the effectiveness of Parkside SSD's delivery of community care services to adult users. Parkside were concerned with issues of equity of service delivery for its service users and carers. At the time of data collection, Parkside SSD organised its adult social care staff into Assessment & Care Management Teams, located geographically in three teams, consisting of social workers (qualified and unqualified<sup>2</sup>), and Occupational Therapists acting as care managers. These three locality teams, as they were known, provided the primary sites for fieldwork and data collection, and will be referred to as North, South and West locality teams throughout the thesis. There were concerns among SSD senior managers arising from earlier monitoring exercises undertaken internally about efficiency and equity of practices across these three locality-based teams. Thus there was a top-down quality control agenda from senior management that drove the studentship. As part of the collaborative arrangements, there was also an expectation of data-driven empirical work that would inform decision-making within the local authority social services. The welfare of service users was the principal driver, though the demands of external performance audit also assumed high significance, particularly in the pressure to produce findings in as short a timeframe as possible. Consequently, the original impetus from Parkside was for reported empirical findings, and academic concerns such as location within a theoretical framework, were not their priority. Similarly, the longer timeframe for

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<sup>2</sup> The period of fieldwork in Parkside preceded the Care Standards Act 2000, and 'social worker' being designated a protected title reserved for qualified social work staff.

a PhD thesis was not easily compatible with the 'quick results' impetus from the authority. An expectation of the studentship was to maintain a visible profile within Parkside and other allied agencies, and produce outputs in terms of reports from commissioned projects for staff, users and other agencies. In return, I received facilities and privileged access to records and data on services and recipients. This had implications for my role as an independent researcher, as being both within and external to the organisation. These issues will be discussed further in Chapter 3, concerning the methodological approach.

### **Political moment of the research: Back to the future.**

The main sequence of data collection in Parkside was conducted between 1996 and 1998, though placement within the authority and the process of familiarisation began the year before. The thesis therefore adopts a long view, taking its starting point as the period within five years of the implementation of the NHSCCA 1990. Legislation, policy directions and financial climates have, unsurprisingly, changed considerably since that time. The passing of devolution legislation in 1998 has also facilitated divergence in policy directions between the constituent nations of the United Kingdom. Nevertheless, it will be argued throughout this thesis that the intervening period has been an opportunity to reflect on the system of care management that was introduced as a universal service from April 1993, and which has now come to the end of its lifecycle with the introduction of principles of personalisation, manifested in different forms for adult care under the Care Act 2014 in England, and in the citizen-directed support approach taken in Wales under the Social Services and Well-being (Wales) Act 2014. The data collection is therefore a snapshot in time of the early days of the development of the mixed economy of care, which will be explored further in Chapter 2. Nevertheless, the thesis retains relevance for current policy and

practice in the field of community care and older people, where frontline practices continue to be exercised by performance-driven imperatives, resource restrictions and the dilemmas of professional discretion within multidisciplinary settings. In spite of key changes to policy and practice since the period of fieldwork that could potentially devalue the data, I argue that a social worker, domiciliary care provider or older person reading the analysis today would recognise the practice examples and analysis put forward in the thesis. To address these issues of currency, the subsequent chapters include and examine continuities and discontinuities in policy and practice since data collection.

### **Narrowing the focus to older people**

The original CASE studentship partners' original conception of the research topic had been to cover all adult services in Parkside, including learning disability and physical disability, but excluding mental health (an area that was investigated separately via another CASE studentship). After the studentship commenced, it was acknowledged that this was an unrealistic target for a single researcher, as this would have encompassed separate organisational teams with different approaches and philosophies. The scope of the project was therefore narrowed to the single user group of older people, operationally defined by Parkside SSD as aged 65 years or over. Choosing older service users as the study population was congruent with my own professional and research interests as a qualified social worker with specialisms in working with older people, and regulation and inspection I could at least be prepared for some of the practical obstacles to be tackled in contacting and communicating with older people, and had practice experience of the 'emotional hard labour' that could be involved (Hey, 1999:105). The narrowed focus was also useful for Parkside, as this group of actual and potential

service users made up about 15.5% of Parkside's population, and were consumers of a major part of Social Services resources. The expenditure identified for direct services to older people for 1994/1995 was around £25 million, representing nearly 65% of the total Social Services expenditure on Adult Care, according to the local authority's Community Care Plan of the time (Parkside, 1995). As the research focus was 'community care services' for older people, these were primarily defined as those received by older people in their own homes, rather than in residential settings. These could include a range of services such as day centres, meals at home, personal care and domestic services, received as part of a care-managed 'package'.

To counteract some of the exclusion of older people from the research process, a participatory approach (Dockery, 2000) would have been desirable. However, at the time of the research, there were no user-led advocacy groups extant in Parkside. Neither was there any user involvement on its Joint Planning Committee, the primary policy body. A reason given by a senior manager in informal discussion for this exclusion from decision-making was that sensitive decisions might be taken at the forum. Thus, the model of user participation in shaping the direction of the research utilised by Barnes, for example in collaboration with Age UK on well-being and participation (Ward, Barnes, Gahagan, 2013), remained an unrealisable aspiration.

### **Integration into Parkside: Observing practice realities**

The first three months of 1995 constituted an introductory period for familiarisation with the structure, services, policies and practices in Parkside. As part of the collaborative arrangements, I was afforded free access to internal meetings, permission to contact individual locality Assessment & Care Management staff teams, and also to examine service user records. I therefore spent time with locality

teams, observing and informally discussing practice with care managers and other staff. At the beginning of the placement within the authority, I attended some of the annual consultation meetings with users and providers on the proposed Community Care Plan, which was a useful introduction to issues within the authority. I participated in a range of management and other meetings from divisional to locality level, including Joint Planning Team meetings, Special Transitional Grant (STG)<sup>3</sup> meetings and consultation with the Social Services Inspectorate. I also took part in consultation meetings with service providers, such as housing agencies and providers of residential and nursing care. In addition, I was invited to observe the contracting and tendering procedure for a bathing service (discussed further in Chapter 5). Attendance at such events provided an overview of policies and their application in practice. I also undertook training in the information system used by Social Services (pseudonymised as ECIS). I also had regular meetings with one of the Senior Managers (Head of Adult Assessment Services) in a supervisory context, to discuss practicalities of undertaking the research in Parkside, and to report back on progress. From an early stage, I was engaged in project work for the authority. I undertook an exploratory investigation on the audit of STG agreement standards regarding referrals from health services for comprehensive assessments. The audit methodology that has been used to monitor the Business Plan was discussed with members of the Planning and Review Unit. I then visited the area-based teams to discuss their recording and monitoring of referrals and information received from other agencies. From these initial discussions, it became apparent that different recording formats

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<sup>3</sup> The STG was introduced by the Department of Health in 1992 in order to transfer funding responsibilities for community care services from the Department of Social Security to local authorities. A condition of the grant (in England) was that 85% of the grant should be spent on the independent sector.

and protocols were in use. This did not provide a common baseline for referrals on which to use the audit methods, and so it was decided not to proceed further. However, the activity did provide useful information on the operation of data collection for the monitoring systems. The discussions with locality team managers also shed more light on areas where there was lack of consistency across localities in practice and recording systems. This initial period of familiarisation with Parkside's organisational structures and working practices provided valuable information on the feasibility of methodological approaches to the research, which I return to later in this chapter.

### **Parkside's demographic context and aims for community care for older people**

In common with many inner city areas, Parkside contained districts characterised by both poverty and affluence. At the time of fieldwork, Conservative councillors were in the majority on the Council, and a Conservative Government (under the leadership of John Major) was in power in a non-devolved United Kingdom. The Parkside Community Care Plan that was contemporaneous with the period of fieldwork based its estimations for services on projections from the London Research Centre (Pettit, 1997), including a disproportionate number of older people without the support of informal carers. In Parkside, there were around 14,500 people of pensionable age living alone (Parkside, 1997), representing 17.5% of all households in the City; above the average of 14% for the surrounding authorities. Within this group, there were around 6,800 people over 75 years living alone, around 1,500 of whom were over 85 years. Additionally, it was estimated that about 12,500 people over 60 had mobility, sensory or personal care difficulties affecting daily activity, around 7,000 of whom were over the age of 75.

The Parkside Community Care Plan (Parkside, 1996) as the policy document available to the public, and Social Services Business Plan for 1997-1998 (Parkside, 1997) presented to the Parkside Social Services Committee, set out the aims and core values of the care services provided to Parkside's residents. These provided the declaration of Parkside's priorities for distribution of its resources, and how it proposed to measure progress. In line with national legislation of the NHSCCA 1990 and the principles of the preceding White Paper *Caring for People* (DH, 1989), the Committee's principal aims were to protect those at risk of significant harm; assess and meet the needs of service users and their carers; enable people to live as independently as possible within their homes or within a family, and to listen and respond to service users' views. Parkside also identified core values to accompany these aims. The most relevant to the delivery of care services to older people were to ensure that all social care services met high quality standards; to develop a high quality mixed economy of care; to target services at the most vulnerable; to work in partnership with users, carers and service providers; to provide services that treated people with respect and dignity, ensure confidentiality and avoid discrimination; and to achieve the best use of available resources. The measurement targets, or outputs to meet these aims were formulated in terms of timescales for assessments.

Parkside had introduced some new services in order to meet their priorities, including a home bathing service (provided by the independent nursing agency pseudonymised as Care Nursing, and discussed further in Chapter 5), jointly commissioned with the Health Authority in order to meet an unmet need. However, it was not noted in this Plan that the reason the bathing need was unmet had been prompted by the recent Health Authority withdrawal from providing bathing assistance as a nursing task. Some flexible additional services had also been introduced, including a handy-person service for small



maintenance and repair jobs in the home, and a putting to bed service run by an independent agency (pseudonymised as Care Solutions) with its own staff. The Community Care Plan noted that progress on both the bathing and handy-person services had been praised by users and carers, and these services will feature in Chapter 4, which presents findings from the interviews with older people.

A significant public acknowledgement was that the Assessment & Care Management Service had received far more referrals since its inception in April 1993 than anticipated. This had resulted in delays in assessments, resulting in the Social Services Committee agreeing £300,000 for 14 new staff for the teams working with older and disabled people, including Occupational Therapists (as seen in Chapter 6, in the interviews with staff in South locality). It was also noted that confusion still existed among the public in Parkside about how care management worked, and that there were difficulties in contacting the Assessment & Care Management teams. In common with the prevailing trends in evaluating satisfaction with home care, discussed earlier, some older service users who had been surveyed by Parkside had reported that they found the domiciliary care services unreliable, whilst others felt happy with the service. In response, Parkside aimed to introduce more specialist personal and domiciliary care services to ensure more consistent and reliable care, and interviews with such provider agencies will be the focus of Chapter 5.

### **Parkside's use of the independent sector**

A distinctive feature of Parkside at the time of fieldwork was its pioneering role in moving away from directly provided home care to the use of independent sector agencies. About 90.5% of social care services were purchased from external providers and Direct Service

Organisations (DSOs), which were formed from the discontinued in-house Home Care Teams, now out-sourced as independent business units, and subject to the same contracting process as external agencies. Within that figure, 64% of services were purchased from the independent sector, and 23% from the DSOs (Parkside, 1997). Following the implementation of the NHSCCA 1990 in 1993, most of the national growth of home care provision in 1994 was in the independent sector, which increased its share of the market from 5% to 19%, whilst the proportion of hours directly provided by local authorities in England as a whole fell from 95% to just over 80% in the same period (Pettit, 1995). Only one neighbouring authority used independent providers for home care more extensively than Parkside, with both contracting out over a third of their home care to the independent sector (Pettit, 1995). At the time of fieldwork, the proportion of social care funds spent by Parkside on independent sector providers was higher than any other authority in the city, and reflected the political make up and philosophy of the council as a 'flagship' Conservative authority. This adoption of increased outsourcing of care services represented an early manifestation of provision within the mixed economy of care, discussed further in Chapters 2 and 5.

### **Evolution of the research question: Locating the original paradigm**

The jointly-commissioned topic for the thesis had originated in a 'what works' effectiveness paradigm, advocated by Macdonald, Sheldon & Gillespie (1992) and in subsequent works (Macdonald, 1997; Sheldon & Macdonald, 1999). This approach was located within an evidence-based approach to social care interventions, and led to the original research question:

*How effective are Parkside Social Services' domiciliary care services in meeting the needs of older people?*

This research question led to consideration of the feasibility of employing some of the methods associated with effectiveness research. An experimental methodology claims to provide the most secure foundations for making causal statements about social phenomena, by attempting to control for extraneous variables that may constitute threats to validity (Frankfort-Nachmias & Nachmias, 2014). However, in social welfare services that are universally provided, the randomised allocation of subjects, with the suggestion of deprivation of service for the control group, can pose severe ethical difficulties. Nevertheless, other approaches could be possible within a quasi-experimental (non-randomised) paradigm, including the use of a waiting list of unallocated cases as a 'natural' control group (Macdonald & Macdonald, 1996). However, in the course of exploratory meetings with care managers in the locality office at an early stage of the studentship, it became apparent that procedures for keeping records of referral enquiries and the application of eligibility criteria differed across the locality Assessment & Care Management teams. This militated against the formulation of a standardised baseline for outcome measurement, and against a pre-test (for example, with those not in receipt of service at time one), post-test (following the intervention at time two) design. Here was an early lesson for the development of the research strategy. The complexity and variation within the processes of care management and the resulting services necessitated an approach that did not fragment their different aspects. A case study strategy (Stake, 2008; Gerring, 2007; Yin, 2014) was chosen as more appropriate and feasible than a quasi-experimental design, involving investigation of the phenomenon of home care within Parkside in its real life context, employing multiple evidence sources (Robson, 2011). Yin (2014) characterises

case study research as an empirical inquiry within the tradition of evaluative research, appropriate where the boundaries between phenomenon and context are not clearly evident. As a fluid, occasionally chaotic, setting for complex social interactions, 'community care' in routine practice could be seen as a suitable subject for such a case study approach, utilising multiple sources of information. This represented an evolution in the conception of the research design, in recognition that there was scope for more a more exploratory evaluation that could combine examination of both the structural context of the organisation and service delivery, and meanings negotiated between different social actors in a post-positivist, 'realist' evaluation (Pawson & Tilley, 1997), discussed further in the next section.

### **The move to a realist ontology and epistemology**

This shift in emphasis was not merely pragmatic in the light of practice realities, but also theoretically based. The thesis adopts a realist epistemological framework (Bhaskar, 1978; Bhaskar, 1980; Sayer, 2000) as a post-positivist evaluative tool. Bhaskar distinguishes between ontology, or ideas about the nature of what exists, and epistemology, or the nature and limits of our knowledge of that existence. In his ontology, there are three layers; the empirical (what we experience), the actual (what occurs, whether it is experienced or not), and the real (the underlying causal mechanisms). However, I do not adopt Bhaskar's term 'critical realism', which has taken a more emancipatory and spiritual turn (Bhaskar, 1993; 2002) and has been the subject of considerable philosophical variation and debate (Sayer, 2000; Campbell, 2012, Porter, 2015). Whilst fascinating in themselves, such debates are beyond the scope of this thesis. As I am examining the operation of a complex organisation, I use the term 'realist', following common usage in the model of

evaluation established by Pawson & Tilley (1997). The Pawson & Tilley evaluative framework acknowledges both the empirical compass of the research (for example, measurement of the impacts of domiciliary care experienced by older people; examining how far services matched assessed need) and how human agency (in terms of motivations, identities, choices etc.) interacts with organisational structures (Archer, 1995; Houston, 2001, 2010) and contributes to the difference between planned and actual policy outcomes (Horrocks, 2010). It places people and all of their sometimes surprising decision-making chains into the evaluation model, and is appropriate for the case study of the workings of a constantly-changing social services organisation like Parkside.

This, then, is the framework within which the components of care management, service provider and older people's responses, and what enables and what constrains provision of good quality domiciliary care in Parkside are analysed in the thesis. This approach has been used fruitfully in nursing empirical research in the United Kingdom, for example in the evaluation of large-scale NHS projects, (Greenhalgh *et al.*, Humphrey *et al.*, 2009; Rycroft-Malone *et al.*, 2010; Rycroft-Malone *et al.*, 2011), and in mental health nursing interventions (Wand, White & Patching 2009; Parlour & McCormack 2011) Realist evaluations related to social care are less well-established, and tend to focus on clearly-bounded interventions, rather than routine practice, as examined in this thesis. However, they include Kazi and Hall's (2010) quantitative approach to analysing housing support, Kazi, Pagkos and Milch's (2011) evaluation of a family support intervention, and Blom & Morén (2010) on individual therapeutic social work in Sweden. Although these authors vary in their interpretations of realist evaluation, their frameworks assume that interventions are context-dependent, and that small changes in conditions may lead to (sometimes unexpected) changes in outcomes. In this way, it differs

from a more linear, successionist theory of causation traditionally (in an arguably over-simplified perspective) associated with positivist methodologies such as Randomised (or quasi-randomised) Controlled Trials. The realist approach to empirical investigation has been summed up by Pawson & Tilley (1997) as seeking what works, for whom, and in what circumstances. As an acknowledgement of the nuanced workings of complex systems such as Social Services Departments, this provides a more plausible alternative to a positivist linear matching of social work inputs to service user outcomes ('what works?'), which had been the initial conception for this research in Parkside (Chapters 1 and 3). Instead, as an explanatory device, realist evaluations are operationalised to explore the fluid relationship over time between context (C), mechanism (M), and outcome (O) (Pawson & Tilley, 1997; Pawson, 2006). The purpose is to investigate which organisational conditions trigger proposed mechanisms to produce identified outcomes, whether intended or not. However, such mechanisms may also remain elusive, hidden at deeper explanatory levels, within a speculative 'black box' (Houston 2010). This theoretical approach is appropriate for the task of an evaluation of a complex 'open system' (Houston, 2010), such as the provision and receipt of domiciliary care services in Parkside, which is a configuration of routine yet rapidly-changing practice rather than a time-limited and more controlled 'test' intervention. In this perspective, programme effectiveness can change with small changes in conditions, so that outcomes will not be uniform in different situations. A system such as home care in Parkside may be subject to conscious striving by managers to regularise it and make it controllable. However, these attempts may have equivocal or unexpected results, given the multiplicity of different conditions that impinge on such a fluid system. It is these factors that are of interest in examining how key participants in systems operate (within Parkside in this case) and hence, how the systems may change in the future.

To do this, realist evaluations use a 'working back' or retroduction from the observed outcomes to identify mechanisms and tendencies that contribute to an implementation gap between planned and actual outcomes in policy (Horrocks, 2010). Such an evaluation is valuable for an organisation like Parkside, where there may be mechanisms in common with other social service establishments, but where local drivers may have a particular impact. Distinguishing between local and more widespread mechanisms may also aid in generalising to other social services organisations. This analysis will be elaborated further in the final discussion in Chapter 7

Epistemologically, realist approaches adopt a pluralist methodological approach, where appropriate to the research focus (Danermark, Ekström, Jakobsen & Karlsson, 2002), which also encompasses more qualitative, interpretive approaches (Greenhalgh *et al.*, 2009). Given the multiple sources of perspectives contributing to the complex nature of home care provision, a multi-method research strategy was adopted (Brewer & Hunter, 2006) with triangulation of data sources, using Denzin's definition as the '(...) combination of methodologies in the study of the same phenomenon' (1978:298). In this thesis, these include the use of qualitative and quantitative data derived from interviews with three principal interest groups of older people receiving services, care managers and provider agencies, the analysis of non-reactive sources (Robson, 2011) such as case records and policy documents, plus field observations of the workings of care management. The perspectives of older people who received home care services themselves were central, but a distinctive feature of the thesis is that it also seeks to investigate how they interacted dynamically with the wider local authority organisation. These multiple data sources are analysed to interpret not only overarching mechanisms but the role of individual agency (Archer, 1995) of older people, practitioners and providers, and their interplay with each other

and organisational structures. Programmes such as home care provision work through active interpretation and implementation by the decision-making of its subjects:

This process of what subjects do with the intervention stratagem is known as the programme 'mechanism' and it is the pivot around which realist evaluation revolves (Pawson 2004: 31-32).

If programme effectiveness can change with small changes in conditions, outcomes are unlikely to be uniform in different situations. This is demonstrated in the research focus on the differences between the locality Assessment & Care Management team practices and resultant effects on equity, which had stimulated such concern among the Parkside senior management. Although these conditions may initially appear hidden within a 'black box' (Pawson & Tilley, 1997; Houston, 2010), it is these mechanisms that are of interest in examining how key participants in systems operate (within Parkside in this case) and hence, how the systems may change in the future. Categorising and distinguishing between contexts and mechanisms is still an enterprise of interpretation (Carter & New, 2004), and my interpretations, based on the empirical data collected, will be elaborated further in the discussion of findings in Chapter 7.

### **Re-formulating the research question**

In order to articulate the revised research question, I will outline how I operationalised the framework for analysis. An intervention or service 'programme theory' (Pawson & Tilley, 1997; Pawson & Manzano-Santaella, 2011) explains how planners expect that intervention to reach its objectives. I address this by looking at the national legislative and policy frameworks that in turn guided Parkside's local aims for community care provision for older people, and home care in particular. The review of literature in Chapter 2



examines these policy drivers, and places them in their temporal context. Following the rationale for a realist evaluative model discussed in the previous sections, the research question shifted from its original commissioned manifestation (*How effective are Parkside Social Services' domiciliary care services in meeting the needs of older people*) to a realist conceptualisation within a case study:

*What works in domiciliary care in Parkside, for whom, and under which circumstances?*

Having identified key perspectives for data collection, these will be analysed in order to identify respective contexts, mechanisms and outcomes. Therefore, I hypothesise that Parkside's individual, infrastructural and institutional contexts (including locality team structures and history, local conditions of demography and provider care markets) will configure and interact with variations in mechanisms (including practitioner, provider and older people's responses and decisions), leading to different outcomes in the implementation of policy and subsequent impacts on service users.

### **Structure of the thesis**

Finally, this section previews the structure of the thesis. Chapter 2 provides a critical narrative review of literature regarding the development of policy and practice in community care for older people in general, and domiciliary provision in particular. The chapter critically reviews policy developments in the United Kingdom and international perspectives, encompassing evaluations of pre-community care pilot projects within the production of welfare framework (Challis & Davies, 1986; Davies & Challis, 1986; Bauld, *et al.*, 2000) to current literature on policy directions, including personalisation (Leece & Peace, 2010; Lymbery & Postle, 2015) and

the future of social work with older people (Ray, *et al.*, 2015). This leads to consideration of empirical service-based research on social work with older people, from the early process of assessment to the provision of flexible, user-defined low-intensity services (Patmore & McNulty, 2005; Andrews, Driffield & Poole 2009). The theoretical bases for the major relevant subject areas of older people and social work practice are also examined to inform the older person focus in Chapter 4. Literature on the state of domiciliary care markets in the mixed economy of care is considered as unpinning Chapter 5 on provider perspectives, and on professional discretion (Harris, 2003; Evans, 2010; Ellis, 2011; Evans, 2012;) for care manager practitioner views in Chapter 6. The review therefore both appraises the empirical and theoretical knowledge base of the different components of the study subject and informs the strategy of the research. It also highlights the gap in the literature of case study approaches from the multiple perspectives in the study of domiciliary care and older people addressed in this thesis.

Chapter 3 considers the methodology and procedures for data collection in more detail. The chapter discusses an exploratory study undertaken at an early stage in my location within Parkside, and the lessons suggested for the main study; the rationale for choosing the methods and instruments for the data collection; ethical considerations; sample selection strategy; and the procedure for data analysis.

The subsequent three chapters form the empirical core of the thesis, presenting the findings from the interviews with the three principal groups. Chapter 4 analyses the views of older people, based on the data from semi-structured interviews. The chapter explores the needs and views of older service users post-assessment who were in receipt of a range of low intensity and high-intensity services; presents and

thematically analyses the qualitative data from these interviews; and presents and analyses quantitative demographic data and needs-related variables.

Chapter 5 analyses the views of all service provider managers commissioned by Parkside. It discusses the empirical findings from individual provider managers regarding their commercial concerns and relations with commissioners and care manager practitioners within Parkside, as well as their working practices with older people.

Chapter 6 analyses findings from group interviews with care manager staff groups from the three Parkside Assessment & Care Management locality teams, contributing to current debates on discretion in professional practice, locating this within critical discussion of Lipsky's (1980) model of street-level bureaucracy (Evans, 2010; Ellis, 2011). Different practices between localities, and their potential impact on service users are appraised, and the paradoxes and tensions arising from the exercise of professional discretion. In addition to the staff group interviews, the chapter provides a qualitative and quantitative content analysis of a random sample of written and electronic case records across the three Parkside localities, and discusses the implications for older service users and commissioners of significant information gaps and deficit-based recording.

The concluding Chapter 7 critically analyses the interwoven threads of the case study. This chapter discusses the main conclusions from the study and its contribution to knowledge; places it within its realist framework of context-mechanism-outcome configurations, and discusses its relevance to the current policy and practice landscape. In this chapter, I review the thesis argument and its contribution to

knowledge, critically evaluate the research process and its strengths and limitations, reflect on the process of the research itself, and highlight indicators for further research.

## **Conclusion**

In summary, this chapter has introduced the context and argument for the thesis, including the origins of the studentship and original framework, the rationale for the change in epistemological approach, and the case study focus on the triad of the three key groups within Parkside that interact within the provision of home care. The following chapter continues placing the thesis within its context of knowledge by critically reviewing the development of policy, theoretical and empirical literature on community care for older people, from its inception to current policy and practice formulations.

## **Chapter 2**

### **The organisational and theoretical contexts of policy and practice in domiciliary care for older people: From community care to personalisation**

#### **Introduction**

In chapter 1, the context for the initial research approach and the rationale for a methodological shift from an effectiveness paradigm to a realist case study were discussed. This design addresses complexities inherent in the research focus on the impact of home care provided Parkside Social Services Department. It was proposed that the provision of care services at home for (if not always with) older people has been problematic historically, and continues to be so. This chapter proceeds with a narrative review of literature on policy and practice, incorporating a temporal dimension in order to trace continuities and discontinuities, from the early development of community care and the debates on consumership that were unfolding at the time of data collection to current debates on personalisation and citizenship. This policy analysis also contributes to the context component of the adopted realist approach. It is proposed that the interactions characterising the provision and receipt of home care are entangled and complex. To examine these further, debates centring on the triad of perspectives from older recipients of care, care managers commissioning the service, and provider agencies supplying the service are also examined. The chapter concludes with discussion of how core policy and social assumptions about ageing and care services provision may persist through time and translate into practice, even as policy and legislation change.

## **Social care in a mixed economy: The development of community care in the United Kingdom**

This chapter does not attempt to duplicate a history of the development of community care in general and care management in particular, as those histories have been written comprehensively elsewhere (for example, Timmins, 2001; Means, Smith & Richards, 2008). However, it is necessary to examine some of the historical context and fundamental concepts that inform policy (whether explicitly or implicitly) since the inception of community care for adults, as it is argued here that social conceptions of ageing in turn shape policy (Hillcoat-Nalletamby, *et al.*, 2010).

The growth in the number of people with multiple needs living at home, and, crucially, the concomitant need for cost containment were recognised at the inception of the idea of care in the community in the United Kingdom as significant drivers for de-institutionalisation from the 1950s onwards (Challis, 1994). Six decades on, they continue to be significant drivers for personalisation in England (SCIE, 2008), and citizen-directed support in Wales (WAG, 2011). Whilst tracing the history of community care follows a path well-trodden path, it is worthwhile outlining the background to the development of the community care reforms in the 1990s, as this informs both the context for the fieldwork in Parkside, and indicates parallels with contemporary policy directions.

The metaphorical shadow exerted by Victorian long-stay hospitals was vividly evoked by Enoch Powell as Minister of Health (Powell, 1961) in his 'Water Tower' speech made to the annual conference of the organisation that later became MIND. Powell's declaration of intent to

eliminate these hospitals and the inertia that had blighted change in the previous decades translated into the Hospital Plan for England and Wales (Ministry of Health, 1962), predicting the closure of half of mental health hospital beds by the mid-1970s. Such developments in de-institutionalisation were not confined to the United Kingdom. Challis (1994) noted common international factors underlying policy developments towards decentralisation and accompanying fragmentation of community services. Policy trends towards the enhancement of home-based care and the development of care management and co-ordination of services have also had parallels in the Netherlands and Sweden, for example (Da Roit, 2012; Szebehely & Trydgård, 2012).

In England and Wales, the Audit Commission report of 1986, *Making a Reality of Community Care*, focused on the move of services and people from hospital to the community services, and commented on the lack of progress of de-institutionalisation, despite a series of official reports since Powell's 1962 Hospital Plan supporting the principle. The White Paper *Growing Older* (DHSS, 1981) had envisaged a more central role for family, friends and neighbours, so that care in the community would increasingly mean care by the community, an entity which lacked detail in stating precisely who 'in the community' would be expected to provide care. Nevertheless, it was a nod to a collective responsibility, beginning within the home (with an emphasis on care by informal carers, and hence, predominantly by women), but also radiating beyond it. This continues to be a dilemma in contemporary policy, where constituent devolved nations diverge. Despite the roots of community care in Conservative political ideology, ironically, a Labour administration in Wales has formulated a communitarian model of citizen-directed services in the Social Services & Well-being (Wales) Act 2014, and, in their White paper *Sustainable Social Services* (WAG, 2011), directly contrasted it

with what they characterise as an individual, marketised interpretation of personalisation in England in the Care Act 2014.

The original drivers and aims of 'care in the community' are pertinent both for the examination of the provision of services in Parkside at the time of the case study, and beyond into current debates on the role of markets in care. In 1986, for the Audit Commission, the relocation out of hospitals into '(...) more local, domestic settings' had stalled (1986: para. 10(b)). The blockages came from uncoordinated inter-agency organisation and funding, inadequate staffing and training, and the 'perverse financial incentive' for inappropriate entry to residential care based on means testing of income to determine eligibility for residential care fees support, rather than assessed need. The Audit Commission therefore called for a government review to decide the issues. However, little further action emerged until the publication of the Griffiths report, two years later. It is worthwhile examining this report in more detail. Sir Roy Griffiths (from the retail sector) was given the terms of reference by the Conservative government under the third Premiership of Margaret Thatcher (1987-1990), to review how public funds were being used to support the development of supports in the community. Implicit in these terms of reference was the impetus for efficiency in costs, moving away from the ruinous expense of maintaining large-scale institutions like long-stay hospitals. However, Griffiths noted that although many of the submissions he received referred to inadequate funding, it was not his remit to deal with the level of funding for community care services. In particular, he emphasised that cost reduction was not the aim of the review (Griffiths, 1988). Although the Audit Commission was satisfied that better value could be obtained from existing resources, Griffiths (1988: para.7) wryly took a different view, with resonances for the present:



(...) many social service departments and voluntary groups grappling with the problems at local level certainly felt that the Israelites faced with the requirement to make bricks without straw had a comparatively routine and possible task.

In addition, he wanted policy and resources to be better co-ordinated, with joint funding, so that direction was given to service provision that had previously been lacking. Because responsibility for community care inputs was divided between the Social Security and Health & Personal Social Services arms of the DHSS, the fragmentation had resulted in '(...) a feeling that community care is a poor relation; everybody's distant relative but nobody's baby' (Griffiths, 1988: para. 9).

Nevertheless, in achieving a shift in social services delivery, he wanted to avoid disruption or major restructuring. In doing this, Griffiths demonstrated an independence of mind that was both surprising to the Conservative administration who were ideologically hostile to local authorities (Timmins, 2001), and to local authorities themselves, who had reason to fear Griffiths as an exemplar of market enterprise given his roots in the retail sector. In doing this, Griffiths had been evidence-based, drawing on the conclusions of the Kent experiments and the PSSRU production of welfare model, discussed later (Challis & Davies, 1986).

The ends to be achieved for Griffiths were to include specific targeting to those in most need in a timely way, and to broaden choice, so that people would be enabled to stay in their own homes for as long as possible, with long-term care settings reserved for those whose needs could not be met in any other way. What seemed to have been lost in this emphasis on individual need and the avoidance of long-term care environments is the 'community' component of community care. The focus had subtly shifted to a service-based model based on individual

need. Griffiths' report was welcomed at the time by the Association of Directors of Social Services (ADSS, 1990). Contrary to the contemporary Conservative's Government's hostility to local government, Griffiths had shown commitment to local decision-making. The ADSS was also pleased at the centrality afforded to local authorities rather than Health Authorities, as had been feared, and because there was an opportunity for Social Services Departments to divest themselves of directly-managed services that were both expensive and the butt of criticism for delivery of poor quality care. The intention to avoid massive disruption in re-organisation was also appreciated. However, there were criticisms. The report assumed people were financially able to provide for their own care needs, without offering supporting evidence. Echoing the earlier White Paper *Growing Older* (DHSS, 1981), the Griffiths Report made it clear that local authorities were not the only agents involved in providing care, and that a primary task of publically-provided services was to support and strengthen networks of friends, relatives and neighbours as (unpaid) carers. Griffiths thereby emphasised the positive role of carers, without noting the burdens. Ungerson (1990) noted that the principles of community care were still vague about the position of informal carers, whose own rights as citizens could be compromised by obligations of extended care for those with chronic illnesses. It is notable that prioritising practical support for carers was explicit in the subsequent White Paper *Caring for People* (DoH, 1989). Nevertheless, the NHSCCA 1990 was followed by a sequence of three corrective Acts of Parliament concerned with carers in 1995, 2000 and 2004, demonstrating that the aim of effective support for carers remained unfulfilled in succeeding decades. The double-edged nature of such emphasis on predominantly female carers has been echoed by feminist perspectives on informal care throughout the period of community care characterised by care management (Parker, 1990; Graham, 1997; Lloyd, 2000; Parker, Arksey & Harden 2010). Reports

on the ineffectual nature of carer support were summarised by Pickard (2004) for the Audit Commission, as a matter of continuing concern. Griffiths also did not address potential problems of the development of the independent sector's role as service providers; an area of particular concern, as the Parkside case study demonstrates.

### **From White Paper to implementation**

Following the publication of the Griffiths Report, there was a further delay of almost two years while his recommendations were considered by the Government. Not all of his proposals reached legislation intact, such as the proposition for a ministerial post to have personal responsibility for the new system, and his call for earmarked funds. However, many of his recommendations were accepted, as seen in the six key objectives of the White Paper *Caring for People* (DoH, 1989). In particular, these promoted targeting services on those with greatest needs, and to develop domiciliary, day and respite services '(...) to enable people to live in their own homes *wherever feasible and sensible*' (DoH, 1989: para 1.11, my emphasis.). In addition to pledging to abolish the 'perverse financial incentive' for residential care and clarify organisations' accountability, the Government also emphasised the role of a flourishing independent sector and value for public money, so that local authorities would become enabling rather than providing agencies. The fourth principle was particularly significant in terms of how the organisation and delivery of community care would be handled: '(...) to make proper assessment of need and good case management the cornerstone of high quality care' (DoH, 1989: para 1.11). This clause also introduced the unlovely term 'package of care', and made case (later called 'care') management the main vehicle of needs assessment and service delivery. In addition, local authorities would be expected to make maximum use of the independent sector. Specific funds were transferred for this purpose in

the Special Transitional Grant. However, the sting in the tail (as far as directly-provided local authority services were concerned) would be that 85% of these funds would have to be earmarked for spending on the independent sector in order to kick-start the market.

The 'cascade of change' (Audit Commission, 1992) required for implementation by local authorities, included changing assessment systems; introducing care management; splitting purchasing arms of the authority from providers; contracting for services with the independent sector; setting up information gathering systems for the construction of community care plans; implementing complaints procedures and inspection, and negotiating joint commissioning and planning. Moreover, the changes were not only organisational, but required the shift in philosophy and delivery from a service-led to needs-led model of welfare. 'Service-led' became a term that denoted inflexibility and placing organisational interests before those of individuals using those services. In theory, that should have placed the individual 'service user' at the centre of consideration. However, it may have made the 'case' or 'care package' the centre instead.

The delays in implementation of care management provoked much debate at a time of great uncertainty, when commentators were aware of the content of legislative change, but doubtful about what impact they may have. Caldock (1993), in interviews with 33 community care professionals conducted in summer 1991 sought to reflect staff understandings about the new assessment arrangements, and their expectations, opinions and anxieties about the forthcoming changes. Data was collected more than a year after the publication of *Caring for People*, and several months after the reforms had been delayed until April 1993. At this time, Caldock found that a substantial minority of staff still had not had access to a complete copy of the White Paper, and were getting their information through the filter of

other people's opinions. He concluded that the postponement of the reforms had led to a loss of momentum, with demoralisation in front-line staff and a '(...) feeling of helplessness and the inability to bring about change or meet assessed needs existed alongside fears about budget-holding compromising objectivity' (Caldock, 1993:142).

As well as introducing the system of care management as the main vehicle of needs assessment and service delivery, a major objective of the White Paper *Caring for People* (DH, 1989) was to stimulate the independent sector, ostensibly to promote user choice and cost effectiveness within a mixed economy of care. In effect, the state ceased to be both the provider and the funder of services (LeGrand, 1993). The neoliberal reforms of the purchaser-provider split implemented in 1993 were attacked at the time as a culture shift in favour of markets, and for introducing the mentality of the supermarket to social care (Walker, 1994; Langan, 1993; Warner 1994), commodifying services into 'packages of care' as if equivalent to groceries. For Phillipson (1994), a crucial issue for community care implementation was whether such internal markets could guarantee predictability in the in the supply of care, in contrast to a uniform and bureaucratic welfare state. However, key differences exist in the hybrid quasi-markets of care, as they retain some state funding whilst encouraging plurality of providers, including for-profit independent agencies, not-for-profit charities and directly organised local authority teams. As LeGrand (1993) has discussed, the quasi-market in social services differs from a 'true' market on both the demand and the supply sides. The supplier is not necessarily out to maximise profits (though this may be the dominant model). On the 'consumer' side, purchasing power is not primarily offered in cash, but via taxes, and the opportunities to exercise choice of provider are limited, if they exist at all. Ultimately, the powers of exit from the market are limited for the less wealthy; the power to exercise choice is still available to

those with the means to fund their care privately. Although presented as a key change in offering choice and empowerment to recipients, the consumer model could be characterised as disingenuous even from its inception, as a key objective in encouraging the market was to obtain enhanced value for money. From a different perspective, Biggs (1994), in a psychodynamically informed paper, declared that social welfare based on a market model presumed atomised interactions based on equal, rational and mutually agreed exchanges of goods and services. It is not necessary to subscribe to Biggs' model of the psyche to acknowledge the criticism of interactions seen as a series of binary interactions, at the expense of individual biography, complexity and imbalances of power.

### **The Origins of Care Management**

The systems of care management contained in the legislation and policy guidance were influenced by models developed in pilot projects in North America and Britain. Variants of care management originated in the United States of America and Canada in the 1970s and 1980s, as a result of concerns about service fragmentation and cost containment in long term care. Challis (1994), in describing these models, contrasted the 'service brokerage' approaches with the 'social entrepreneurship' of British models, which had emphasised the move from service-led to needs-led provision.

Before the implementation of the 1990 Act, pioneering work had taken place piloting and evaluating models of community care practice in different settings. The Department of Health had sponsored a diverse series of projects in community care with all client groups from 1983 onwards. The Personal Social Services Unit (PSSRU) at the University of Kent also devised evaluated interventions, based on a theoretical model of the 'production of welfare' (Challis & Davies, 1986). In this

framework derived from economics, welfare is produced via the interaction of inputs, for example, the work of service providers, facilities and resources available. These produce welfare outcomes, with intermediate outcomes being the kinds of services produced, and final outcomes the effects on individuals and the costs involved. In the Thanet care in the community project discussed by Challis & Davies (1986), 100 older people were selected who were deemed to be at the margin of entry to long term residential care. The project featured teams of experienced social workers, in contrast to the less experienced and qualified staff who often worked with older people in the mainstream services at the time. These teams also had access to decentralised budgets, with workers able to spend money on a variety of services not usually available. With this access came the expectation on social workers to cost their packages of care, and to stay within two thirds of the residential budget. These packages were to have the explicit involvement of a mixture of informal care, such as paying expenses to carers willing to perform tasks such as handling finances, semi-formal care, such as a daily visiting 'helper', and statutory services. This role of 'helper' bore similarities to the 'auxiliary force' proposed by Griffiths (1988: para.35):

There may in fact be a tendency to over elaborate, both as to the professional input and the training required. Many of the needs of elderly and disabled people are for help of a practical nature (getting dressed, shopping, cleaning). There is a need for a new multi-purpose auxiliary force to be given limited training and to give help of a practical nature in the field of community care.

Griffiths here pinpointed the need for what later became known as 'low-intensity' services (Clark, Dyer & Horwood, 1998), and which were to suffer in subsequent periods of tightening eligibility criteria. Griffiths' practical role designation omitted relational aspects of care,

however, and reduced assistance with getting dressed, for example, to a purely functional mechanism.

Outcomes from the Thanet intervention were compared with matched pairs who received mainstream services. Overall, the results were positive. In the intervention group the probability of death within one year was reduced, and the probability of staying at home doubled. In addition, informal carers felt more supported, the well-being of users was enhanced, and the costs of care were lowered. The results were replicated in different settings such as in Gateshead and Darlington. (Davies and Challis, 1986; Challis *et al.*, 1989; Challis *et al.* 1990). This was in contrast with the Department of Health sponsored pilot studies, which suffered from problems of comparability and replication. However, there were criticisms of the approach. Askham and Thompson (1990) claimed that those with dementia lived longer in residential or hospital care than in the community, whereas Pilling (1992) claimed that the level of home care delivered to people with dementia made no difference to outcome. There were also criticisms that the Thanet study had excluded 'difficult' older people, and carers who were not prepared to take on the extra tasks (Askham & Thompson, 1990).

Hudson (1994) critiqued another contemporary care management experiment that took place in Stirling, and which shared many of the features of the PSSRU Thanet model. However, the Scottish project did not enjoy the same success. Perceived failures of EPIC were connected by Hudson to the lack of shared definitions of the meanings and process of the project within the multi-disciplinary steering group. What was startling about the project, and was a source of resentment from other staff, was the small size of the caseloads involved, averaging 12 cases over 2 years. Other features which might be considered luxurious, and which caused ill-feeling among referrers



included the decision to not to accept certain categories of older service user. These included those who were on the waiting list for residential care; those already costing more than two-thirds of the equivalent residential placement (in practice those suffering from dementia and attending the day hospital); and those who were crisis referrals. Hudson concluded that referrals to EPIC were being made because of the need for the extra help and resources that the project had privileged access to, rather than because of the benefits of the specialist role of case manager. As the project drew to a close, it was seen by some steering committee members as a University-generated experiment with little generalisability, and rather than offering a distinct approach, was a continuation of social work already being practiced.

The objectives of care management were stated by Challis (1994: 4) as:

(...) concerned with providing services to a specific target group and need not be seen as the mechanism for providing all forms of care for those who need assistance in coping with everyday living.

He cautioned that this had not always been a clear focus in the UK. For example, the Social Services Inspectorate (SSI, 1991) did not distinguish between care management as an organisational process, which ensured that core tasks are undertaken more effectively for all clients, and intensive care management, which offered a style of response for particularly vulnerable groups, via designated workers. However, as Lewis (1994) noted, in many local authorities there had been elision of care management both as a process and as a job. For organisations not to address this was a severe weakness in Challis' view, potentially reducing the effectiveness of care management in implementation. In other words, care management could not be seen

as a panacea. He continued in this vein to discuss the need for targeting those at risk of entry to residential care, as not all users needed care management with its increased overhead costs. *Caring for People* (DH, 1989) also implied that care management applies to all care, but Challis points out that, even with targeting, this approach might not necessarily produce overall cost savings. Indeed, there was a risk that costs would be raised.

The tensions and ambiguities present in the legislation and policy and practice guidance were also the subject of much comment at the time of implementation. Jack (1992) characterised care management as a system designed to secure efficient resource allocation and management, seeing it as intimately linked to the mixed economy of welfare. As a consequence, he envisaged care managers being in a position of denying services to those in need. In Jack's (1992:5) terms,

(...) what has been represented as a vehicle for effective resource management has in fact been employed as a Trojan horse introducing not just new management techniques but new values which will profoundly alter the ideology underpinning these departments.

Callahan (1989) reviewed care management carried out in the United States of America. This study took a randomised sample of 6,327 older people participating in a care management model that had devolved budgets and cash limits of 60% of average nursing home rates. An 18 month follow up of the experimental subjects found substantial increases in the use of community services, but no significant effect on institutionalisation, personal functioning or mortality rates, and that subsistence, medical and long term care costs increased substantially. Callahan claimed that fifteen years of research had failed to support most of the claims of its effectiveness.

This seems hard to reconcile with the PSSRU findings, and it is difficult from the information given to identify what may be crucial differences in characteristics of clients of approach that can produce such different conclusions. Davies (1992) responded to this argument by saying that the PSSRU experiments had not been intended to demonstrate an automatic link between structures and outcomes. In particular, the Kent research had not suggested that there would be improvements in the welfare of older people if care managers with lower budgets and higher caseloads targeted high priority cases. However, with more than a little glee, Jack (1992) noted that Kent SSD managers had made known their disappointment with emerging layers of bureaucracy and budget restrictions that had replaced initial enthusiasm.

### **Implementing the care management model: Bringing policy and practice together**

With care management becoming a universally-applied service in 1993, there were a number of reports from that period attempting to monitor progress with implementation. Lewis (1994) studied care management assessments in five local authorities shortly after implementation, combining intensive observation of processes with formal interviews of key participants. For Lewis, while the origins of care management were firmly associated with the work of the PSSRU, the circumstances in which the legislation was implemented were sufficiently different as to bring new tensions to the surface.

Many of these difficulties were rooted in inherent contradictions embedded in the legislation. In particular, Lewis focussed on the lack of mention of targeting in the 1989 White Paper, which had also been an issue for Griffiths, and the implications for controlling costs through rationing services. Though the new funding structure removed the

perverse incentive favouring residential and nursing homes, it also removed the link that Griffiths had built in between the responsibilities of local government and of ministers for ensuring that resources were sufficient to meet objectives. According to Lewis, this resulted in an embedded tension between need identification and resource constraints. As the 1990 Act made clear, it is the local authority that is responsible for assessing need, rather than solely self-identification by the older person. Local authority emphasis had shifted to the stage of the process given temporal priority; that of setting eligibility criteria for determining the level of assessment of need. This had led to confusion among the authorities in Lewis' study as to whether this initial stage of assessment constituted an assessment itself, or if it was a screening-out device to focus on those most at risk, so that '(...) need is tending to translate into those whom social services cannot ignore' (Lewis, 1994:3).

Another significant area of difficulty found in Lewis' group of local authorities that continues to resonate was the difficulty experienced by social work trained care managers in switching from a provider to a purchaser culture. The split also affected the process of reviewing services. Lewis argued that SSI practice guidance (1991) recommended that reviewing services was part of the cycle of care management to be carried out by the purchaser, with implications for staff costs and time. In a later article, Lewis, Bernstock & Bovell (1995) argued that making services needs-led was not the same as making them user-led, which has continued to resonate. The theme of the centrality (or otherwise) of users and carers was also pursued at an early point in the implementation of the NHSCCA 1990 by Wilson (1994). In her study considering how a community-based sample of people over 75 retained independence and autonomy, Wilson argued that welfare organisations failed to recognise the contribution older

people make to their own care; an argument which will be returned to throughout the thesis.

It is useful at this stage to recap the development of the key roles for social work that preceded care management and continued after its implementation in the period of fieldwork, both to see what has been lost and what has been retained, and to understand the model in place at the time of fieldwork. In their account of what they designate as the first community care project, Challis and Davies (1986) refer back to the work of Goldberg and Connelly (1982), identifying the key social work roles in the care of older people as assessing need, mobilising resources, direct casework, coordination and monitoring, consultancy to others involved in the care, and finally, community work. There are similarities in this model with the later system of care management introduced after the NHSCCA 1990, but also key differences. Community work, for example, fell into steep decline after the inception of care management, although it is promising a resurgence, in Wales at least, under the citizen-directed support principles of the Social Services and Well-being (Wales) Act 2014. The notable differences between pre-NHSCCA 1990 models also emphasise direct social work with service users, rather than commissioning others. In the PSSRU experiments, budgets were devolved to team level, which included dedicated home care staff who carried out the majority of care tasks in the home. However, the PSSRU experiments were not operating within the mixed economy of care later implemented in 1993. In their research and policy update (2010), the PSSRU summarised the principles from the 1988 Griffiths Report that provided the blueprint for the development of community care over the subsequent two decades. The core tasks that local authorities must undertake to provide support were the identification of the needs of individuals; the diversion of resources away from institutional care settings in order to support people within their homes; the provision

of a care package tailored to need and provided within the available budget, with the process and overseen by a care manager. Despite the intervening two decades, this commentary argued that many of Griffiths' recommendations remained aspirational rather than implemented. To a large extent, this incompletely realised implementation has been attributed to chronic underfunding of social care, highlighted by Davies, Fernández & Nomer, (2000) and Davies (2007), drawing on the evidence from PSSRU studies showing that care services provided highly valued outcomes at levels of funding not established for health services, and further emphasised in the Wanless review of social care (Wanless *et al.*, 2008).

Although the purchaser-provider split had been introduced under a Conservative administration, a New Labour government (1997-2010) under the Premiership of Tony Blair was elected, declaring the 'Third Way' of neither free market nor state control, with welfare reform in its manifesto. This Labour government adopted the market reforms of its Conservative predecessors, also embracing a business ethos in welfare, and couched in the vocabulary of modernisation. The White Paper *Modernising Social Services* (DH, 1998) had key objectives of raising standards in care services, and increasing protection for service users, increasing the scope of regulation and introducing a performance assessment framework. (Netten *et al.*, 2005). Local authorities were to develop their purchasing and contracting role, to become 'enabling authorities' (DH, 1998, para 3.1.3), which in turn, it was claimed, would result in increased competition between providers, increased value for money and wider choice and flexibility of services. Not all commentators were content with the New Labour Government continuation of the mixed economy model of care. Scourfield (2006) noted the instability and uncertainty in home care markets, coupled with difficulties with recruitment. In response, he called for an increased role for in-house provision for domiciliary care, to provide

the flexible, accountability and person-centred care that could be lacking in the independent sector provision. At the same time, and with an air of resignation, Scourfield recognised that such calls would be seen as 'welfarist' in the contemporary policy discourse, and virtually unsayable. Indeed, there has been no such return to direct provision.

Subsequent policy initiatives from the New Labour Government (DH, 2005), and the subsequent Coalition Government (2010-2015) have proposed a number of reforms for England including outcomes-focussed framework for care, increased user choice through personalisation, including self-assessment, Personal Budgets, and the aim of balancing prevention and meeting low-level needs with provision to support those with the highest level of needs. The Parkside case study highlights some of the tensions evident in the market-led model of delivery of care, which will be discussed further in later chapters, but which include market fragmentation, and difficulties in recruiting suitable home care staff. Such difficulties have persisted into the supposedly more individually-tailored, personalised models of care. Problems of recruitment, retention and training of suitable staff to act in the role of individual Personal Assistant have continued with the introduction of Personal Budgets in England (Baxter, Wilberforce & Glendinning, 2011).

### **Ageing in place and the ingress of 'care' into the home**

It is recognised that the demographics of ageing populations poses challenges across advanced capitalist economies (Demos, 2012). Ageing in place has been a key component of social policy over the last half century in the United Kingdom (Peace, Holland & Kellaheer, 2006; Means, Smith & Richards, 2008). This emphasis is also evident in North America (AARP, 2011), Australasia (Wiles *et al.*, 2012), and

European countries (Benoit & Hallgrímsdóttir, 2011; Vabø, 2012; Rostgaard, Timonen & Glendinning, 2012). As discussed in the preceding sections, ageing in place was the basis for de-institutionalisation from the 1950s onwards (Means, 2007; Means, Smith & Richards, 2008), and has been taken in an individualised direction in the way personalisation has been adopted in the United Kingdom, and England in particular (SCIE, 2010). More recently, the Law Commission (2010) reiterated that an assumption of home-based living should be the basis of statutory principles in adult care law. Care for older people has thus changed site from hospital and other long-term settings to the home, and care by the community has shifted the locus of the paid provider from local authorities to independent agencies (with informal carers remaining as the unpaid providers). However, the people being cared for have remained constant. These continuities in policy, and the drive towards a market of care have spanned the period since data collection in the Parkside case study.

Services provided within the home, supplemented by communal facilities such as day care, are intended promote independent or supported living in the home, and to prevent or delay costly entry to long-term care settings and hospital, and speedier discharge under the Community Care (Delayed Discharges etc.) Act 2003. Ageing in place has also been justified as reflecting generally expressed preferences of older people to be supported to remain in their own homes, rather than move into long-term care environments (Angus, 2005; Bowers *et al.*, 2009; Bowers *et al.*, 2011; Blood, 2014). This assumption is predicated on a binary construct of 'home' placed in opposition to a model of longer-term care based on a residential care home, nursing home or hospital model. This may be an overly simplistic model for the future, as more innovative designs of care



environments such as extra-care housing (Burholt & Windle, 2007; Phillips *et al.*, 2015) have been, and continue to be developed.

The 'home' in home care can appear in policy as a relatively uncomplicated construct, signalling the physical location where the functions of care are supplied, contrasted with provision outside these confines. The models of home care discussed here are based on paid care staff physically entering the home to provide a range of care tasks. 'Home' is seen as an inherently more suitable environment to provide and receive care in than hospital or residential or nursing homes. The person in his or her own home is (in principle) able to regulate access to the space and control decisions. However, this takes little account of the impact on temporal routines, adaptation of physical spaces, as well as kinship and social relations (Daly, 2011; Percival, 2002; Wiles, 2005; Wiles *et al.*, 2012), where 'place' is in a more dynamic association of mutual influence, potentially fraught with emotion and conflict. The home as a place of attachment has been studied by social geographers such as Rowles (1978). This perspective highlights the importance of routines and familiar objects in their place. These can be fundamentally changed with the ingress of care workers, who have their own requirements both in terms of when they arrive and the environments they require in order to carry out their work. Milligan (2009) identifies three core aspects; home as haven or protected space, home as site of identity, and home with familiarity of setting and routines. All of these can be affected by physical changes to the home (such as adaptations), changes in routine and loss of control over who has access.

As well as physical space, time is also an organising concept in home care, in that continuity in daily living can be disrupted by the imposed routines of waiting in and conforming to the timescales of others' work. Twigg (2002) discusses the temporal aspects of care and

inflexibility of bringing workers together at the time needed of the older person, imposing a different and bureaucratic 'body-clock' on the recipient. Isaacs and Neville's (1979) account of intervals of need are useful in the assessment-rooted classification of unpredictability of certain needs and associated perceived levels of risk, although Twigg does point out the discontinuity between the 'clock time' of service delivery, and the body time of necessary functions and domestic crises: 'Old people are time rich. But they know that their time does not have value in the way that a worker's does. Their time is *not* money.' (Twigg, 2002:99).

However, the home is not necessarily a new site of provision of care. As Wiles (2005) points out, doctors visiting homes used to be a more routine practice, and family members (mainly women) shouldered care responsibilities in multi-generational households. Nevertheless, as the individual's home has increasingly become the locus of care (with informal carers as a constant means of support), so new sets of care relationships and interrelationships between the older person in their home, care managers and service providers have developed (Milligan, 2009). As boundaries between public and private spaces blur, the potential for some of the characteristics of institutionalisation to shift location into the home also increases, as first noted by Gavilan (1992). Although home visits by doctors may have become less frequent, this provision of care in the home (including community nursing) has also been referred to as the medicalisation of personal space (Ceci, Björnsdóttir and Purkis, 2012), turning the dwelling space into a '(...) suburb of the healthcare system.' (May, 2012: xii).

Social and health care provided to and within the home is not the only component of ageing in place. In study by Wiles *et al.* (2012) of 121 older people in Aotearoa New Zealand, being able to exert choices about where and how to age was a prominent theme, echoed by the

AARP (formerly the American Association of Retired Persons) survey (2011) of elders in the USA. Ageing in place related not just to the physical fabric of the domicile, but interacted beyond the built environment with a sense of security and emotional connections to the present community.

Personal care is just one component of the range of potential tasks that may assist people in their own homes. What constitutes 'personal care' has been an area successive government administrations have been loath to define, as the potential range of tasks is very wide. However, the legal emphasis has more recently been concentrated on the more intimate physical tasks of personal care. The Care Standards Act 2000, under which regulations are made, does not define the meaning of personal care. However, other law-making bodies have specified the scope of personal care. For example, the Domiciliary Care Agencies (Wales) Regulations 2004 (National Assembly for Wales, 219, W.23) determine the current boundaries for domiciliary care in Wales. Included in the definition is 'personal care' which involves: '(...) assistance with bodily functions such as feeding, bathing, walking and toileting; and care which falls just short of assistance with bodily functions, but still involving physical and intimate touching'.

This definition reflects standard policy assumptions (for example, enshrined in FACS eligibility criteria), and is focussed on the body in a material way. The emotional labour of 'body work' in care, and the lowly status of employees who actually touch their clients is discussed by Twigg in relation to the 'social bath' and the retreat of medicine and nursing from long-term care (Twigg, 1997; Twigg, 2000; Twigg *et al.*, 2011). In this policy definition of 'personal care', the complex, sensitive interdependence between the person being cared for and the person providing the assistance is notably absent. Such definitions

retain their continuity in policy. The definition of 'personal care' has been further specified in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (s3), which also focus on physical assistance in daily routine task such as eating, drinking, toileting, washing, oral and skin care, and including prompting and supervision to carry out such tasks. It is apparent that such definitions are very functional, with the older person a passive recipient of assistance. They say nothing about befriending, listening, supporting or enabling. Instead, they are rooted within a 'traditional' gerontological loss-deficit model of ageing (Knight, 2004), emphasising the inevitability of loss and illness as the norm in the ageing process. This model adopts a negative approach to life span development and portrays the normative course of later life as a series of losses, with depression as a typical response (Gitelson, 1948; Berezin, 1963). It does little to reinforce strengths perspectives (Saleebey, 2005) or a model based on mutuality and reciprocity (Janlöv et al., 2006; Bowers *et al.*, 2011; Blood, 2013). These later definitions of personal care, whilst focussing on bodily assistance, also do not include shopping and other domestic duties, which can be seen as 'lost' aspects of care, under contemporary eligibility criteria, discussed below. However, at the time of fieldwork, these domestic provisions were still evident in practice, which will be explored further in the discussion of findings of interviews with older people in Chapter 4.

### **Squeezing through the eligibility hoops**

Fair Access to Care (FACS) was introduced in 2002 with the intention of providing a framework for a fair, transparent system of resource allocation, based on four bands of assessment of need (DH, 2002). These were critical, severe, moderate or low, depending on levels of perceived risk and/or loss of independence. Tanner (2005), writing a

few years after implementation argued that although such policy changes regarding eligibility were ostensibly focused on prevention, they were unlikely to widen access for those categorised at low levels of need, and that focussing on high risk implied dependence, surveillance and loss of older people's control over what and how services are received. This was prescient, as there has been a well-documented trend for local authorities to restrict eligibility for services in response to financial restrictions. Resources have been targetted on those people assessed with critical and high needs, eliminating provision for those seen as falling into low and moderate categories in many local authorities (CSCI, 2008; CQC, 2010; Age UK, 2011; Humphries, 2011; ADASS, 2011). The CSCI (2008) investigation of the implementation of these eligibility criteria was critical of the complexity of the system, inconsistent application leading to a lack of fairness, and incompatibility with the principles of personalisation. Guidance was updated by the Department of Health in 2010 for England (other devolved nations retained their own systems), incorporating an outcomes-based approach within the context of personalisation, which also claimed to enhance prevention, early intervention and support for carers (DH, 2010). Nevertheless, the bandings remained unchanged, as local authorities still wielded discretion on where they set the thresholds for eligibility, and how they applied the criteria. The PSSRU was commissioned by the Policy Research Programme in the Department of Health to survey local authorities in England (Fernández and Snell, 2013) in order to understand how eligibility was being assessed and determined across a range of needs characteristics and groups of service users. In order to do this, they incorporated a questionnaire for care managers, presenting a range of vignettes differentiated by user group, asking them to specify which FACS band they felt applied to each individual. Their results demonstrated the subjectivity of assessors' interpretations, with significant heterogeneity in the range of

judgements by care managers, both within and between local authorities. In particular, they suggested systematic disparities in how different service user groups were perceived within FACS. Responses indicated linkage between the local authority eligibility policies and the banding levels at which they care managers placed individuals. Care managers were more likely to place service users in a higher band where their local authority has tighter eligibility criteria. Only just over half of the care managers who conducted assessments were qualified social workers, and hence registerable with the regulatory body. One area for further investigation not addressed directly by the survey is how the differential assessments are applied between different groups; older people and younger physically disabled adults, for example. Inferences can be drawn from the vignettes that social inclusion is accorded less importance for older people, but further research in this area is needed. One effect of the rising eligibility thresholds has been the reduction in the numbers of people receiving publically funded home care services. The UKHCA overview of home care (UKHCA, 2015) noted an 18% decrease from 2009-2014 as a result of tightening eligibility criteria. Thus the overall picture of home care over the past two decades has been one of increased removal of people from entitlement to funded care, with increasing focus on those seen as 'high risk' and requiring high levels of assistance with bodily tasks.

### **Care and community**

The issue needs to be raised of how home care in the United Kingdom came to be so 'embodied' and functional, and separated from other routes of support. In order to address that, key terminology routinely used in policy requires further examination. Separately and together, the terms 'care' and 'community' are entrenched, uncritically, in welfare policy in the United Kingdom. Just as the 'home' in home care

emerges as freighted with complex meaning, these terms are deceptively simple, depicting, as Titmuss (1968: 107) remarked; '(...) a sense of warmth and human kindness, essentially personal and comforting (...).'

Nevertheless, they remain contested concepts within the discourse of care (Fine, 2007; Daly, 2011, Barnes, 2012). Symonds (1998:7) referred in her sociological analysis to the '(...) concrete unreality of a place called the community which nevertheless has achieved an identity and social reality of its own.'

Raymond Williams (1983: 76) also selected the '(...) warmly persuasive word (...) 'community' as one of his 'keywords' in modern culture, noting its distinction in never being given a positive opposing term. The elusiveness of other terms used in community care is also notable. For example, Thomas (1993), in an early commentary on the post-NHSCCA 1990 arrangements for community care, discussed how the central concept of 'care' itself is fraught and inconsistently defined by analysts and policy makers. This critique has persisted through discourse on community care, as Rummery and Fine (2012) consider how far the term may mean care by, care with, or care instead of. 'Care' is also gendered in the context of provision of social care (Ungerson, 1990; Graham, 1991), carried out by subordinate groups in a feminised provider market that relies heavily on low paid, migrant workers; a theme that will be returned to in Chapter 5.

Other terms and processes in the implemented model of care management are also subject to lack of clarity and tension between theory and practice. Particular attention had focused on the process of assessment, and its contentious central concepts of need and risk. Risk is linked to unpredictability, which Isaacs and Neville (1976) incorporated into their concept of time intervals between episodes of

specified need. They defined three such levels of 'interval need' from critical need (constant supervision due to unpredictability and severity) long interval need (predictable) and short interval (frequent but predictable). Such functionally-based definitions of need were employed in the implementation of community care, where the care manager is responsible for assessing levels of need and risk, and also informed later eligibility thresholds. The Royal Commission on Long-Term Care (1999) employed a different approach, adopting the following four categories taken from Bradshaw's taxonomy of social need (1972), which indicate the elements included in the attempts of both the person themselves and others to classify need. These encompass 'normative need', or what the professional 'expert' defines as need, based on a predetermined standard. This is the model of need assessment embedded in the NHSCCA 1990 approach (Law Commission, 2011), and may be practically constructed within the organisational and resource constraints of the welfare agency responsible for assessment (Smith, 1980). However, Bradshaw contrasts this with 'felt need', or what people actually want. Felt need is widely used in satisfaction studies and the Department of Health User Experience Surveys, but may be limited or inflated by people's perceptions. This is then translated (or not) into 'expressed need', or demand. The final category is 'comparative need', where those requiring a service are compared to those with similar characteristics who are not in receipt; an important issue where there is inconsistency in application of eligibility criteria.

### **Triad of key perspectives**

The discussion now turns to debates on the perspectives of each of the three core intersecting groups within the Parkside case study, which in turn inform the data collection and discussion in Chapters 4, 5 and 6 respectively. Firstly, research on the views of older recipients



of home care is examined, with emphasis on the domains of choice and perceptions of quality of services, and how these may intersect with interactions with both service providers and purchasers. Secondly, the role of the providers of home care services in quasi-markets and critiques of the 'businessology' of social work (Harris, 2003) are appraised. Thirdly, the standpoints of care managers dealing with uncertainty, interacting with care markets, and rationing services are considered. Debates on the exercise or curtailment of professional discretion are central in the context of the care management model, and continuities are highlighted with the evolution into personalisation.

### **Older peoples' view from home**

As noted earlier, the conceptualisation of older people in early gerontological literature has tended to be based on an unspoken, accumulation model of ageing, originating in gerontology practitioners working with 'frail' older people, assumes inevitable decline, with the role of welfare provision to help people to adjust to this inevitability of loss (Woodward, 1991; Hugman, 1999). This perspective has been supplanted in critical gerontology (Ray & Phillips, 2012) and counterposed with theories of 'successful' ageing, originally posed by Havighurst (1961). Social work practice with older people has shifted its framework to one of independence and autonomy (Tanner, 2010). Nevertheless, it is argued here that 'needs-led' assessment has remained focussed on functional deficits.

Ageing in place relies on notions of independence, and maintaining 'successful ageing' (Baltes, 1996). 'Successful ageing' is therefore counterposed against 'unsuccessful ageing' characterised by high levels of dependence and frailty. Although independence is central to current policy, its achievement is compromised by reducing resources

and services (Secker *et al.*, 2003), and may be viewed more as exclusion or abandonment by those it is bestowed upon (Plath, 2008; Lloyd *et al.*, 2013). This is a debate that is continuing on individualised models of personalisation and 'responsibilisation' of people at risk (or 'vulnerable') that shifts responsibility for care from the state to the person (Brown, 2012; Duffy, 2014).

The experience of receiving care in the home can be seen as more than simple receipt (or rejection) of services. A simplified 'flow chart' of care management tasks incorporating the cycle of assessment of need and matching services as provided in the Social Services Inspectorate policy guidance (SSI, 1991) does not acknowledge the potential changes in status and identity that these transactions entail. A more nuanced concept of supported independence as a life stage is discussed by Hale, Barrett & Gauld (2010) whereby there is an uncelebrated transition (which they refer to as a 'secular ritual') into contact with formalised home care services. In their interviews with older people receiving care services in the home in New Zealand, the authors view this transition into the environs of 'welfare' in terms of a rite of passage, an anthropological concept drawing on the work of Victor Turner (Turner, 1969) that represents liminality, loss, 'biographical disruption' (Bury, 1982) and movement into a more ambiguous social space.

Independence has been formulated in policy as a positive attribute to be promoted, from the time of *Caring for People* (DH 1989). Dependence, as its opposite, is seen in a negative light, both for the individual and the State, signifying entry into (expensive) long-term care. However, the acceptance of care is an acknowledgement of some level of increasing dependence, but this does not negate the importance of autonomy and choice over that care. There has been a more recent shift in conceptualising care from seeing it as a work

function to more relational practice (Ceci, Björnsdóttir & Purkis, 2012). For example, Nolan *et al.* (2006) emphasise inter-dependence in the 'Senses' Framework, not just independence and autonomy. This framework, originally applied in working with older people in long-term care settings, focuses on enriched environments that promote senses of security, belonging, continuity, purpose, achievement and significance. By extension, this also contributes to current debates on realigning care in home settings away from task-oriented, time-starved work to relational models (Nolan *et al.*, 2006; Andrews, Driffield, & Poole, 2009; Ceci, Björnsdóttir & Purkis, 2012). In addition, literature on 'low-intensity services' in the home demonstrates the value placed by older people on direct practical support, including housework, shopping and domestic services (Clark, Dyer & Horwood, 1998; Raynes *et al.*, 2001; Clark & Raynes, 2006; Clough *et al.*, 2008; Patmore & McNulty, 2005; CSCI, 2006; EHRC 2011; Office of the Older People's Commissioner for Wales, 2012). However, such services are the most likely to be lost as eligibility thresholds for services rise.

Older people, already potentially entering a stage of social marginalisation as a 'liminal' group (Hey, 1999; Hales, Barratt & Gauld, 2010), may be thrust into this unfamiliar system by force of circumstance and with choices already severely limited. In common with other surveys on domiciliary care (for example; Henwood *et al.*, 1998; Francis & Netten, 2003; Patmore, 2003; Netten *et al.*, 2004; Richardson & Pearson, 2005; Clough *et al.*, 2007; Office of the Older People's Commissioner for Wales, 2012), the value placed on reliability, consistency and competence of staff all figured highly. These are findings that have remained remarkably constant over the past two decades since the implementation of community care, and will be revisited in the views of the older people and their relatives interviewed in this study.

## **Providers and care markets**

At the time of the Parkside study in the NHS&CCA 1990 post-implementation period, the provider perspective was relatively absent in contemporary studies on community care, despite the tremendous responsibility for a vulnerable population inherent in the provision of domiciliary care. The expansion of residential care had levelled out, and the numbers of local authority funded home care contact hours had grown substantially; by 53% from 1.7 million in a Department of Health 1992 survey week to 2.6 million in 1997 (Hardy, Young & Wistow, 1999). This growth in home care was largely due to the expansion of the independent sector, whose share of the Local Authority funded home care market grew from 2.3% in 1992 to 44% in 1997 (DH, 1998), within the period of this fieldwork. Despite the growth in supply, volume and variety, domiciliary care continued to be seen as a 'Cinderella' service, according to the chair of the Joint Advisory Group of Domiciliary Care Organisations (Bell, 1999). Underlying this view was a perceived underdevelopment in the market.

Provider markets themselves and purchaser perceptions of them were changing. Wistow *et al.* (1996) revisited in 1993 a sample of twenty-five local authorities first surveyed in 1991 to evaluate how they were coping with the implementation of the purchaser-provider split. They found managers and practitioners in social services very resistant to the idea of working with social care markets in 1991, as the organisational changes were imminent. However, just after implementation, two-thirds of their interviewees (particularly Directors of Social Services) had become more pragmatic than sceptical. They could see advantages in the new arrangements, in terms of being aware of and in control of costs, and for the opportunities to increase

choice for users. In the two years after the implementation of the NHSCCA 1990, Young & Wistow analysed the results of the 1995 United Kingdom Home Care Association (UKHCA) survey of provider markets. Although relations between local authority purchasers and the independent agencies were improving, the market was still operating from a fragile base of small providers dependent on a narrow business base (for example, solely providing domiciliary care). It should also be noted that such provider markets may be best suited to urban areas (like Parkside), where travel distances for staff are shorter compared to rural areas (Patmore, 2003; Pugh *et al.*, 2007). However, this period of expansion in home care has now reversed, which will be returned to at the end of the section.

Ford, Quilgars and Rugg (1998) surveyed purchasers, providers and care workers in three different local authorities in order to examine the state of market in the post-1993 implementation period. They found that employment opportunities in domiciliary care expanded during this period, although this was difficult to quantify given the lack of baseline data. They also painted a picture of a fragmented independent sector, stimulated by local authority use of the Special Transitional Grant, with the majority of recently established independent providers having a client base of 100 or less. The warning signs of disadvantageous employment conditions were evident at that early stage. Local authority providers, and specialist or not-for-profit independent sector employers paid higher rates of pay, guaranteed minimum numbers of hours of work, and also provided training, holiday and sick pay. Probably as a consequence, this relatively stable working environment had less turnover of staff.

However, in contrast, there also existed a poorly paid and casualised employment sector. These were mainly for-profit independent sector providers that lacked training, had poorer working conditions, and had

a non-unionised workforce with high staff turnover. Local authorities as purchasers had a major role in shaping this very competitive market. The practices of spot contracting and short-term contracts also contributed to instability for the provider organisations. Three years later, Ware *et al.* (2002) reported on a continuation of a PSSRU study from 1995 (Hardy *et al.*, 1996) of independent sector domiciliary care providers in 11 local authorities. They noted that Department of Health figures for 2000 showed that the independent sector share of the publicly funded domiciliary care market had risen to 51% at the time of their work, and that contact hours by the independent sector outstripped those provided in-house by local authorities by 8.1 hours compared to 5.2 hours. In common with Ford, Quilgars and Rugg's 1998 survey, Ware *et al.* (2002) also found that over a quarter of the agencies surveyed provided 250 hours or less per week. In addition, more than half of the providers sampled reported that new service users had higher levels of assessed needs. Although some local authorities were increasing the prices paid to providers the authors reported that independent domiciliary care providers were feeling squeezed financially. A fifth reduced their costs, including profits, some were considering exiting the market, whilst the most common response was to reduce staff wages and training, streamline administration, and seek more privately funded clients.

The Care Standards Act 2000 brought domiciliary care within a regulatory framework for the first time, including National Minimum Standards (DH 2003). Leece (2003) marked the recent implementation of these standards by examining the future of recruitment and retention in domiciliary care, and potential effects of the commodification of care. Prefiguring contemporary concerns, Leece also noted with concern the practice of 15-minute slots for domiciliary care workers to perform their care tasks, and echoed previous alarms over the low pay and status of domiciliary care

workers and financial squeeze on local authorities passed on to their contracted providers. Laing and Buisson (2003) described the domiciliary care market at that time as fragmented, with providers diversifying from nursing agencies or residential care provisions, but remaining predominantly small scale. McClimont and Grove's survey of providers (2004) found that recruitment had also fallen. One conjecture by the authors is that this may have been due to an unwillingness to bear the high costs associated with new staff recruitment, including Criminal Records Bureau checks and qualification training. Three quarters of the providers who responded cited difficulties in recruitment, and in particular, lack of available and suitable people. Netten *et al.* (2005), drawing on DH annual returns, noted that in-house provision fell by 38% in the period 1992 to 2003, as the role of the independent sector increased. Correspondingly, the number of households receiving home care services fell by 27%, reflecting the intensification of services targeting those with higher levels of need, and a move away from domestic or 'low intensity support services' (Quilgars, 2000) to higher eligibility criteria of need and more intimate personal care, discussed earlier. The newly constituted Commission for Social Care Inspection (CSCI, 2006) summarised evidence on the performance of home care in England, and the capacity of the sector to expand and develop. Although some excellent outcomes for enabling people to live more independently were reported, CSCI also criticised the trend towards intensification of services at the expense of preventive work. As with the previous commentaries discussed, CSCI noted the fragility of the care market, and warned about its capacity to be able to improve, given problems with recruitment and flexibility of working. Damningly, CSCI identified a gap between what people said they wanted and needed, and what publically- funded services were able to deliver.

The introduction of Direct Payments from 1997 had had little initial impact on provider practices, due to low take up and care managers selectively offering the service (Ellis, 2007; WAG, 2007). However, a decade later in 2007, the New Labour Government announced the expansion of cash for care with the introduction of Personal Budgets (PBs) for everyone eligible for publically funded care in England. Baxter, Glendinning & Clarke (2008) examined threats and opportunities in this changing funding structure for care, and found providers unprepared to respond to the potential for increased user choice stemming from these developments. In particular, agencies experienced difficulties with late or non-payment by PB holders, were expected by PB holders to provide a wider range of services, and found themselves being undercut by cheaper self-employed care workers. 2011 saw the collapse of a major residential care provider, Southern Cross Health Care PLC, followed by Castlebeck two years later (CQC, 2014). Although these companies were in the care home sector, their market conditions in a low wage, under-trained sector has parallels with domiciliary care providers in terms of care market stability.

The pattern of local authority funded home care services may now be contracting, according to the Laing and Buisson report on the UK home care market (2013), which showed that 2011-12 showed a second successive year of shrinking volumes, following a run of increases in the previous fifteen years. Some of this reversal can be attributed to financial restrictions, and to the personalisation agenda and the rise in use of Direct Payments. In March 2012, 107,000 people were receiving direct payments (compared to 94,400 in March 2011). Of this number 61% were older people, marking a strong increase for older people on the scheme with 41,900 in 2011/12 compared to 34,900 older people recorded on the scheme in March 2011. Independent sector homecare businesses continued to increase



their market share, growing a further 5% over Laing and Buisson's last recorded figure to achieve an 89% share of the hours funded by local authorities in 2011/12. This trend of increasing demand, reductions in funding and fewer people supported by publically funded services is echoed by Age UK's 'Care in Crisis' campaign (2014).

In 2003, Harris described talking with a private sector home care worker. She was driving three miles in each direction to assist an older person with going to bed in the evening. For this she was allowed fifteen minutes, was paid no travelling expenses, and earned below what was later established as the minimum wage. This reflected the conditions of the 'business ethos' (Harris 2003:3) for frontline staff at the time. This experience from over ten years ago has resonances with contemporary accounts of 'call clipping' or shaving time meant for care in order to travel between visits. Such practices have been deemed unacceptable by the UKHCA (2015), as they impact both on the experience of care and on the under-payment of care staff. The previous discussion has traced the development of care markets within the mixed economy of care, and how this has also contributed to shaping older people's experiences of care. In turn, care management practitioners' interactions with markets has helped to shape social work practices (Harris, 1998; Harris, 2008).

### **Practitioners and professional discretion**

Social workers (who at the time of the Parkside study had become designated 'care managers') operate within changing policies and structural reorganisations, and with uncertainty inherent in the nature of their routine work. There has been considerable debate on the uses of professional discretion and the application of the concept of street-level bureaucracy (Lipsky, 1980). This has been applied to social work in the United Kingdom since the inception of community care

(Baldwin, 2000; Evans & Harris, 2004; Evans & Harris, 2006; Evans, 2010a; Evans, 2010b), and to other countries and professional domains (Myking, 1999; Keiser, 2003; Musil *et al.*, 2004; Allen, Griffiths & Lyle, 2004). In Lipsky's formulation, such public service workers act under competing pressures and with limited information, so in response simplify the nature of job and adapt it. In effect, they are the ultimate policy makers, as experienced directly by those receiving their services. The bureaucracies themselves are characterised by tensions between scarce resources, ill-defined organisational goals and unrealistically high expectations of performance (Lipsky, 1980). Crucially, they are organisations in which: '(...) performance oriented toward goal achievement tends to be difficult if not impossible to measure.' (Lipsky 1980:28).

This has implications for attempts at evaluation of the efficacy of routine work in social services departments, which is itself an under-researched area. Ash (2013: 99), in her discussion of adult safeguarding in the context of street-level bureaucracy noted the dearth of studies of: '(...) the day-to-day reality of social workers charged with implementing public policy.'

These debates fall into two main arguments on the different uses and impacts of discretion, although these need not be regarded as a rigid distinction (Evans & Harris, 2004). In his critique of Lipsky, Howe (1991) and more latterly Lymbery (1998; 2000) present a pessimistic line of reasoning on curtailment of discretion, based on the shift away from individual professional autonomy due to imposition of restrictive statute and managerialist constraints. Other studies (Lewis & Glennerster, 1996; Ellis, Davis & Rummery, 1999; Ellis, 2007) emphasise that, despite organisational constrictions, social workers still find ways in which to exercise their professional judgement. How far this may act for or against the interests of service users has been

reviewed by Ellis (2011), who proposes that frontline decision making interacts dynamically with countervailing forces of street-level bureaucracy and attempts to exercise top-down control. This thesis adds to these debates by examining the operation of discretion by care managers in the specific case of Parkside in Chapters 4 and 6.

### **Echoes from the past for current policy and practice directions: personalisation and citizenship**

The preceding discussions have demonstrated underlying assumptions about some of the key concepts that are embedded in the care management framework itself, and in implementation gaps between policy rhetoric and application in practice. This section has also addressed current directions in United Kingdom policy towards models also adopted by other European countries such as Austria, France, Germany, Italy, the Netherlands and Sweden (da Roit & La Bihan, 2010) of personalisation and cash for care. Landmark changes in policy were implemented before, during and after the data collection in this study. This study has therefore engaged with the post-implementation period of care management, its continuation under the New Labour government (1997-2010) and the introduction of cash for care systems, starting with Direct Payments and their extension into Personal Budgets. During this time, the domiciliary care market has expanded and experienced some shrinkage again, while the services have shifted focus away from low to intensity to high. Nevertheless, the key roles of purchaser and provider acting in the mixed economy of care in an environment of resource restriction have persisted. Subsequent legislative changes, in particular the Care Act 2014 in England and the Social Services and Well-being (Wales) Act 2014 in Wales, characterise care management as an outmoded model of delivery, a view supported in recent commentaries by Lloyd *et al.* (2014), and Ray *et al.* (2014) on the future of social work with older

people. However, these countries diverge in their interpretation of the principles of personalisation, with Wales adopting a community-oriented rather than a more individual, marketised model of support claimed to be practiced in England (WAG, 2011). In this legislation and policy, the Welsh Government employs the term 'citizen' to denote the focus inter-connections beyond the individual; an emphasis in social work that dates back at least to Attlee in 1920. Just as the now seemingly out-dated "community" in community care appealed to a nostalgic view of cooperative support, so the Welsh Government appeals to 'strong communities' (WAG, 2011) and Wales as the home of Aneurin Bevan and mutuality. Although the political language differs, both approaches are stimulated by the twin drivers of financial austerity and demographic changes leading to rising levels of complex need (WAG, 2011). As the realities of resource constraints persist across the decades, both countries intend to employ frameworks for determining eligibility for services. It remains to be seen whether these will lead to similar inequities and emphasis on critical levels of need to those documented for the previous system of FACS. Nevertheless, despite these legislative changes, the market paradigm of the purchaser-provider split has persisted since the introduction of care management under the NHSCCA 1990 to the present.

### **Drawing the threads together**

In this review, home care has been shown to consist of a set of multifaceted relations that encompass the interactions in a mixed economy between older people, care managers and service providers; the three main groups I examine in the Parkside case study. The realist consideration of what works for whom and under what circumstances, is apt in such complex situations, as there may be fundamental differences between the interests and understandings of

the respective actors, which may also vary across different organisational and social contexts. However, evaluations of home care from Goldberg and Connelly (1982) to the successive decades covering the implementation of care management (Godfrey *et al.*, 2000) and foreshadowing its demise (EHRC, 2013) indicate that this tripartite analysis remains largely lacking. By tracing policy developments, their underlying assumptions and implementation gaps relating to home care for older people, it is proposed that personalisation is not a break from care management but a continuation, focussing on assessment for eligibility in the context of restricted resources, and operating within the market of care. Subsequent chapters draw on these review themes in the analysis and discussion of the empirical data from interviews with the three core groups of interest.

## **Chapter 3**

### **Methodology and procedures for data collection**

#### **Introduction**

This chapter addresses the specific methods and procedures used in the case study. The first section reviews the issues of ethical governance. The choice of methods employed to address the research questions are then considered, with each source of data discussed in turn. The adoption of a realist approach was outlined in Chapter 1 and will be returned to in Chapter 6. However, this chapter discusses the original influences on the research design, and the impact of organisational (r)evolution in Parkside.

#### **Ethical governance**

Dominant cultural perceptions equate ageing with incapacity (Wilson, 2000) and a 'problem' orientation (Bytheway, 1995; Ray, Sharp & Abrams, 2006), particularly for those people in contact with health and social care agencies. Carrying out research with potentially 'at risk' older people can be regarded as a sensitive topic (Lee, 1993), carrying potential vulnerabilities both for the researcher and respondents in terms of safety and the possibilities of unintended consequences such as psychological harm. The researcher's stance in relation to older people as research respondents may be one of a perceived structural power imbalance, however unwanted that might be (Hey, 1999). The dangers of gathering users' views to no discernable effect, leading to 'consultation fatigue' (Alderson, 1999) are discussed further in Chapter 4 on the findings from user and carer responses.

Social work perspectives emphasise countering discrimination and valuing uniqueness and diversity (International Federation of Social Workers, 2014). However, for a profession that may lay claim to distinctiveness for its value base, there have been notable gaps in structural scrutiny of ethical issues in social work research. At the time of the data collection, there was no formal mechanism such as an ethics committee within the Parkside Social Services Department for ethical screening and clearance for projects. This landscape has changed, as currently the Mental Capacity Act 2005 (Sections 30-34) requires research proposals for working with individuals who may lack mental capacity to be scrutinised by an 'appropriate body'; in England a Research Ethics Committee (REC) recognised by the Secretary of State. From April 2015, the National Social Care Research Ethics Committee (under the auspices of the NHS Health Research Authority) has taken responsibility for social care research, separate from Higher Education RECs. However, as discussed in Chapter 1, approval of research procedures, including access to confidential records and for contacting and interviewing service users themselves, was in the hands of Parkside senior managers, although the research project was subject to internal University research ethics scrutiny and approval. The Parkside ethics process contrasted with the local Health Authorities, which all had established ethics committees. My route through an ethical governance framework was therefore less rigorous than it would be in current research processes. There was an almost insouciant approach to ethical approval. It was deemed sufficient that senior managers had sanctioned my access to service user case records that also provided the personal details that enabled me to write to, and later telephone older people in order to introduce myself, give information and request consent for interview. However, although this imprimatur did afford the crucial opportunities to enable the research to proceed, it did bring its own difficulties, particularly in the

changing perception of my role by practitioners, which will be discussed further in Chapter 6. This is discussed further in Chapter 6, which presents the findings from group interviews with Assessment & Care Management locality teams.

The following sections expand upon the methods used to tackle the research questions for each source of data, starting with an exploratory project.

### **Gathering empirical data: Exploratory project**

The research strategy, and the methodological shift to a realist framework have been introduced in Chapter 1. The overall research design was not originally conceptualised within an action research model (Hart & Bond, 1995), where there is an explicit, cyclical intervention and change component to the research, but was commissioned as a project examining effectiveness of services. I have outlined in Chapter 1 how the initial familiarisation period in Parkside brought the realisation that the everyday, routine practices of organisation and recording within the Social Services Department were not conducive to pre-test, post-test designs more suited to controlled interventions. The following exploratory study further illustrates how the operation of the research itself also fed into changing the object of study by engaging in reporting back to the commissioning agency, resulting in changes to the organisation, and, arguably, resulting in *de facto* action research.

The project involved an exploratory study carried out from one locality office at an early stage of the studentship, at the request of Parkside for reasons explained below. The methods used in this exploratory study differed from the rest of the research project in a number of ways, and pre-dated the finalised research questions. However, the



findings helped to inform the design of the later period of data collection, and the process illustrated some of the tensions within both the care management system in Parkside, and in my position in relation to the organisation.

This was a small-scale, time limited survey of the views of older users and their carers who were receiving complex packages of care in the community. The impetus for this survey derived from Parkside senior management concerns over possible detrimental effects on older service users of fragmentation of services resulting in a variety of care staff from different provider agencies entering their homes. The study therefore stemmed from a request to seek the views of a group of service users who were otherwise unable to participate in the Parkside's wider consultation process, which at the time of fieldwork centred around public meetings, inaccessible for service users who were less mobile, for example. Although the study would assist Parkside, it was also an early exercise in becoming known to staff in the localities, and testing the practicalities of the process of contacting and interviewing a target population of older people. The mechanics of obtaining suitable identification for visiting respondents at home illustrates some of the ambiguity inherent in my role. I wanted a photo-based identification card that would both confirm my status as a *bona fide* researcher and reinforce my independence from social services. Although the ID card supplied by Parkside literally opened doors within the local authority organisation, it would not have been suitable for home visiting purposes, as it would also compromise my independence from the Parkside structure. Enquiries established that the University did not routinely issue photo identity cards for students. Nevertheless, vending cards for use in obtaining food and drink from authorised machines on the campus carried both the logo of the University and a photo of the bearer. This acted as my improvised identity card for home visits.

## **Selection of older participants**

The purpose of this early study was explained to staff groups in the three locality offices through staff meetings and personal informal discussions with managers and individual staff, which also acted as a means of introducing myself to key personnel. The sample inclusion criterion was that potential older interviewees were recipients of complex care packages with multiple services, as described earlier. All target 'cases' had an allocated care manager, who nominated individuals on their caseload who fitted this criterion, and advised whether there were special circumstances such as communication difficulties, or whether proxies such as informal carers needed to be approached. Sinclair, Gibbs & Hicks noted the importance and difficulties of gaining a sample of recipients of social services:

(...) often recruitment depends on the willingness of social workers to introduce the study. They are busy, not necessarily great believers in research, and have a complicated enough agenda to transact with their clients as it is (2000:6).

I was certainly aware of my dependency on the cooperation of staff, and the need to be both diplomatic and efficient in my dealings with them.

## **Procedure for data collection in the exploratory project**

I wrote individual letters to potential respondents, including an initial information sheet about the study (Appendix 1), which were followed up by a telephone call to arrange a convenient time and place for interview, provided consent was given. The target sample size was a dozen people, in order to complete the study relatively quickly, which was a stipulation of the project from the senior managers' perspective.

The final sample size was 11 households, totalling 18 individuals, comprising a mixture of users and carers, whether living together or not. Of the 11 households contacted, one declined to take part, one was unavailable because of hospital admission, and one was unable to arrange an interview time, making a household response rate of 73%. Interviews subsequently took place over a 4-week period between March and April 1995, with 7 users and 6 carers. All of the older people in the final sample were receiving a number of different services from a range of in-house and independent provider agencies.

### **Interview topic guide**

As the purpose of this round of interviews was exploratory, an unstructured interview topic guide was devised (Robson, 2011, where respondents were encouraged to expand on their answers. The time actually taken to complete the interviews varied from  $\frac{3}{4}$  hour to 2 hours, as some respondents were more expansive than others. The less structured approach permitted this capacity for a more relaxed pace, although there was a dilemma over whether longer interviews were beneficial to the respondent or tiring. A constant 'checking back' process was necessary, to test the continuing acceptability of the interview to the interviewee. The domains elicited views of users and carers on their initial contact with Social Services; current services received; the quality of any information received on the services; services for carers; and overall views on the perceived quality of services provided, which were within the parameters of the project aims.

### **Data analysis**

Interviews were tape-recorded with permission, which was explained to interviewees as being to aid my memory. This permission was withheld on one occasion. The right to refuse or withdraw had been

explained prior to interview, as an essential ethical consideration. No reason for refusal needed to be given or was sought. In addition, notes were taken during the interview. The qualitative data of the interview contents were analysed manually to identify broad themes, which were reported back to the organisation in the form of an internal report, distributed to the three locality team managers and staff, and to selected other interested agencies such as the local carers' organisation.

### **Influence on later study**

This exploratory study served a number of functions. It looked at a particular moment in care management, with some of the cases representing early examples of this form of intervention, exemplified by heavy input of services with accompanying high costs. It identified themes in users' and carers' views which were of particular concern both to those receiving services and to the Social Services care management staff and their managers, and which were followed up more systematically in the later study, and are incorporated into the findings in Chapter 4. The process also prompted refinements on the sampling and contact procedures and instruments, detailed later in this chapter. Further directives on providing clear written information and care plans were sent out by senior managers to care management staff as a result of the findings, an example of a feedback loop where the research process and findings effected changes in the organisation under study. As a concluding note, despite discussion of ethical considerations including anonymity of respondents, the Senior Manager for North locality asked for a full list of all those agreeing to interview. I did not comply with this request.

## **Main study interviews with older people**

The exploratory study was useful in developing staff contacts and becoming familiar with the vagaries of the procedures used by one of the Assessment & Care Management locality teams. In order to address the research topic of the impact of domiciliary care services on older people in Parkside (through examining the processes of assessment of needs, matching of services to needs and the quality of service delivery), the strategy of direct interviews with service users and available carers had been trialled and found appropriate.

The main data collection tool developed for the larger study was a semi-structured interview schedule (Robson, 2011), which encouraged users, and carers acting as proxies where appropriate, to talk about their experiences in detail, but which also gave scope for the collection of quantitative data, such as demographic information. A particular influence on the structure and content of the interviews with service users was the work of the PSRRU study (PSSRU, 1995), *Evaluating Community Care for Elderly People (ECCEP)*. This ECCEP study built on the pre-NHSCCA 1990 experimental work in community care (Challis & Davies, 1986; Davies and Challis, 1986; Davies, Bebbington & Charnley, 1990) by evaluating the post-NHSCCA 1990 reforms. In order to do this, it interviewed 76 service users, their carers and social services staff in 10 areas in England and Wales. These service users were a mix of newly referred older people as well as those already receiving services, but requiring an increase in the level or quantity of such services. The older people were interviewed as soon after assessment as possible and again six months later. The ECCEP interview schedules also included validated standardised measures used in previous PSSRU studies for comparability of service user characteristics of need, covering cognitive impairment, daily living abilities and morale. Following this model, I also incorporated

standardised measures into my interview schedule, and codings that would permit both qualitative and quantitative analysis of the data. However, as will be seen below, the ECCEP model of two rounds of interviews (which were conducted by a commissioned independent research company) proved to be impractical for a single researcher, both in terms of time available and because of the problematic nature of sampling, discussed in the following section.

### **Sampling procedure for older people**

The population under study consisted of those people aged 65 or over who were in receipt of community care services in their homes. Where the older person receiving care was not able to participate in an interview informal carers were asked both for proxy information, and for some information on their experiences of services in their own right. However, as the majority of the older people interviewed lived alone, or with a partner who was also a service user in their own right, the situation of informal carers was not the main focus of the study, and would deserve separate attention. However, those informal carers who were originally interviewed in the role of proxy informants did express their views on their experiences with Parkside SSD on behalf of their relative, and the impacts these had on them.

The selection frame used Parkside referral records for one round of interviews. The service user sample was a non-probability, purposive sample (Frankfort-Nachmias & Nachmias, 2014). The sample size aimed to be greater than 30 respondents of users and carers, in order for inferential statistical analysis to be feasible (Frankfort-Nachmias & Leon-Guerrero, 2014). The final sample consisted of 23 service users and 10 carers (interviewed both as proxies where appropriate and in their own right), not including those 13 users and carers interviewed in the exploratory study.

The initial range of potential interviewees were selected by means of consecutive sampling case records of older people over 65 who had received an assessment (usually by home visit) by a care manager for a new or increased service from Social Services. This aimed to address the original effectiveness research question, based on the Care Management model of matching services to needs. In order to do this, the aim was to interview older people who had received an assessment recently. Within this selection frame, the sampling method reflected organisational procedures, using the tripartite levels of need categories introduced by Parkside within their service user database (ECIS) Following scoring according to the needs criteria, service users were categorised into three broad categories based on 'dependency'; high, medium and low, as illustrated in Table 3.1 below. This grid was devised internally by Parkside (although the ECIS database itself was in national use), and pre-dated the later national Fair Access to Care four-level classification of needs and hence, eligibility (DH, 2003), and the contemporary Care Act 2014 national criteria for care and support. At the time of the study, this grid had been piloted in North locality, and, senior managers had directed that its use be rolled out to the other two locality teams.

**Table 3.1 ECIS Needs Scoring Grid**

<b>Functional Ability</b>	<b>Medical Factors</b>	<b>Risk Factors</b>	<b>Support Network</b>	<b>Score</b>
Unable/unwilling to perform activities of daily living & personal care tasks	Acute (sudden) mental or physical illness or disability	Risk to life or serious harm or abuse to self or others	No support network, or refuses services	10
	Deteriorating mental or physical illness	Homeless; or at imminent risk of losing accommodation or being discharged from hospital whilst homeless	Isolation an issue, or self isolating	9
Significantly impaired mobility/ability to perform daily living tasks	Chronic (long-standing) severe mental or physical illness or disability	Inability to cope in daily living situation or current accommodation. Self neglecting	Inability to cope in daily living	8
	Severe personality disorder	Possibility of danger to self or others		7
	Breakdown in psychological/emotional functioning e.g. trauma or bereavement	Having difficulties in coping. Further deterioration likely		6



<b>Functional Ability</b>	<b>Medical Factors</b>	<b>Risk Factors</b>	<b>Support Network</b>	<b>Score</b>
Difficulty with mobility on transfers	Low to moderate physical or cognitive functioning		Existing support networks may be insufficient	4-5
Difficulties with daily living tasks	Long-standing physical or mental health problem (not severe)	Existing accommodation no longer adequate for elderly or disabled person	Client/carer needs respite/support/assistance	3
Self care skills generally good, but occasionally impaired	Major physical injury/emotional difficulty/ or substance misuse the primary problem	Currently coping	Some relationship problems but social networks adequate	2
Good self care and living skills	Mentally well/physically fit	Adequate accommodation	Support network adequate	1

The initial period chosen for the referrals was a window of six weeks in the duty diary in each locality. I provided an introductory letter for care manager staff in the locality offices, together with an outline sampling framework, and sample contact letters for service users. Suitability for further contact with the services users was then checked with care managers, in order to screen out those people for whom a professional judgement was made that an interview would be detrimental to their health or well-being. In this way, the sample was subject to some selection bias by care managers (Barnard, 1994). However, it was justified as an attempt to minimise non-response in a

frail population, and to address ethical issues of potential harm to people in crisis. The final sample consisted of a consecutive sample of 45 service users in the 3 localities who had experienced an assessment in the previous 6 weeks. The initial intention was to stratify this sample according to implementation of the ECIS eligibility grid of low/moderate/high needs. However, it was determined after initial viewing of case records in the exploratory project that this grid was not being used consistently by locality Assessment & Care Management Teams. As the target number was reached, I discussed with relevant care managers whether there were circumstances that would militate against making contact by letter, such as cognitive or visual impairment, or mental health issues where anxiety levels could be raised. This reduced the number by 6. I then contacted the remaining sample of older people first by letter (see Appendix 1), with a follow-up telephone call if feasible to discuss and arrange an introductory visit if verbal consent was given. This round of contact resulted in 2 refusals; 4 people were uncontactable, and 7 became unavailable after consent had been given, predominantly through illness or entry into hospital. This resulted in a final sample of 24 older people and 10 carers. The mean age was 81 years, and 70% were female. The first five interviews acted as a pilot study to test out the research procedures and instruments. The second round of user and carer interviews were completed within a subsequent 5-month period, when a further 18 users and 10 carers were interviewed. The semi-structured interview schedule covered both user and carer concerns, using a combination of closed, pre-coded and open, post-coded questions (Rose & Sullivan, 1996). However, the total number of interviews spanned a period of a year (to July 1997), as there were two significant interruptions during the data collection process following the pilot interviews, due to a period of illness and industrial action by Parkside SSD staff. This disrupted the interview process, and

made a 6-month follow-up round of interviews impractical within the period allocated for data collection.

### **Behind the scenes of sampling**

The process of obtaining a sample of suitable contacts from care managers was not straightforward, however. A bald statement of sampling strategy and final size does not reflect the potential pitfalls, which the following experiential example exemplifies. As noted above, there had been a period of strike action by SSD staff, stimulated by a performance review commissioned from an external audit company that recommended reorganisation and reduction of the number of locality teams from three to two. In South locality, which had experienced a series of external research projects requesting access to service users prior to my arrival in Parkside, I encountered some resistance for the first time, in the form of suspicion about the uses to which research could be put. In particular, some staff were anxious to know whether the work had been commissioned directly by Parkside councillors or the current Director of Social Services, citing lack of trust in the organisation's motives. I also encountered what the South team leader had predicted as 'passive resistance', with care managers not filling in the sampling request. After discussing first with the team leader, and giving sampling and information forms in advance, I made an appointment to talk to each of the staff groups as a slot in their team meetings, to emphasise my request for details of special requirements, and to answer questions. I made another appointment at the team meetings to return and collect names, followed by telephone confirmation. The end result was a visit to an empty room, no sampling forms at all, and 22 members of staff giving five names in total on post-it notes, with no further detail given. This was in contrast to the level of co-operation from care managers prior to the industrial action. However, I persisted with follow-up visits and

individual conversations with care managers, and did obtain details of older people receiving home care services with sufficient information to enable me to contact them.

The relatively high levels of refusal and of patchy supply of eligible names provided by care managers were also issues in the ECCEP study (1995), where the number of eligible referrals from which the sample should have been drawn was less than estimated and required. The ECCEP Team identified possible reasons that were offered by staff for the low number of cases, including high refusal rate by older people, long waiting lists for assessments, short-term increase in provision of services, staff forgetfulness and increasing workloads. Dickinson (2006: 368) also encountered similar difficulties when undertaking research into the implementation of the Single Assessment Process:

Recruitment of front-line practitioners to the study was difficult. As the study progressed, it became clear that many practitioners had decided not to undertake the SAP [*Single Assessment Process*] overview assessments. As they were acting as gatekeepers to service-users, this had a knock-on effect on access to older people and their carers.

She linked this to the operation of street-level bureaucracy by staff (Lipsky, 1980), and this area of professional discretion will be discussed further in Chapter 6. As a result of the complexity of obtaining a contactable sample of older people who were able and willing to be interviewed, the variability in availability of baseline information in case records, and the unavoidable breaks in the data collection timescale, the interviewing process was changed from a two-phase strategy to single interviews focused on current needs, assessment and services provided.

## **Standardised measures: Mental Status Questionnaire**

The notion of 'dependency' is a contested concept, which has been discussed in the review of literature in Chapter 2. However, to investigate the appropriateness of the assessment of need, and derive some baseline comparisons between respondents, standardised measures were included in the interview schedule. The use of the Mental Status Questionnaire (MSQ: Kahn *et al.*, 1960) in the context of this study was three-fold; to ascertain the prevalence of cognitive impairment in the sample for comparative purposes, as an indicator of high levels of need, and as an indicator of possible difficulties in understanding during the course of the interview. The simplicity, brevity and relative informality of the MSQ was a deciding factor in its use, particularly when applied to a population that includes a large number of people without significant impairment. The MSQ was claimed to be as reliable as longer tests. In its shortened form (Pfeiffer, 1975), it comprises a series of nine brief questions, four of which can arise naturally in the course of the interview (e.g. age, month born, year born) and five which are more obviously artificial and a test (for example, the name of current and previous Prime Ministers). Researchers applying the questionnaire in a pre-hospital admission sample of older people at home found that:

(...) this brief and simple verbal test can generally be given without causing fatigue, anxiety or embarrassment, even to the seriously ill and disabled.  
(Wilson & Brass, 1973: 92)

The MSQ score counts the number of errors, so a score of 0 is ideal; omissions are counted as errors. Three groups of severity of cognitive impairment were proposed according to number of errors made: 0-2 errors – none or minimal; 3-8 errors – moderate; 9 or 10 errors –

severe. Nelson *et al.* (1986) compared five cognitive screening instruments including the MSQ, noting that all of the available tools had issues with false negative scores. In addition, sensitivity had to be exercised to the possibility that such overt psychometric assessment could arouse anxiety in an older population (Keady & Bender, 1998).

### **Physical status: Lambeth Disability Schedule**

For measures covering levels of physical disability, the Lambeth Disability Schedule (Patrick *et al.*, 1981), henceforth abbreviated to LDS, was chosen. This measure was also used in the National Institute of Social Work (NISW) dementia study (Webb, Moriarty & Levin, 1998; Moriarty & Webb, 2000) that was on-going at the time of the Parkside study. It was chosen for its brevity, ease of use and applicability to a community sample. This questionnaire had the advantage that it could also be self-administered, if preferred (although no-one interviewed opted to do this when asked), and informal carers could score on behalf of users if there was a problem in communication or understanding with the service user. The LDS, in its shortened physical disability format for people over 65 (Charlton, Patrick & Peach, 1983), was used as a guide to levels of physical disability, covering areas of ambulation, mobility, confinement, bathing, household tasks and ability to carry out social and leisure activities. There are some reservations about its sensitivity to change and use in smaller scale samples (Wilkin *et al.*, 1992). However, the authors, on further testing of this form of the questionnaire, noted that individual category scores or single items could be used for knowledge of prevalence of specific difficulties:

(...) Some workers may still wish to use individual category scores or even individual items for particular studies. For example, distributing aids designed to circumvent specific physical disabilities will require knowledge of the prevalence of walking, bathing problems, etc. (Charlton *et al.*, 1983:303)

## **Philadelphia Geriatric Center Morale Scale**

Neither the MSQ nor the Lambeth Disability Schedule cover affective disorders. In order not to ignore this area, the Adapted Version of the Philadelphia Geriatric Center Morale Scale, was used in the pilot study, in the version anglicised by Challis and Knapp (1980) for use in their Kent care management studies. However, following the five pilot interviews, I chose to discontinue its use in my subsequent interviews in Parkside. Its unrelenting negative and medical tone was potentially distressing to older people being interviewed (and to the interviewer), and jarred in an interview context where the main focus was on social care services. To complement information derived from the interviews, any case record based measures of disability were also noted. These were generally recorded as Activities of Daily Living (ADL) scores, relating to personal care tasks such as bathing, washing, dressing, feeding, getting in and out of bed, using the toilet and continence management (Walker, 1999). Nurse assessments could also include a Barthel Index score (Bowling, 2001) for daily living activities. However, there may be a problem in older service users over- or under-estimating their capabilities. This may also apply to ADL scores recorded in care manager assessments, where the functional abilities of older people have not been directly observed. These scoring systems, derived from nursing assessments, were rather crude and medicalised instruments, which the ECIS eligibility system echoed. However, they were the only indicators that recorded potential comparators of service user need. In order to obtain the subjective views of service users (and available informal carers) on their experiences of contact with Parkside and service delivery, open-ended questions were included in the older people interview schedule (Appendix 3). These probed for user knowledge of available services, experience of and involvement in the assessment process. The views

of users and carers were sought on the quality and acceptability of a range of current services received, including aids and adaptations, again using open-ended questioning. Problems with satisfaction ratings have been discussed in the context of health and human services research (for example, Carr-Hill, 1995). For the purposes of this study, simple scales about satisfaction were avoided, and probes for dissatisfaction were included, given the phenomenon of response bias and inflated satisfaction scores in surveys, particularly when used with an older, service-based population in health and social care (Bowling, 2002; Mazor *et al.*, 2002).

### **Service providers**

To obtain a different perspective on the research questions relating to service delivery, the views of service provider managers were sought by direct interview. Questions were included to cover wider viewpoints from providers on their experience of the contracting process. The research question relating to the feasibility of outcome measurement was also included with this group.

The sample consisted of the managers of all the provider agencies, taken from the list of the current approved block and spot contract providers supplied by the Contracts Section in Parkside. Five independent agencies were represented, including two additional interviews with local office managers for two agencies, plus three managers from the Local Authority Business Units (formerly 'in-house' home care provision and now known as Direct Service Organisations.). All of the agencies were contacted with written information about the research (adapted from the information sheet developed earlier for contact with older people). Verbal consent to interview was obtained, and convenient times for interview negotiated by telephone. All interviews were taped with consent and transcribed.



An interview topic guide was developed (Appendix 5), to encourage open-ended answers. The domains covered details of the provider agency's service delivery, experience of contracting with Parkside centrally (comparing with contracting with other London Local Authorities where applicable), training provision, quality assurance mechanisms, user feedback on the quality of services, local communication with care managers, and the agency role in outcome measurement. The interview topic guide was constructed to be completed in approximately one hour. Interviews were tape-recorded with permission, and contemporaneous notes taken.

Following identification of the provider agencies, letters were written to the managers concerned, and permission for interview sought. The response rate was 100% (n=10) Interviews were undertaken over a one month period; a much speedier processes than with either care managers or service users, as provider managers were office-based, easily accessible, and appeared eager to be involved and voice their views. Although my independence from Parkside had been emphasised, there could still could be presumptions about my influence with the commissioners of their services. Findings and commentary on these interviews are included in Chapter 5.

### **Care managers**

For care manager perspectives on assessment processes, service delivery and outcome measurement, the strategy of recorded group discussion was adopted. It had proven difficult to arrange individual interviews with care managers because of their busy and often unpredictable work schedules, which also reduced their availability. This may have also linked to some reservations about my role and the research, although this was not directly articulated at the time. In the

original planning for the sequence of data collection, interviews with care managers had been scheduled for a period that (as it emerged) followed industrial action. However, the locality team meetings provided a forum where the attendance of the care managers was most likely. This strategy attempted to ascertain the views of as large a number of care managers as possible, given both the lack of staff time and staff turnover. The disadvantages were that the time available for discussion was restricted to 30-40 minutes, and the composition of the groups was unpredictable. Arrangements were made with the managers of the three locality Assessment & Care Management Teams for group discussion time to be incorporated into the end of regular staff meetings. Each staff group approached agreed to take part. Three staff group discussions took place. Using an interview topic guide (Appendix 6), the ensuing group discussions were recorded using a tape recorder with a multi-directional microphone. The interview guide covered the usefulness of existing assessment tools, staff views on communications with other agencies (e.g. Health Authority services, provider agencies), effectiveness of monitoring service quality, and views on outcome measurement. As best practice in conducting focus groups (Robson, 2011), another person acting as a separate scribe to my role as interview facilitator would have been useful to assist in recording these interviews, but this was not possible to arrange. Findings from these three group interviews are discussed in Chapter 6.

### **The content analysis of case records**

Gathering different types of information within a mixed-methods strategy can broaden the range of understanding and reduce the risk of findings reflecting the limitations of using one source of data (Fielding & Fielding, 1986; Robson, 2011). At the time of the case study, paper case records were the primary source of recording in the

Parkside locality teams; electronic case recording using the ECIS database was in its first year of implementation. As the 'working tools' of care managers and assistant care managers, these documentary records were subjected to content analysis (Padgett, 1998; Hayes & Devaney, 2004). The case records detailed the results of assessment, and provided some evidence of the aims of intervention, any services provided, and monitoring, with re-assessment where necessary. A schedule for the content analysis was developed, covering the domains of referral details, case status, assessed needs including the ECIS scoring grid and other recorded measures; assessment details, including participants; actions taken; details of the resulting care plan, and indicators of monitoring and outcomes. These variables are presented in Table 6.2, in the discussion of the content analysis findings in Chapter 6.

A random sample of 30 case records in each of the three locality teams that worked with older people was identified, (n=90). These were obtained in each of the locality offices by a systematic randomised sample (Robson, 2011) of every 10<sup>th</sup> file taken from referrals that had resulted in an assessment within the previous 6 weeks (congruent with the time frame chosen for obtaining a sample of older services users). There was no reason to believe that the systematic framework conceals a hidden pattern or periodic trait in the records. These covered a range of current active duty and allocated cases across the three dependency levels. In addition, the set of computer records of enquiries received in a three-month period and logged in the ECIS information system was analysed (West locality n=133; North locality n=154; South locality n=42, plus a Hospital-based team linked to West locality n=50). The purpose of looking at sequential records of enquiries entered on the ECIS system was to assess how the information tools were used for case recording in the different locality teams, and to provide a cross-sectional

snapshot of the volume and variety of referrals logged as initial enquiries. However, as discussed in Chapter 6, the latter aim was only partially realised due to the patchy quality of information recorded.

### **Triangulating the data**

As detailed in the preceding sections, a variety of sources and types of information, integrating both qualitative and quantitative methods was employed, summarised in Table 3.2 below.

**Table 3.2 Data Sources**

<b>Domain</b>	<b>Sources of Information</b>	<b>Standardised Instruments</b>	<b>Method of data collection</b>
<b>Intervention Aims</b>			
Referrals and enquiries to locality teams	Electronic records (ECIS)		Tracking electronic records (n=379)
Aims of case interventions	Case file records		Case file analysis (n=90)
<b>Older Person Perspectives</b>			
Older person's circumstances	Older person. Available carer. Case file records		Interview with user (n=23). Interview with available carer as proxy (n=10)
Health and well-being	Older person and/or proxy carer	Lambeth Disability Schedule	Interview with user/proxy carer
Cognitive state	Older person	Mental Status Questionnaire	Interview with user/proxy carer
Experience of assessment	Older person and/or proxy carer		Interview with user/proxy carer
Views on services received	Older person. Available carer		Interview with user/proxy carer

<b>Domain</b>	<b>Sources of Information</b>	<b>Standardised Instruments</b>	<b>Method of data collection</b>
<b>Provider Perspectives</b>	Provider managers		Interview (n=10)
<b>Staff Perspectives</b>	Staff managers and staff groups		3 group interviews
<b>Contextual data</b>	Inspection & Quality Assurance Unit; Contracts manager; voluntary agencies; public consultation events; contract tendering		Interviews and observation
<b>Outcomes from services</b>			Case records, interview with user and/or proxy carer

The classic view of convergence or triangulation of data to counter threats to validity through corroboration of a single conclusion (Fielding & Fielding, 1986) was one consideration in using multiple sources. However, multiple data sources can also be used to examine different but complementary aspects of the same phenomenon (Maxwell, 2012).

### **Strategies for data analysis**

The computer software package SPSS (Statistical Package for the Social Sciences; Norusis, 1995) and winMAX 97 (Kuckartz, 1998) were chosen as tools for quantitative and qualitative analysis of the data collected. SPSS was chosen as a standard, powerful data management and statistical analysis package for quantitative data (Bryman & Kramer, 2001). This was used primarily for summarising the data from interviews and to enable bivariate analysis of associations between variables (Bryman & Cramer, 1997; Bryman, 2012). Further inferential statistical analysis was more limited because of the non-probability sampling discussed earlier, although random samples can also suffer from biases introduced by non-response (Bryman, 2012). Kuckartz's (1998) software was developed for a case-oriented quantification model, with the objective of comparing cases and creating types or categories, thereby claiming heuristic value in theory building. This cumulative process is outlined below. Originally, winMAX 97 was chosen to analyse qualitative data, as one of the contemporary number of computer-assisted qualitative data analysis (CAQDAS) software packages, that at the time had become part of a standard toolkit for systematic content analysis of text-based qualitative data (Seale *et al.*, 2007). winMax was chosen because of its relative simplicity of use in its basic functions as an 'electronic filing cabinet' (Lee & Fielding, 1995) for the coding and retrieval of transcribed interview data. It can also act as a text analysis tool that facilitates

the analysis of a combination of quantitative and qualitative data, which can cross-reference data and variables within SPSS. This was appropriate in assisting in the analysis of the data collected from the interviews with users and carers, which linked and integrated quantitative data (for example, in demographic information, standardised measures, etc.) and qualitative data in longer, open-ended responses (Miles, Huberman & Saldaña 2014). However, I later moved away from a Windows platform, and this package became obsolete. Data was transferred to DeDoose, a Web 2.0-based cross-platform tool developed from its predecessor, EthnoNotes (Lieber, 2009) that specifically focusses on analysing data from qualitative and mixed-methods research. Such programmes therefore help the researcher to be systematic and in handling and comparing qualitative data as well as quantitative data, rather than using 'selective plausibilization' (Flick, 2009:384), or a patchwork quilt approach (Richards, 2009), using quotations to illustrate the author's argument only. However, as with any computer-assisted analysis tool, the outputs and resulting conclusions are only as rigorous as the inputs and the imposition of conceptual interpretations of the researcher.

## **Conclusion**

This chapter has reviewed the specific sampling and data collection methods used in the multi-method research strategy, employing a range of data sources and types. It has discussed the influence of the PSSRU empirical approach adopted in their ECEEP study, and how this was modified in the light of information and sampling constraints, resulting in a move away from the model of pre-post intervention interviews. It has incorporated an account of how the research strategy was modified to reflect the location within a complex, fluid organisation, influenced from the perspectives of different significant individuals and groups acting in different contexts. As discussed in



Chapter 1 this process of revision was nevertheless compatible with a move to a realist approach. The following chapters examine the empirical findings from the fieldwork undertaken, firstly from the interviews with older people who had received services in their homes.

## **Chapter 4**

### **User voices: The view from home**

#### **Introduction**

This chapter presents and discusses the qualitative and quantitative findings from semi-structured interviews with older service users in their homes about the domiciliary services they received, (n=24) The majority of older people in this sample lived alone, or with a partner who was also a service user in their own right. Where the older person was not directly interviewable due to poor health or entry into long-term care, proxies (usually relatives) were interviewed about the care provided. Lessons from the preliminary study (see Chapter 3) are integrated into the discussion, as many of the themes recur in this later, main study. Vignettes of each of the older people are presented in Appendix 4, which provide fuller biographical details. The examination of the service user views and responses forms the first component of the triad of key actors that will inform analysis about how the domiciliary care system operated in Parkside.

#### **Lessons from the preliminary study**

As discussed in Chapter 3, within the first few months of placement within the local authority, Parkside commissioned me to undertake a short, preliminary study based on open-ended interviews with 7 carers and 4 service users (11 households) on their experiences of receiving services at home. All lived in North locality catchment area, which was chosen as the pioneer locality for the new ECIS eligibility and dependency grid. This was to be 'quick and dirty' research (the commissioning senior manager's term) undertaken at Parkside's request to inform a corporate quality monitoring process. I produced a

short report based on the interview findings, which was distributed internally to the Locality team managers and selected external agencies, such as the local carers' organisation. As the study was undertaken to an external deadline, it was based on a convenience sample of service users or carers of users with complex needs living in the community covered by the North locality Assessment & Care Management team. All of the older service users were receiving a number of different services from a range of in-house and independent provider agencies.

Although not a formal pilot study, these interviews provided a useful preview of themes to be explored further in the main study, and an introduction to the local assessment and recording processes for sampling purposes. However, more detailed demographic information was not sought at this stage, and the interviews were loosely structured as an exploratory study. Responses are incorporated in the presentation of findings from the later, main study. Older people or their carers from this exploratory study are identified by pseudonym, with an indication of their participation in the exploratory study.

### **Procedure for sampling for main study**

The main round of interviews with older people was undertaken a further six months after the preliminary study. As detailed in Chapter 3, a purposive sampling approach was adopted, using the ECIS eligibility categories devised by Parkside, of low, medium and high levels of need. Because of the sensitivities of interviewing potentially frail service users in their own homes, there was close consultation with care managers about contact details and any changes in circumstances that may have affected the approaches made to possible respondents. Care managers in the three locality offices were briefed about the purpose of the fieldwork via appointments at staff

meetings and through individual contact. Potential respondents who had had an assessment for a service in the previous three months were identified through the locality information systems, and the case files consulted for basic details. Care managers who had had dealings with the service users were then approached for further details about the assessment and any special circumstances, using a contact sheet. An attempt was made to obtain potential respondents in each of the three dependency categories in order to sample a range of service users and services. Whilst most care managers were very helpful and generous in their time, using care managers as a filter in this way also posed difficulties of blocking access, or potentially skewing the sample away from respondents who might be seen as 'difficult', or towards those perceived as more cooperative, not necessarily consciously. The drawbacks of reliance on SSD staff and records by researchers, so that final samples differ from those originally intended has been commented on by others (Hardy, Young & Wistow 1999; Hayes and Devaney, 2004; Hayes, 2005). Hayes (2005) also discusses the issues of increasing restrictions on data access for social work research, although more from the perspective of overzealous application of data protection guidelines. Nevertheless, 39 older people were identified as appropriate for further contact.

In the next stage, an information letter and leaflet was sent out to services users (Appendix 1) describing the purpose of the research and giving contact details. This was followed by telephone calls to discuss further and seek verbal to visit. At this stage, 2 service users refused over the telephone, one citing 'great age' (83), and the other feeling ill and under strain. The remaining 37 agreed to further contact. However, it is an indicator of the precarious health of an older service user group that there was only a brief window available between initial contact and arranging a firm interview date. Although attempts were made to arrange a visit time very soon after verbal

consent was obtained, 8 respondents became too ill to be interviewed or entered hospital before the arranged visit took place. This illustrates the slim health margins of those referred to the SSD. A further 3 were not available on the days of arranged interview, and did not respond to further contacts, without reasons for non-contact being clarified. The final total of service users who were interviewed was 24 (a response rate of 61.5%). 10 informal carers were interviewed as proxies for older people who had either entered hospital or residential care. One home care staff member acted as a proxy for Miss Taggart, who was present but not interviewable at the time due to cognitive impairment. This total is in addition to the 6 service users and 7 informal carers interviewed in the preliminary study undertaken in North locality.

### **Analytic procedure**

The interview schedule used for the main round of interviews is contained in Appendix 3. The domains track progress through the care management cycle elements of assessment and provision of services. A mixture of pre-coded responses and open sections was included, and consent to tape recording the interview was sought (which was refused by one respondent, Mrs Connelly). For the analysis, a systematic approach was adopted. Pre-coded interview variables were entered into the Statistical Package for Social Sciences (SPSS) using individual interviews as separate cases. These variables ensured that all responses were accounted for, to counter risks of selective anecdotalism by the researcher. However, to avoid reductionism, the older people's narratives were analysed with the aid of a qualitative research analysis tool (as discussed in Chapter 3). This qualitative analysis addressed the older people's experiences of the process of entering the Social Services systems and receiving services. Although not all of the interviewees were able to articulate their views, other

themes emerged from the qualitative analysis that had not been anticipated and were not coded in advance for quantitative purposes. This demonstrates the appropriateness of a mixed method approach in an exploratory investigation, that may do justice to all of the data (not just what an individual researcher may find personally appealing), and may address some of the more personal experiences of the respondents. Fuller biographical vignettes of the 24 older people interviewed are contained in Appendix 4. All of those interviewed have been assigned pseudonyms to protect their identities.

The following Table 4.1 indicates the following domains from the interviews and standardised measures: Age at time of interview; the relevant Locality office; the status of the case as recorded in the case file; the level of need recorded in the case file, if given; the score for the Mental Status Questionnaire; the score for the Lambeth Disability Schedule; and the summary of response for whether the person rated their health as better or worse in relation to others of their age. 'N/A' (for 'Not Applicable') in the Mental Status Questionnaire score column indicates that the questionnaire at the time of interview due to cognitive impairment.

The Mental Status Questionnaire (Kahn *et al*, 1960) is scored 0-9, with highest scores denoting all answered correctly, and lower scores indicating degrees of cognitive impairment. The Lambeth Disability Schedule (Patrick, 1981) addresses self-reported difficulties in activities of daily living using binary scoring ('difficult' score = 1, 'not difficult' score =2). Possible scores range from 20-40; a lower score indicating greater difficulty in daily living activities. Interviewees were asked how they regarded their present state of health overall, in relation to other people of their own age. Older people were also asked whether they had had admissions to hospital in the past year. 'Dependency Level' refers to the assignation taken from the case file

record, and refers to whether the ECIS eligibility criteria were recorded on file.

**Table 4.1 Older People Demographic Summary**

<b>Name</b>	<b>Age</b>	<b>Locality</b>	<b>Case status</b>	<b>Recorded level of need</b>	<b>MSQ</b>	<b>LDS</b>	<b>Health</b>	<b>Hospital in past year</b>
1. Mrs Peploe	88	North	Duty	Not recorded	9	28	Worse	Yes
2. Mrs Burley	75	North	Closed	Not recorded	8	27	Worse	No
3. Mrs Grant	86	North	Duty	Not recorded	9	30	About right	No
4. Mrs Herman	84	North	Open for allocation	Not recorded	9	23	Worse	No
5. Mr Sergy	75	North	Allocated	Not recorded	9	31	About right	No
6. Mrs Yates	89	South	Open for allocation	Medium-high	N/A	32	Worse	Yes
7. Miss McTaggart	84	South	Allocated	High	N/A	26	N/A	Yes
8. Mr Stewart	82	South	Closed	Medium	5	29	Worse	No
9. Mrs Stewart	79	South	Closed	Not recorded	4	32	Worse	No
10. Mrs Lowe	91	South	Allocated	Medium	7	26	Worse	No
11. Mr Wilder	89	West	Allocated	High	9	26	Worse	Yes
12. Mrs Connelly	75	West	Duty	Not recorded	8	37	About right	No
13. Mr Smith	75	South	Allocated	High	5	21	Worse	Yes
14. Mr Garfield	75	West	Not recorded	Not recorded	9	32	Worse	Yes
15. Mrs Pigeon	91	West	Duty	Not recorded	7	26	Worse	No



<b>Name</b>	<b>Age</b>	<b>Locality</b>	<b>Case status</b>	<b>Recorded level of need</b>	<b>MSQ</b>	<b>LDS</b>	<b>Health</b>	<b>Hospital in past year</b>
16. Mrs Said	74	West	Allocated	High	N/A	23	N/A	Yes
17. Mrs Cornwell	84	West	Duty	Medium	4	26	Worse	No
18. Mrs Earl	92	North	Allocated	Not recorded	Declined	24	Worse	Yes
19. Mrs Markova	81	West	Closed	Not recorded	9	39	About right	Yes
20. Mr Adams	78	North	Not recorded	Not recorded	3	25	Worse	Yes
21. Mrs Shea	78	South	Closed	Not recorded	3	34	Worse	Yes
22. Mrs Bugno	83	South	Not recorded	Not recorded	9	34	Better	Yes
23. Miss Jura	Not	South	Not recorded	Not recorded	9	35	About	Yes
24. Mr Marsh	75	South	Not recorded	Not recorded	8	30	About	Yes

### **Self-reported health status**

As seen from Table 4.1, 33% of the older people interviewed lived alone, and 45% had a degree of cognitive impairment (measured by the MSQ). The aggregated responses of self-reported needs demonstrate a sample of older people who viewed their health as problematic. Only one respondent (Mrs Bugno) considered her health to be better than others of her own age, and she reported difficulties in doing housework, seeing friends and pursuing hobbies, as measured by the LDS. A further six thought their health was 'about right' for their age, but the majority felt that their general health did not compare well with that of other older people, feeling themselves to be untypical. None of those in these categories had any dependency scores recorded in case files. Fourteen (58%) had had at least one hospital admission (resulting in staying overnight) within the previous year. In addition, a further four reported having had a serious accident in the past year, which had not resulted in a hospital admission. This route provided an entry into social services for nine. From the LDS responses, it can be seen that there were substantial areas of impairment in daily life.

**Table 4.2 Areas of Difficulty in Everyday Tasks**

<b>Type of difficulty</b>	<b>Self -reported difficulty on LDS</b>	<b>Received service if reported difficulty</b>
Difficulty bathing	66%	13/18
Difficulty dressing	54%	Aggregated into 'putting to bed' service
Difficulty getting to bed	46%	1/10
Difficulty going to the toilet unaided	33%	Aggregated into home care service
Difficulty cooking a hot meal	63%	2/15
Difficulty with housework	96%	16/23
Difficulty getting out of the house	54%	Not given as separate service

However, given these levels of expressed need, services did not necessarily address those areas. For example, ninety-one per cent of those reporting difficulty getting to bed did not get a service; 72% with difficulty bathing did not get a bathing service; and 44% of those reporting difficulty in doing housework did not receive this help.

The issue of recording of dependency levels in the SSD information system (ECIS) is considered in the following section, drawing on SPSS analysis of pre-coded variables.

### **4.3 Recording of Dependency Levels:**

<b>ECIS Dependency recording</b>	<b>Frequency</b>	<b>Percent</b>
High	6	25
Medium	3	12.5
Not recorded	15	62.5

It can be seen that the ECIS dependency levels were not recorded consistently. This theme of gaps in recording information is reinforced in the wider case file content analysis undertaken (in Chapter 6). Of those recorded, there are none in the 'low' dependency category, which may have reflected the raised eligibility hurdle implied in the ECIS eligibility system. This would filter those seen to be in lowest need from the care management cycle. The incomplete nature of the information held by Parkside clearly poses difficulties for external scrutiny of service 'effectiveness'.

### **Mental Status Questionnaire**

In the 9-item MSQ, the highest attainable score is 9. One interviewee, Mrs Earl, refused the Questionnaire, and it was not administered to Mrs Said, for whom English was not her home language. 9 out of the 22 respondents who answered the questions had the highest score. The measure was chosen because of its brevity, simplicity, and 'naturalness' with which it could be introduced in a conversational rather than more clinical context. However, as noted in the vignettes (Appendix 4), there can be doubts about the sensitivity of the measure, as it did not indicate any cognitive impairment in Mr Garfield, who had been assessed by a psycho-geriatrician previously as having 'mild confusion'.

## **Lambeth Disability Schedule**

The LDS covers a broader range of activities (including quality of life indicators) than the Activities of Daily Living (ADLs; Lawton & Brody, 1969), which were used by some care managers and other assessors such as nurses. Using the LDS indication of which tasks were difficult or not difficult (18) in daily life, those areas of life addressed by ADLs are presented in the following tables and diagrams. These are areas seen as central to independent living, and which are linked to the domiciliary services provided by the SSD. The cross-tabulated results compare the scores in selected domains with matching to the relevant services received<sup>1</sup>, and these findings will be discussed in the next sections.

## **Matching services and needs**

The following table (Table 4.4) summarises the range of services, both within and outside the home that were received by each of the older people interviewed. This information was gleaned both from the written case records and by self-report. The table also indicates where spouses or other relatives provided care.

**Table 4.4 Services Received**

<b>Name &amp; interview number</b>	<b>Home care visits per day</b>	<b>Days</b>	<b>Tasks</b>	<b>Other services in the home</b>	<b>Day Centre</b>	<b>Informal Carer</b>
1. Mrs Peploe	3	6	Getting up; personal care; dinner; tea	Putting to bed service	x1	
2. Mrs Burley	1	2	Cleaning, laundry		x1	
3. Mrs Grant	1	1	Cleaning, laundry	Bathing service x1	x2	
4. Mrs Herman	24-hour	7	24-hour care with live-in carer			
5. Mr Sergy	1	2	Cleaning, laundry, shopping			
6. Mrs Yates	2	7	Getting up, putting to bed, personal care		x1	Visits x2 daily for meals
7. Miss McTaggart	3	7	Getting up, personal care, breakfast, tea, putting to bed	Meals at home lunch x7		Home carer proxy
8. Mr Stewart	1		Cleaning, laundry, shopping	District Nurse x7, Meals at home lunch x7		
9. Mrs Stewart	1		Cleaning, laundry, shopping	District Nurse x7, Meals at home lunch x7		

<b>Name &amp; interview number</b>	<b>Home care visits per day</b>	<b>Days</b>	<b>Tasks</b>	<b>Other services in the home</b>	<b>Day Centre</b>	<b>Informal Carer</b>
10. Mrs Lowe	3	7	Get up, personal care, breakfast, evening pop-in a& snack, cleaning, shopping & pension	Meals at home		Weekly visits
11. Mr Wilder	3	7	Breakfast, lunch, tea, cleaning			
12. Mrs Connelly	1	2	Shopping, cleaning			
13. Mr Smith	0	0	N/A	Sitting service x5 evenings	x3	Spouse all other care
14. Mr Garfield	1	2	Shopping , cleaning			Niece daily visits
15. Mrs Pigeon	0	0	N/A	Adaptations to the home		Grand-daughter main carer
16. Mrs Said	1	2	Personal care		Day hospital x1; Day Centre x1	Daughter main carer
17. Mrs Cornwell	0	0	N/A	Sitting service x2	Day hospital x1; Day centre x3	Daughter
18. Mrs Earl	4	7	Getting up & to bed, personal care, meals			

<b>Name &amp; interview number</b>	<b>Home care visits per day</b>	<b>Days</b>	<b>Tasks</b>	<b>Other services in the home</b>	<b>Day Centre</b>	<b>Informal Carer</b>
19. Mrs Markova	0	0	0	Alarm, handyperson		
20. Mr Adams	1	2	Bath, personal care	Sitting service x2	x5	Spouse
21. Mrs Shea	1	1	Cleaning			
22. Mrs Bugno	1	1	Cleaning			
23. Miss Jura	1	1	Cleaning; service terminated at time of interview			
24. Mr Marsh	1	1	Cleaning & shopping; service terminated at time of interview			



From responses to the LDS, 75% (18) of respondents found bathing unaided to be a difficult activity. However, 13 of those reporting such difficulty did not receive a bathing service, which was offered as a discrete service by Parkside via the independent Care Nursing agency (see Chapter 5).

**Table 4.5 Matching Bathing Service with Difficulty Bathing**

	<b>Finds bathing difficult</b>	<b>Does not find bathing difficult</b>
Receives bathing service	5	0
Does not receive bathing service	13	6

Despite her difficulties getting in and out of the bath, Mrs Shea reported that she tried to struggle on:

Oh god, don't talk about that. It's frightening really because you hear of people slipping. I do with a struggle but sometimes I have a good wash down. (Mrs Shea)

Nearly half of respondents (45.8%, n=11), had difficulty getting in and out of bed. For this need to be addressed, a service would have to be provided at the beginning and end of each day. However, 10 people who reported difficulty did not receive this service.

**Table 4.6 Matching Needing Assistance with Going to Bed with 'Putting to Bed' Service**

	<b>Finds going to bed difficult</b>	<b>Does not find going to bed difficult</b>
Receives putting to bed service	1	3
Does not receive putting to bed service	10	10

A third of respondents (n=8) reported difficulty in going to the toilet unaided. This is a critical interval need, requiring frequent assistance at unpredictable times (Isaacs and Neville, 1976), and so should rank as a high level risk. However, these services were not disaggregated in the case records, so that such targeted services were not recorded other than under the general category of home care.

The ability to cook a hot meal for oneself was reportedly difficult for almost a third of the sample (n=15). This could be addressed the provision of the Meals at Home service. However, as will be seen from the later analysis of the views of recipients of Meals at Home, services users could be very critical of the quality and convenience of these meals, and were liable to exercise their choice by refusing or exiting from the service. Miss Jura linked Meals at Home to quality and maintaining some degree of independence in cooking for herself:

I think I had them daily for a short time. I then changed my mind to three days a week and now I only have them twice a week. [What made you decide you wanted them less and less?] I didn't particularly like them! Some were more eatable than others and also I'm still able to do a bit of cooking. [Do they give you enough choice in advance?] No. They're fixed from week to week. They're the same every day of the week in rotation. Friday I have because the fried fish is quite nice but

liver and bacon - the liver's more like leather. I know it's difficult for them to provide food on such a scale. (Mrs Jura)

Mrs Lowe and her daughter, Mrs Fitter, were concerned over the quality and poor timekeeping of the delivery the meals, and for Mrs Burley, the first sight of them was enough for her to refuse the service. Mr and Mrs Stewart discontinued Meals at Home because of cost and quality:

We didn't like them. And they charged us for them. And I said for what they charge, I can make cheaper meals myself. And I love cooking. (...) I said for what you charge me, I can make two days' meals out of. And I begrudged it. No, they were very bland. (Mrs Stewart)

They are a good thing for poor people, who haven't got the money."(Mr Stewart)

Where for reasons of exiting the meals service by choice, or not being offered it, there was a shortfall in provision for those finding difficulty in cooking themselves a hot meal that was not being matched either by the Meals at Home service or by attendance at Day Care, where hot meals could be purchased.

**Table 4.7 Matching Difficulty with Cooking a Hot Meal with Receipt of Meals at Home Service**

	<b>Finds cooking a hot meal difficult</b>	<b>Does not find cooking difficult</b>
Receives Meals at Home service	2	0
Does not receive Meals at Home	13	9

However, it should be noted that home care services did include meal preparation for some of the older people interviewed where there were additional needs, such as personal care or help with eating. Two had also tried the Meals at Home service, but later decided to discontinue them, as they were not to their taste. In comparison with the difficulties encountered in cooking a meal, difficulties in physically eating and drinking were less prevalent, but still affected a quarter of the sample (n=6).

Of all the obstacles in daily living experienced by respondents, it was evident that the ability to continue doing housework posed the highest rate of difficulty, affecting all but one of the older people in the sample (n=23). However, as discussed in chapters 1 and 2, it is an area of SSD service provision under threat of withdrawal, as eligibility criteria tighten, and services are targeted on those seen to be in greatest need, interpreted as those most physically and/or mentally frail.

**Table 4.8 Matching Difficulty with Doing Housework with Receipt of Domestic Home Care**

	<b>Finds housework difficult</b>	<b>Does not find housework difficult</b>
Receives domestic home care	16	1
Does not receive domestic home care	7	0

One person, Mrs Markova, reported receiving inappropriate home care, as she had no difficulty completing housework herself, and exited the service. However seven other older people in the sample

reported finding difficulty with housework, but did not receive a service to address this.

For just over half of the respondents (54.2%, n=13), the ability to get outside their front door in order to shop, socialise and participate in the wider community life was restricted. Mrs Grant employed the rather risky strategy of passing money through her ground-floor flat window to strangers in order for them to buy her small everyday items. She had refused a move to a sheltered flat above the ground floor;

Well they tried to get me to move, but it was quite high up. One was on the 5th floor, and one was on the 3rd floor, and you see I've got this walking thing (a Zimmer frame). If I were stuck high up I would be marooned. So I've refused it.  
(Mrs Grant)

The following sections track the progress of service users through the elements of the care management process of referral, assessment, receipt of services, and impact.

### **First contact with social services**

Table 4.9 below summarises the remembered routes into contact with social services for each service user.

**Table 4.9 Referral & First Contact with SSD**

<b>Older Person</b>	<b>How first heard of SSD</b>	<b>Remember first contact</b>	<b>Who contacted SSD</b>	<b>Whose idea to contact SSD</b>	<b>Consent to contact</b>
Mrs Peploe	other	no	hospital	someone else's	yes
Mrs Burley	hospital	yes	SSD agency	own idea	yes
Mrs Grant	hospital	no	self	own idea	yes
Mrs Herman	doctor	no	GP	someone else's	don't know
Mr Sergy	hospital	yes	hospital	someone else's	yes
Mrs Yates	family	no	family	someone else's	don't know
Miss McTaggart	not known	no	self	own idea	yes
Mr Stewart	doctor	yes	GP	someone else's	no
Mrs Stewart	doctor	yes	GP	someone else's	no
Mrs Lowe	can't remember	yes	family	someone else's	yes
Mr Wilder	not known	yes	hospital	someone else's	yes
Mrs Connelly	can't remember	yes	don't know	someone else's	no
Mr Smith	hospital	no	hospital	someone else's	yes
Mr Garfield	voluntary organisation	no	voluntary organisation	someone else's	yes
Mrs Pigeon	family	yes	family	someone else's	yes
Mrs Said	hospital	no	hospital	someone else's	don't know

<b>Older Person</b>	<b>How first heard of SSD</b>	<b>Remember first contact</b>	<b>Who contacted SSD</b>	<b>Whose idea to contact SSD</b>	<b>Consent to contact</b>
Mrs Cornwell	family	no	family	someone else's	don't know
Mrs Earl	hospital	no	hospital	someone else's	don't know
Mrs Markova	family	yes	family	someone else's	yes
Mr Adams	hospital	no	hospital	someone else's	yes
Mrs Shea	hospital	no	hospital	someone else's	yes
Mrs Bugno	family	no	family	someone else's	yes
Miss Jura	doctor	yes	GP	someone else's	yes
Mr Marsh	hospital	no	hospital	someone else's	don't know

The responses regarding who had instigated contact with the SSD indicates the relative lack of control in seeking assistance or making arrangements for care. It was also striking from the interviews that the memory of how people had entered the system was very poor. Fourteen (58.3%) stated that they could not remember how they had entered the social services systems. Only three (12%) people reported that their first contact with the SSD was their own idea, with two of these self-referrals, and nine (37%) being referred via hospital. Only Mrs Markova (still cycling aged 81) recalled that she had approached Social Services, with a request for an alarm following a broken hip. Mr and Mrs Stewart and Mrs Connelly stated that they had been referred without their consent, the Stewarts being referred by their GP. Mrs Connelly was particularly angry about this, and maintained that she had no idea who had made the referral. A later analysis of 533 enquiries to the locality offices recorded on the computerised information system demonstrated that only 12% were older people making their own enquiries (discussed further in Chapter 6)

Ms Hastings, who was 21 years old, pregnant and the main carer for her grandfather, Mr. Hastings, currently in hospital, exemplified confusion over the designation and role of personnel she had seen from the SSD;

I don't remember if she was a social worker that got involved, but I only spoke to her for about two weeks, and she left, and I had to start with someone else that had known me there, and there was a couple of year gap, and this other lady that I was linked to for quite a while now, but I'm not sure if she was a social worker or care manager. (Ms Hastings, carer)

She also did not know what services she could be entitled to, and was not impressed by the response by the SSD in providing services for her grandfather:



Well, we started on questions like what is it you think you need and my only reply to that was I don't know what's on offer. I've never been told what I'm entitled to and what there is. So it's pretty hard for me, so they said to me you can have this, this and this, but nothing's come of it. (Ms Hastings, carer)

Mr Garfield made contact with the SSD through a voluntary agency working with older people. He also exhibited a confused narrative, confounding home care services and voluntary sector staff. Mrs Markova gave an example of a more general lack of awareness of what services could be available, and did not seem to consider that she might be eligible, stating that she thought the role of social care was '(...) for people stuck at home.' Mrs Bugno had her first contact with the SSD following her own admission to hospital, and also found it difficult to absorb the information while in a state of crisis:

Somebody came and did say, but I wasn't really with it. It was my daughter who started it off, but I do think somebody came to my bedside and said something about the services but it didn't sink in. (Mrs Bugno)

Similarly, Mr Marsh could not take in information at hospital, or remember who came to see him;

I can't remember...I wasn't with it...I'm not with it now as far as that goes...I'm trying to take it steady. (Mr Marsh)

Mrs Peploe illustrates the crisis of illness & the fuzziness of remembered details. In her account, she makes a verbal slip, nearly confusing her deceased husband and son:

I don't remember about the ward, no. But I did have a meeting in the hospital, in a little room. My hus - my son came along and we spoke things over there. And they assessed me for this and that, you know. That's when they ordered everything for me, all these things, you see. (Mrs Peploe)

Mrs Shea was also assessed in the hospital, and learned from a previous stay that she should acknowledge that she was in need of further help at home:

That's when they first started about this. I told them I was all right. I think I made a mistake. The last time I was in, I told them the lot and that is how I got the cleaning. (Mrs Shea)

These responses illustrate bewilderment in times of ill-health and crisis, and lack of knowledge of social care processes, including under-representation of personal needs to assessors. The following section examines the users' experience of the assessment process in more detail.

### **Assessment**

Respondents were asked whether they knew the purpose of the assessment visit(s), and how far they felt that they were able to state their wishes during assessment interviews. They were asked whether they had any differences of opinion with the assessor; whether they felt that they were assessed on their strengths; whether they had to wait for services to be provided; and whether they had been given services they did not want, or had refused services.

From a carer perspective, Mrs Collins, following her mother's (Mrs Yates) admission to hospital, decided to request residential care directly, but without knowing much about the service or alternatives. Mrs Sadat showed similarities with Mrs Collins in initiating the request for residential care for her relative, Mrs Said, but felt that this was not responded to in the assessment:

They said, well you know, instead of doing this, we can do this. I think we're used to it now, but as I say, first off I did really want residential care. [Why do think that was?] Because

this is cheaper (laughs). Resources. It's a wonderful word, resources. [Did you feel you had a say in what plans made?] No. Because I wanted one thing, and they said, well you can have the other thing. (Mrs Sadat)

Mrs Herman echoed some of issues raised by Mrs Wieder in the preliminary study, commenting on the bewildering number of people coming to visit, and clashes in generational cultures;

I saw so many people, but I am too old fashioned, too old, and when he, I said what's your name, and he said, 'call me Paul', and I still can't get used to calling people 'Maureen' or 'Paul'. And since then of course I went on calling him 'Mr Clifton'. [Have you been asked how you would like to be called?] No. [What do you think about that?] I have got so many novelties to get used to, and I never knew I had so much sense of humour. (Mrs Herman)

Nevertheless, she also expressed appreciation of service received from the same social worker in coming to deal with malfunctioning wheelchair. In this instance, the same attributes of youth were seen as an asset;

And he was so helpful and so young. Anybody who is young, of course my heart is open for them. When he said 'I'll ring you back tomorrow', and I had so much bad experience, I said 'Oh yes that will be the day', and he rang back the same afternoon. (Mrs Herman)

Mrs Pigeon was also quick to express satisfaction with her care manager: 'I can't praise her enough. She was really nice.' Mrs Stewart, when asked who had visited her to assess her and her husband, made interesting comparisons with my role as a research interviewer:

[Has any other Social Worker come to visit recently?] Only the home help, I think. I'm trying to remember. And someone like yourself, a smiley lady, came a couple of weeks ago, and

asked me a lot of questions, but she didn't have one of those (points to tape recorder). [What sort of questions?] Well, the same as you, you know. Do you want, have you got, and all this thing.

Mrs Peplow was very pleased with the personal attention she received from her care manager. The fact that: 'They were very interested in me'

held particular significance, even if the care manager had not been in contact for a while. She went on to confirm that she had felt 'listened to' in her contact with her care manager, although it seems she was told what she needed, rather than articulating that herself:

[Were you able to say what you wanted?] Oh, definitely, definitely. They used to tell me what I needed. They were the ones that suggested having that bannister downstairs, by the steps, I could hold onto when I go down. They suggested that. I didn't. It cost them a lot of money to fix that up. A small fortune, I know. (Mrs Peplow)

On the other hand, Mr Sergy was assertive, and negotiated fiercely for a service that he felt met his needs:

[The care manager] came to see me. I said to her, Look, Try to understand my case. I know you go according to a book. Boom, Boom, boom. Breakfast, et cetera. But I'm not like that, you make an effort to be flexible. I don't need much. One hour a week. Let me know what time, and send me somebody honest, that's all I want. [Have you been content since?] Since then, yes. Since I put my foot down, yes. (Mr Sergy)

### **Unwanted services and exit from services:**

There were instances of receipt of services that were not wanted on the terms offered across the localities, as shown in Table 4.10 below.

**Table 4.10 Unwanted Services**

<b>Locality</b>	<b>Given unwanted service</b>	<b>Not given unwanted service</b>	<b>Don't know</b>
West	4	7	0
South	4	4	2
North	1	1	1

'Unwanted' covered a range of reasons why the older people interviewed did not wish to continue with some services. Some were an expression of dissatisfaction with the quality of service on offer. As seen earlier, Meals at Home were not to everyone's taste, so that two people chose to discontinue or refuse them, and had the means to manage without them. However, other expressions of dissatisfaction were entangled with more complex feelings of compromised independence. One of the older people interviewed in the exploratory study, Mrs Wieder, had what seemed to her to be a bewildering array of agency personnel with different roles and tasks entering her home to provide domestic and personal care (such as helping with going to the toilet) both day and night. She complained that Parkside were sending 'strangers' and 'children' in to her home, the first voicing of this viewpoint. She was mentally alert, but had had a number of falls. She valued her independence highly, to the extent that she disliked staff carrying out domestic task for her. Despite her history of falls, she demonstrated inventiveness and a determination to maintain independence by cleaning floors herself again with a towel wrapped around one foot, after the home carers had carried out this task. In short, she said that 'I do the cleaning, and the worker messes it up.'

Mrs Stewart felt that unwanted home care services compromised the independence of her and her husband, and had worked out a strategy

for maintaining a pretence that tasks were being completed by the staff;

[Was the home care something you wanted?] No. I never did want it. I didn't need it. [Who suggested it?] Well I suppose the welfare people sent them down, but there's never anything for them to do. [How long will they keep coming if you don't really want them?] Oh, they've got to keep coming, apparently. They said they've got to come, in case at any time I really needed them. I said, I'll sign your paper to say you've been, and you've done what you got to do. I said as long as you can take that back, you needn't worry. I said I won't get you into trouble. (Mrs Stewart)

For Mrs Peplow, similar issues of preserving independence arose, even though an item (the commode) could still be kept as 'insurance':

I've stopped using it, because I feel I need a little more exercise. So I go out to the bathroom, because I keep my lights on day and night. God knows what my bill will be like. Even though I don't use the commode, I'm still keeping it for an emergency. You see, I don't want to part with it in case I do need it. Just to be on the safe side, yes. (Mrs Peplow)

For some users, the difficulties with services centred on perceived gaps in the service, rather than an excess of services that were not wanted. Mrs Grant related frustration at the selection by agencies in what services are carried out, in the context of cuts in services:

[What about your laundry?] I do a little bit. But I have to send it out. But they don't seem to be available recently. I've got a basket full that needs washing. See they either do the washing or they do the cleaning. Whereas before, they used to have two a week. We arranged that one day they did the washing, one day they did the cleaning. But by cutting it down, I've sooner them do the cleaning, because I can't push the Hoover or anything like that. (Mrs Grant)

Mrs Bugno was bemused by the apparent limits to cleaning tasks that could be carried out by home care staff, also illustrating gulfs in expectations:

All right, they would do the staircase but they wouldn't do the sides, dust the sides of the paintwork. So I said to her, at that time, I couldn't do it at all, and so I said they won't dust the sides of the stairs ever. So she said very nicely, they don't come here to spring-clean. She called that spring-cleaning. I don't expect them to wash the walls. (Mrs Bugno)

This was Mrs Bugno's single, brief experience of home care. She decided that the apparent limitations of what tasks home carers could carry out, coupled with unpredictability of the timing of visits would not be convenient, despite being assessed as in need. The use of a waiting list here proved to be an additional deterrent to accepting services.

The issue of racism had arisen in the earlier exploratory study. Mrs Wieder had been embroiled in a very delicate situation. She objected to having Nigerian staff as her care staff. This posed a difficulty for the provider agency in balancing the needs of an older person at risk of falls with implementing a non-discriminatory service. The issue was discussed with Mrs Wieder, but she reported that she felt 'demeaned' when told their attitude was racist by a manager. Whatever the complex reasons for her preferences, she was at pains to vehemently deny racism, giving anecdotes from her own émigrée personal history. The reason she gave for her dissatisfaction was that she felt the staff were of lower status and education. These issues of cultural clashes in relation to class and status are echoed in the later study, in Mrs Herman's account. These matters were very personal to her, and talking about them caused her some agitation.

Mrs Cornwell, who attended a Day Centre, had refused received offers of any further services in the home: 'It was offered, I must say, but I declined it because I thought oh well, I'm all right - I can cook. I can do everything really'. Such refusals of service occurred across the localities, as seen in Table 4.11.

**Table 4.11 Refusal of services**

<b>Locality</b>	<b>Refused services</b>	<b>Did not refuse services</b>
West	4	7
South	5	5
North	1	2

**Information on care planning and available services**

Older care recipients and informal carers were asked whether they were given written information on services, and given a copy of a written care plan. Not a single respondent in any of the localities thought that they had been given a care plan. There was also a dearth in receipt of more general written information about services, such as leaflets, as indicated earlier by Ms Hastings and Mrs Collins. The following table presents where people had been given written information (including care plans) or not. It can be seen that the majority of older people (18) had not been given written information, with a further 3 uncertain.



**Table 4.12 Written Information and Care Plans**

<b>Locality</b>	<b>Given written information</b>	<b>Not given written information</b>	<b>Don't know</b>
West	2	9	0
South	0	8	2
North	1	1	1

### **Satisfaction, ambivalence and frustration with Home Care**

The older people interviewed were also asked about their overall satisfaction with the services received, and about how far payment for services had been discussed. Mrs Peploe was happy with services, emphasising both the home care staff's familiarity with her needs, but also their compatibility in personality:

I'm very, very grateful. What she did today - she's lovely - she cleaned it all up for me, did all that. She says 'I'll wash that for you when I come back again'. She's going to brush all the chairs and everything, and she polished the tables this morning. Everything she did this morning she says 'I'll do some more tomorrow'. Oh she'll be here for tea soon. She comes back to make me a cup of tea. She's very sweet, a lovely girl, very nice. And she knows where everything is. And we're so friendly together, you know, so nice. (Mrs Peploe)

However, Mrs Herman, who was from an affluent background, had strong views about her home care staff:

She asked how much my was my income, why did I come from Hungary, was I in prison or something, and she was extremely low class, stupid, limited, and I answered her but then after a time it can get tiresome. She was extremely rude. A very low class, very uneducated, strong young Australian girl. I have not any animosity against [the home care agency]. I'm not

dreaming of a University companion, but I'm dreaming of someone of a decent family. My previous carer went to the pub every afternoon at 5 o'clock. And she said she had six pints of beer each time. Is that a companion for me? (Mrs Herman)

Earlier, Mrs Herman had referred to another home carer as a '(...) lower class peasant girl'. The difficulties some services users from wealthier (and self-perceived more educated) backgrounds experienced with their home carers was also noticed by some of the provider agency managers interviewed, as discussed in Chapter 5.

Mr Sergy had conflicts with his home carer over quality of home care services, honesty, and flexibility to meet his perceived more modest needs:

They used to do breakfast for people, cooking for people, shopping. I don't need that sort of service. All I need is a girl to come and take my laundry, do the flat once a week, is enough. And eventually do some shopping. They think that by bullying people, you know elderly people, they get away with everything. [In what way were you being bullied?] Well. Take it or leave it. You must have that girl. But I said, she's dishonest. You must have her. So I said I don't want her. Then you won't have nothing. (Mr Sergy)

Mrs Stewart had also encountered staff dishonesty, complained and had that home carer replaced by the agency:

Well, whoever was responsible at the time for sending her, I told them not to send her again. And she got real huffy about it, apparently. I didn't see her again. She frightened me. The fact she asked me if I had any money, I just answered her yes, I got my housekeeping money. (Mrs Stewart)

Mrs Peplow had experienced a clash over independence and asserting her wishes, but was reluctant to go to a more formal complaints procedure:

I made one a little time ago, I did. I had a little aggro with her. Resented me being in the kitchen. But now I've got it sorted out it doesn't matter. I've got my regular one back again, so I'm happy. I wouldn't complain to anybody, you know. (Mrs Peploe)

Mr Wilder had experienced catastrophic visual impairment that disoriented him in his flat. He accused staff of stealing from him, although these claims could not be verified. He felt that problems with paid carers had delayed his recovery:

The worry I've had since I came here has put me back. I was so confident because I knew every inch of my flat but I've had such upsets with the carers and that - unbelievable - horrendous. I got cleaned out, my place was ransacked. The police got all the particulars and nobody takes a blind - as though nothing's happened and I've suffered here like mad. Dreadful is putting it mildly. Even now, all they do is keep taking things. (Mr Wilder)

Alleged lack of honesty was not necessarily about stealing. More frequently it was non-completion of tasks or not staying for the allocated period of time. For example, Mr Marsh explained that he made additional arrangements with a friend:

I had this one cleaner - she was bloody hopeless. She never done no work. All she wanted to do was sit. I thought she was bloody lazy. I've got a pal that comes in and does it. He's pretty good. He only leaves it three or four days. He comes in Mondays and a couple of days during the week. He does my washing sometimes .I give him a couple of bob. Because with these home helps, they don't seem to want to work - all they seem to want to do is shopping. (Mr Marsh)

Mrs Grant also thought that the level of work was inadequate:

[What does your Home Carer do now?] As little as possible. I'm supposed to have them for an hour and a half. Usually they are here for about 20 minutes, half an hour and they are done. (Mrs Grant)

Mrs Bugno also commented on the lack of willingness to do certain tasks, but was more charitable (or ironic) about possible reasons: 'She's tired, the poor girl'. Conversely, Mrs Peploe detailed with appreciation the amount of help she received, four visits a day, from getting up to going to bed. She had regular staff, and waited for this help rather than trying to do it for herself:

In the morning, I get tottery. I shake a lot -I'm getting stronger, but to be on the safe side, I wait till they come, early in the morning. Because I don't want to fall. It'll set me back. I'm taking great care of myself that don't have another accident.  
(Mrs Peploe)

She also valued the relationship she had with her current home carer, giving an example of the initiative shown:

Now I've got her, I don't want anybody else now. So I don't want to trouble anybody else. Because, look, I didn't know the floor was dirty, she says I'm going to wash the floor now. That's what I mean. (Whispers) See if you get the right girl, and she's sensible, and knows what she's doing, you'll be OK.  
(Mrs Peploe)

Mrs Fitter, informal carer for her mother, Mrs Lowe also appreciated the initiative shown by some home care staff:

She (Mrs Lowe) feels the cold, especially in the winter, and they used to pop in and do a her a hot water bottle and make sure she was sitting in her chair, and made her a cup of tea, just to see, you know when she's been of colour, and they've just popped back to see she's OK, which is nice. And they phone me, and inform me if she's not well, just to let me know, what's going on, although I speak to her every day. (Mrs Fitter)

Another informal carer from the exploratory study, Mr Bennett who, together with his spouse cared for his mother in her home, said:

One of the wonderful things about the needs-led care plan is that it allowed [his spouse] and me to her relatives, without having to do loads of jobs. (Mr Bennett, exploratory study).

Mrs Burley also reported staff doing beyond their allocated tasks:

On Wednesday she does a lot more than she's supposed to. She's supposed to do all the cleaning, but she does my washing as well. (Mrs Burley)

In contrast, Mrs Bugno carried out a lot of preparative work before her home care staff arrived (providing a counterpoint to Mrs Wieder's attempts to clean her kitchen again after the home care visit was over):

Well, I don't ask her to do anything else, and I prepare all this room before she comes; take that and put it on here, this here, I undo all the wiring, plugging because they vacuum over the wires; there's quite a few wires round here. I put everything out of place so it's easy for her to do. [So you've done quite a bit of work before she comes?] Yes, and really, she wouldn't lift that piece of marble, it's terribly heavy. I find it quite heavy myself but I wouldn't dare ask her, so I manage to do it. (Mrs Bugno)

The value of staff and personal relationship was very important if home care staff were liked. Mrs Yates and Mrs Collins had had their expectations exceeded by some individual staff:

Well, with Jennifer, it's better than expected, actually. I mean, we did have some prior to Jennifer that just didn't seem to care much, you know. (Mrs Collins)

Mrs Peploe plainly got on well with her home carer, having a jokey relationship that may not suit everyone, however:

She's very sweet, a lovely girl, very nice. And she knows where everything is. And we're so friendly together, you know, so nice. And I have the most lovely girl at breakfast, Pamela. Oh she's gorgeous. And she goes [raises voice] 'Come on you lazy bones - get up!' [laughs] And she takes me in the bathroom, you know, helps me with everything. (Mrs Peploe)

She did not have disagreements with her home carer:

Never. Never. I got everything I wanted. In fact she used to suggest this and suggest that, I goes OK, OK I agree with you. I'm very, very grateful; they are very nice. (Mrs Peploe)

Mrs Burley summed up the essence and value of a good relationship: 'She's a real carer. We just get on well together. We can talk to each other'. For Mrs Burley, the ability to be conversational was a crucial attribute of what made a 'real carer', rather than someone who just performed the task. However, having a friendly relationship with the home carer was not welcomed by everyone. As seen earlier, Mrs Herman had been disparaging towards her home carer, and found them incompatible with her. In the exploratory study, Mr Downing, who lived with his spouse as his informal carer, needed assistance with personal care such as washing and shaving following a stroke. He described the variability of quality of those coming into the home as ranging from '(...) the absolutely hopeless to the Angel Gabriel.' In particular, he found personal incompatibility with some (though not all) all of the care staff. He felt that staff were too eager to try to engage him in conversation when they had finished their practical tasks:

There are those who apparently have the impression that when they have done their duty (...) their function is to sit and talk to you, which might be all right for some, but as far as I'm concerned, I cannot engage in small talk for more than five minutes. (...) It becomes an effort on my part, and I am obliged to ask my wife to keep them away from me please. Not that I

dislike them, (...) it's merely they are monstrously unconversational. (Mr Downing, exploratory study)

His spouse echoed the awkwardness of the situation for both of them:

I have sometimes [left the house] in trepidation. He will sit in front of the [word processor] and say to the girl 'I go to bed in the afternoon'. Just anything to keep out of their way. That can be awful. And then there are some very good ones. (Mrs Downing, exploratory study)

However, there were a number of services that respondents would have liked to have received. Mrs Peploe asked her son to do 'odd jobs':

And I haven't had my curtains done since, oh, since I've been home. What can I do. I can't do nothing about it because they must not stretch out like that. And they can't stand on any ladders, nothing like that, they can't do the windows. (Mrs Peploe)

Mrs Burley wanted help with unpacking, illustrating the importance of low-intensity services that could nevertheless make a difference to the quality of individuals' daily lives. Mrs Burley also wanted a bath and toenails clipping, as did Mrs Grant: 'Well I can't get in the bath. All I can do is sit on the slats. You see, you can't call that a bath'. Getting out of the house was also important, as Mr Marsh noted:

I wish I had somebody to take me out in my wheelchair. That's the only thing I'm short of. Well that would be somebody, a man, like a volunteer, to come and take me out for an hour in the chair, and maybe I can do a little bit of shopping while I'm out or something like that. Just to go round the square or a little bit up the road, you know. Because my children haven't got the time for it, you see. (Mr Marsh)

Mrs Peploe had been talking about advertising for live in help after her stroke, but was too ill to interview applicants. She still wanted a

companion in the house. It was not clear how realistic this was, as she was not in a position to offer wages.

### **Home Care Punctuality & Reliability**

Reliability and punctuality of home care staff was a continuing concern, as seen from Table 4.13 summarising the older people's reports on the home care services they received.



**Table 4.13 Home Care Punctuality**

<b>Locality</b>	<b>Home care punctual</b>	<b>Home care not punctual</b>	<b>Mixed</b>	<b>Not applicable</b>
West	3	4	1	2
South	4	2	0	4
North	1	1	0	1

Mrs Fitter reported lack of punctuality, or staff not turning up following the discharge of her mother (Mrs Lowe) from hospital, which may also indicate a lack of inter-agency communication. Staff were coming into the home to assist with putting Mrs Lowe to bed even in advance of the scheduled 6pm time:

I mean the hospital arranges everything, and then she comes home, and nothing starts that day, it's the following day. And they say, oh, we didn't know she was home that day. It's happened a few times. Not always, but. Or else they haven't notified meals on wheels, and so the first day comes and goes and there's been no dinner. (...) On a couple of instances, no-one's turned up for the evening visit. She's not seen anyone in the evening at all. And sometimes, the case was just that they haven't phoned in to say they weren't coming to work. Of course, they don't know, until the next day, and they don't realise that mum hasn't had anybody the night before, because they've not been told themselves, which is not their fault. Sometimes they tend to come what is supposed to be the evening visit, you see, and they're here at 4 o'clock in the afternoon. Which is a bit early. Mrs Fitter)

In contrast, Mr Garfield said he was always notified in advance if there were going to be changes in home carer schedules. Mrs Bugno also noted that the agency would always ring to inform if there were any cancellations. Mrs Burley's home carer was valued for her reliability, and apology if kept late by her previous client. This was not the experience of Mr Sergy, though:

The only thing I object to, is that they don't ring you when the girl doesn't come. They could warn you at least, and say look, Mr Sergy, your girl is not coming, another one will come, something like that. Or she is coming between this time and that time. (Mr Sergy)

Mrs Peplow was notified by phone if lateness was anticipated, however, and showed understanding even when the service was unreliable: 'They used to phone me saying sorry they couldn't get somebody to me, but they will be coming along soon, and all that. Oh yes, they phone me and let me know'. Mrs Grant was not so forgiving, and was very disgruntled about unreliability:

Unfortunately, they promise to come and they never do. (...) Promise you faithfully he'll be with you half past one. Half past one come, nobody. Promise faithfully they'll be there 3 o'clock. Nobody come. So he [provider agency manager] says, I'm going to send somebody on Saturday morning, half past 9. Nobody comes. I say, 'You're so sweet. You really sound helpful, but nothing happens'. I would like somebody much better than these home helps. They just cancel it. But I can't expect anything any more. They seem to either forget to come, or they've probably gone over their time limit and they probably go home. They've probably got a certain amount of people to do in a day. But what annoys me so much is this man that's in charge. Promises the world, without fail, and they never come. (Mrs Grant)

For Mr Smith, having consistency in home care staff was also very important: 'So that's very important, having the same person. When you've got a good person, you want to hang on to them'. Mrs Bugno pointed out the difficulty of establishing a good relationship or rapport with staff if there are many different faces:

Some were very good and some not so good. You know, I saw about - I'm not exaggerating- fifty different faces and you were told to build up a rapport with my home help. Well, how

can you when you have a different one all the time turning up?  
(Mrs Bugno)

### **Promotion of dependence or independence**

Views on how far home care services were assisting or impeding independence (subjectively defined) were mixed, as summarised in Table 4.14.

**Table 4.14 Home Care Encouraging Independence**

Locality	Home care encourages independence				
	More	Same	Less	Not sure	Not applicable
West	3	1	4	0	2
South	3	0	2	0	5
North	1	0	0	1	2

A number of older people and carers expressed the limitations that increasing frailty had imposed on them. Miss Cornwell took the initiative in restricting her mother's independence in going out, because of perceived risk. This was a topic of considerable conflict between them:

That's why I don't allow mum to go out at all on her own, even round the corner now. Mum used to like going round the corner, coming right the way back, doing a full circle but she fell over on the pavement. She was carted up to the hospital and she's cut above her eye, a deep...no, mum you can't go out...I know your heart's willing but your legs give out. (Mrs Cornwell)

Mrs Earl was nervous about being alone, particularly at night, whilst Mrs Herman described how her life had become limited:

This is now the first time since early last year that haven't been out of the house, and I'm afraid to go. Now I'm afraid to

go to Torquay. I don't know why. I just want to die here. (Mrs Herman)

Home care in this instance literally meant care within the home. However, the need being expressed was for greater opportunities to socialise safely. Mrs Markova demonstrated ambivalence over having to ask family for assistance, preferring to pay privately for help with larger domestic tasks. Mrs Bugno also displayed ambivalence over receiving help, preferring to improvise and assert her independence:

I just strip myself and end up with my feet in a bowl; I fill the bowl with a little pudding basin. But that works fine... It works. I'd rather do that than think I can't do it, have someone to come and wash you and dress you. (Mrs Bugno)

She thought a reduced service better than excessive help, and so requested a reduction in services:

I tried them for over a week and I said I know I can do that. Well, they offered me all kinds, everything, and I've had them come and say "What about the dusting?". I said, no, leave it, thank you. I can manage that myself, but there are others that will avoid if possible and the others say "Shall I dust for you?" I say "No, thank you very much", because that makes me feel dreadful mentally, redundant, useless, call it what you like, and I've always done for myself. It's a little independence that makes me feel a bit useful. And I can make my own bed. They were changing my sheets and I thought let me try. I found I could do it. I said "No, I'll do it myself". They were wanting to put the sheets in the washing machine. I said "No, I can do that". I said I didn't need it so it gradually diminished. I found I could do all my things, because they wanted to cook for me, wash me, so I thought, no, well, what's the use of living, so I decided I only wanted someone to do the vacuuming. I think it's only fair if you can manage to do so. I don't believe in asking for services if you can manage. Well, I've helped myself to be independent because I refused their help, didn't I? (Mrs Bugno)

Mr and Mrs Stewart wanted to 'keep going' in their own home as long as possible, despite physical fragility and progressive memory loss.

Mrs Stewart explained the division of labour in the household, including some ingenious strategies for cleaning:

Oh I wouldn't go out of here. No, this is our home. We are too old to go anywhere else. When we do go, either feet first in wooden box, or we get put into an old people's home. I want to stay put as long as I can. I can still do my bit of housework. He Hoovers once a week. I put the carpet sweeper around in the day, in the hall and that. And I sit on the kitchen floor, and wipe around the tiles, and the same in the bathroom around the bowl, to keep it clean. And I get a home help come in, but there's nothing for her to do. I sit on the cushion on the kitchen floor, brush my mat off, I wipe the tiles around, and I do the same in the bedroom. I mean, I defy anybody- I'll even wash the walls down in the bedroom when they've sweated off. There's nothing for them to do. Not even help me make the bed. It's generally done. Yes, we like our independence, and as long as I can be independent, when I need somebody I shall scream help. (Mrs Stewart)

It should be noted that Mrs Stewart's daughter had warned care managers that her mother felt intimidated by the Home Care staff, but Mrs Stewart continued with her determination to continue managing for herself. Mrs Peploe had also experienced conflict with some staff over independence:

I want to do things for myself, and at first a couple of the girls that I had here, a couple of the women, they used to resent me going in the kitchen. So I had a little barney a little while ago. I said ' Now look, dear, I said, I want to get better. I says I want to help myself. I says, just mix it up for me. I says, and put these ingredients in and then I'll do it myself. I did. See I fried up some things that I fancied in my own Jewish way, you see, and enjoyed it. I had such a thrill out of it. (Mrs Peploe)

Mrs Herman regretted the loss of her independence in relation to her previously active life, particularly in terms of loss of social contact:

But now I am not feeling safe and going out, me who had been in one or two countries of the world on my own. I was all

right on my own, absolutely independent, now I am dreading to go out, and unfortunately I realise how badly I am losing my memory. The other day I woke up and I wondered where Selfridges was. I was world famous for my navigation. Now life's changed enormously, beyond recognition. (Mrs Herman)

Mrs Peplow regretted the loss of her previous levels of activity and hobbies, which included crocheting scarves for Social Services to sell, as an example of reciprocity in action:

This was when I was OK. When I got ill I couldn't do it any more. You see, that's all stopped and that's upsetting me, because all I have now, my only pleasure now is the television. [Long pause] I used to do embroidery and everything. There wasn't anything I couldn't do at one time. I can't even sew any more now. I'm helpless where my hands are concerned. It's upsetting me terribly. I can't do any hobbies at all. My hobbies are all finished. (Mrs Peplow)

Some of these feelings of loss may be associated with depression, as described by Mrs Herman:

Sometimes I forget to eat. I'm a very bad eater. Very bad sleeper, too. But they tell you don't need any more than about 3 hours. Not when you get to my age. The worst thing is sitting watching the dawn coming up. (Mrs Herman)

These responses illustrate the multi-faceted nature of how independence was perceived, including social contacts, reciprocity, as well as self-sufficiency and choice over the care provided

### **Impacts of home care services on the lives of older people**

The question of how far the services received made a difference in the lives of the recipients is inevitably based on subjective opinions. However, such accounts reflect the lived experiences and sometimes ambivalences of those people interviewed. One of the informal carers

in the exploratory study, Mrs Goodwood, who lived away from her relative, summed up ambivalence over the services provided:

There's no in-between. Either it's a success or a complete failure. When it is good, it is very, very good; when it is bad it is horrid. (Mrs. Goodwood, exploratory study)

Nevertheless, the quantitative data also demonstrates mixed views, as shown in Table 4.15:

***Table 4.15 Older People's Views on the Impact of Services by Locality***

<b>Locality</b>	<b>Life better</b>	<b>Life a lot better</b>	<b>Life mixed</b>	<b>Life worse</b>	<b>Life a lot worse</b>	<b>Not applicable</b>
West	2	1	3	1	1	2
South	1	0	4	0	0	5
North	1	0	1	0	0	1

**Conclusions: What makes home care 'work' for some people?**

The experience of receiving care in the home can be seen as more than simple receipt (or rejection) of services. A crude, technocratic 'flow chart' social work model of assess need and match services in a mixed economy of transactions as in the original SSI policy guidance (1991) does not acknowledge the potential changes in status and identity that these transactions entail. Older people designated as frail, already marginalised, may be thrust into this unfamiliar system by force of circumstance and with choices already severely limited. The older interviewees in this study placed far more emphasis in their narratives on their health rather than their social care needs, reflecting their immediate concerns regarding the events that precipitated their biographical disruption (Bury, 1982). They were

nevertheless exercising their own agency in making their preferences known.

From evaluation of community care implementation, Barrett (1993, 1996) discussed the misunderstandings and 'coded' language (from both professionals and those 'being assessed') that may be encountered in care assessments. Older people and carers interviewed in this study had not known what to expect or what could be provided by social services, constricting their ability to express their wishes. None had copies of their assessment records or written care plans, and memory of the assessment events was poor. Nonetheless, all respondents expressed some satisfaction with at least one aspect of the services they received, with some anxious to emphasise how pleasantly surprised they were at the services they were able to receive. Nevertheless, once the gratitude had been indicated, it was as though permission was granted for other issues of discontent to be aired. In common with other surveys on domiciliary care (for example; Francis & Netten, 2003; Patmore, 2003; Richardson & Pearson, 2005; Clough *et al.*, 2007; Office of the Older People's Commissioner for Wales, 2012), the value placed on reliability, consistency and competence of staff all figured highly. These are findings that have remained remarkably constant over the past two decades since the implementation of community care, and are replicated in the views of the older people and their relatives interviewed in this study.

Increased choice was prized by the service users interviewed. However, the circumstances and narratives of the older people interviewed demonstrated that there was a limited script of normative needs that were being recognised and addressed by care managers and providers (Ceci, 2008), with a range of unmet needs being articulated. Some of the low-intensity services that were most prized



are those most likely to be cut in times of increased austerity, with rising eligibility thresholds and intensification of care discussed in Chapter 2. Some users couched their attempts to maintain independence and doing tasks their own way as a struggle not only with their physical frailties, but also with staff who tried to do things for them. There was variability both in the quality and amount of work being done; for some, too little to effect change, and for others the imposition of unwanted services that induced dependence.

Older people as users of services may have limited power in this context. Nevertheless, these interviews indicate a continuum from compliant to complaint, with some older people resisting, refusing or exiting services. How home care staff themselves experienced their interactions with their older 'clients' was not a focus of this study. However, there is a current emphasis on exploring ways in which this dyad can be reciprocal and mutual, in the United Kingdom (Blood, 2013) and internationally (for example in Canada; Byrne *et.al.*, (2011); in Denmark; Rostgaard, (2012)). There was also self-reported evidence that services had made a difference to people's lives, and that the relationships between some service users and their paid carer was valued, with the potential for a more empowering relationship. However, perceived class, ethnic, generational and cultural gulfs between some users and care staff emerged in accounts, with Mrs Wieder, Mrs Herman (home care staff as 'peasants') and Mr Downing all expressing their incompatibility with their home carers.

Sensitive personal care work in the home is usually carried out in isolation, away from the gaze of direct managerial or peer supervision. How far the policy direction in England of personalisation with unregulated personal assistants may further compromise safeguarding and quality is yet to be answered. The vulnerability of both staff and older people became evident in the interviews, exemplified by the

virtual imprisonment in the home of Mrs Peploe by her agency live-in carer. Staff could also be vulnerable, both to accusations of misconduct and to exposure to aggression, which in the example of Mr Smith led to withdrawal of services, resulting in a desperate situation for both Mr Smith and his spouse, increasing the vulnerability of both. Dishonesty in staff was also a recurring theme in the interviews, whether by allegations of theft (Mr Wilder), or accounts of care staff not staying for allocated times. Recipients of domiciliary services could thus perceive their paid carers as invaluable friends or disturbing 'strangers'.

It is argued here that the structures of home care are still located within a loss-deficit model, despite the contemporary moves towards personalisation of care. Independence is formulated in policy as a positive attribute to be promoted. Dependence, as its opposite, is seen in a negative light, both for the individual and the State. However, the acceptance of care is an acknowledgement of some level of increasing dependence, but this does not negate the importance of autonomy and choice over that care, which older people were keen to emphasise in the interviews.

### **Connecting to wider contexts: Provider agency perspectives**

To summarise, this chapter has discussed the responses of older people receiving care services in their home. These relationships lying below the surface are just one component of a complex, shifting and inherently paradoxical system such as social care, however. The wider analysis of the study also encompasses how differing professional practices of both the purchasing care managers and the providers of domiciliary care services act as interlocking systems that impact on the older people's experiences of care. Regardless of affluence, all of the older participants were enmeshed in the mixed economy of care,

encountering the vagaries of a patchwork of independent care providers. This links their experiences to the issues explored in the subsequent chapter, which discusses the perspectives of the managers of the care provider agencies.

## **Chapter 5**

### **Provider Perspectives**

#### **Introduction**

In the preceding chapter, the views of older people were presented. This chapter sets out the perspectives of the agencies providing the services in the home. In particular, the responses of provider agency managers are placed within the context of market conditions existing in Parkside at the time, and examined for continuities with more recent trends.

In order to gain a more complete picture of the provision of community care services in Parkside, the provider agencies' views on working in Parkside were sought as representing a crucial stakeholder perspective that had been acknowledged by senior managers as neglected in previous Parkside consultation processes. The following chapter presents the themes from individual interviews with 10 service provider managers. All of the agencies involved in domiciliary care for older people (5 independent agencies, and 3 former 'in-house' provider teams) were represented. Details of the provider agency's service delivery linked to the care management cycle from referral to monitoring were addressed in the interview topic guide (Appendix 5). Their experience of contracting, quality assurance mechanisms, user feedback and local communication with care managers were also addressed. The wider organisational context of domiciliary care agencies in Parkside is outlined first, then the profiles of the provider agencies involved in the context of their roles within the authority. Finally, the qualitative findings from the interviews are presented and analysed in the light of continuing trends in care markets.

## **The wider organisational context: The Parkside provider market**

The city where Parkside is located faced particular problems at the time of data collection, both with domiciliary care staff recruitment and matching their services to the distinctive demographic characteristics of older people in the area. Although there were fewer older people in the inner parts of the city, many were likely to need social care as a result of poor health, poverty, poor housing and lack of social support. (Laing, 2005; Robinson & Banks, 2005). In Parkside, the Community Care Plan that was published jointly with the local Health Authority (Parkside, 1997) estimated that the SSD would spend £32,908,200 on services for older people. Of this, £16,225,500 would be spent on community care services, with approximately 90.5% of services to be purchased from independent providers and Direct Service Organisations (DSOs), which had been developed from the externalised 'in house' home care service. This was beyond the 85% spend on the private or voluntary sector from the Special Transitional Grant (STG), announced in Parliament on 10<sup>th</sup> February 1994 by John Bowis, Under-Secretary for Health as £564.4 million in 1993-4 (HC Deb 1993-1994, 237 col. 423). Around 500 new care packages which included some independent provision were started during the year that the interviews took place. The high proportion of monies spent in the independent sector reflects the alignment made by Parkside with an early and extensive commitment to the mixed economy of care. This move was in the context of a highly politicised local council, which prided itself on being a Local Authority flagship for engagement with business.

It can be seen that the interviews took place in the context of rapid change regarding the emerging market of domiciliary care. A housework contract, introduced in the year before the interviews, had been extended for a second year, and its coverage broadened across

all of Parkside. Help with light shopping was also introduced as a new service, so that there was no longer a need for service users to be referred to a separate contractor. Two personal care contracts began in the previous year. These were run by the former in-house services, (which had become Direct Service Organisations at the time the study), with help from subcontractor or partner independent agencies with a local presence. According to the Parkside Community Care Plan (Parkside, 1997), this was intended to significantly reduce the number of different care agencies in home care, for consistency, continuity and familiarity. In public consultation undertaken with local communities by Parkside, people had expressed concerns at multiple representatives coming into homes. A Home Bathing service (jointly-funded with the local Health Authority,) popular for low to moderate needs, had been extended in the year before the interviews. As part of the fieldwork I had sat in as an observer on the tendering process for the bathing contract. This had been awarded to a nursing agency (Care Nursing). It had been remarked by some of the panel members that the contract had been awarded for a charged-for service carried out by some of the same nurses who had previously provided the service free under the NHS. Parkside had moved to a policy of longer term 'block' contracts to 'preferred providers', based on cost, volume and quality. This drive for 'Value for Money' (VFM) was in line with the John Major Conservative Government (1990-1997) directives of the day (House of Commons Committee of Public Accounts, 1999). This signalled a move away from more ad hoc 'spot' contracts, which tended to be more expensive and variable in quality, although could provide flexibility in filling gaps in services, as discussed in Chapter 2. In the North locality area, the original preferred provider experienced significant problems with quality, in what the interviewee (6) from North Direct Service Organisation (DSO) called a 'disaster'. It was this agency who provided the live-in carer for Mrs Herman (discussed in Chapter 5) who effectively held her hostage. The agency never signed

the contract, the arrangement collapsed, and Care Solutions filled the gap at short notice.

**Response to request for interview:**

The procedure for contacting the agencies is described in Chapter 3. It was a feature of arranging the interviews that there was a high level of cooperation from the provider agencies: a typical comment was that it was 'refreshing' to be asking for their views in this way, and certainly unusual. All of the agencies contacted agreed to be interviewed. The process of interviewing itself took place over a period of just over a month. This relatively swift completion can be compared with the length of time that it took to arrange interviews with both service users (Chapter 4) and care management staff (Chapter 6), although for different reasons detailed in the respective chapters.

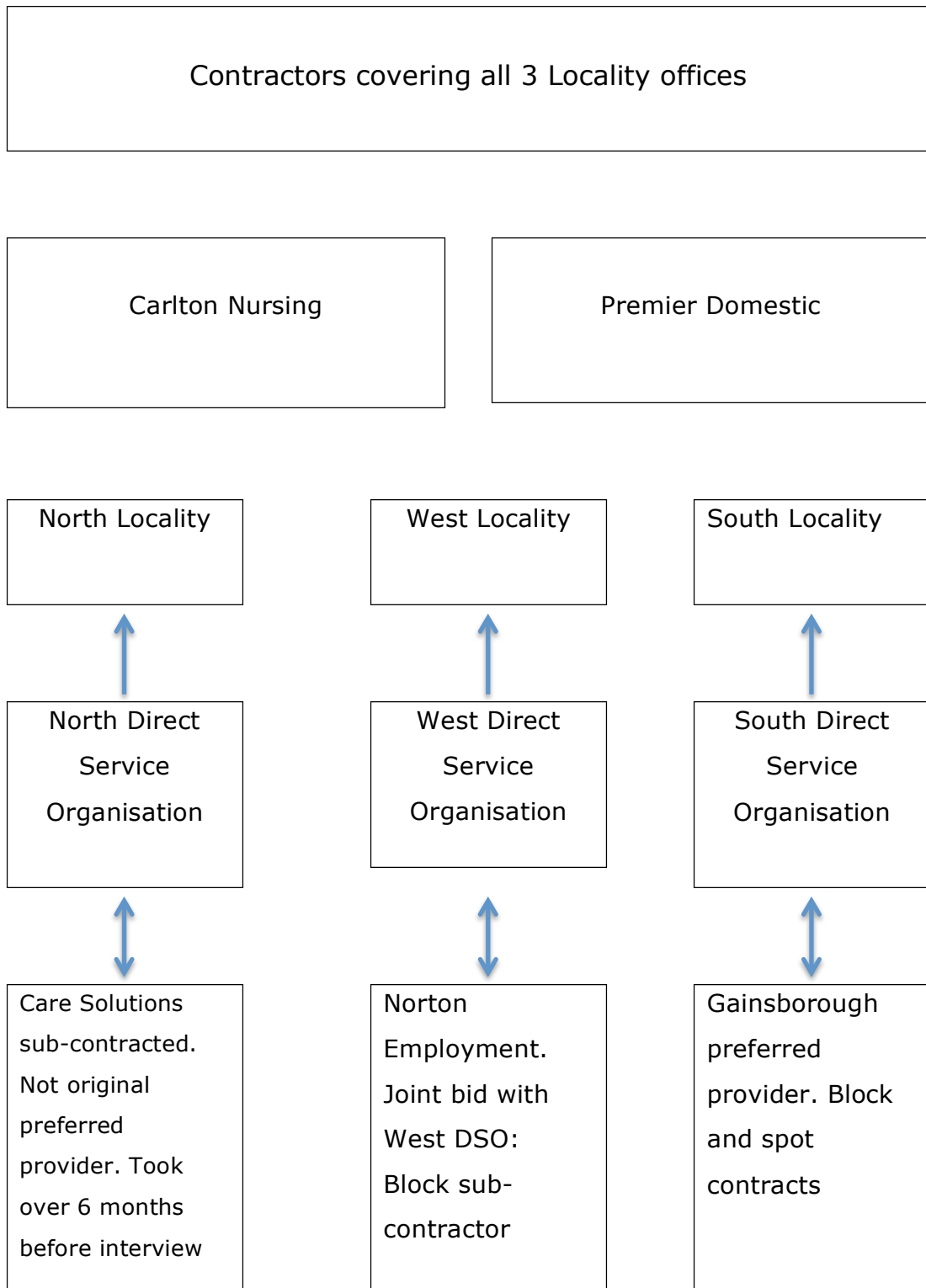
The following table (Table 5.1) summarises the roles undertaken by the different provider agencies. As with all interviews, the names of those interviewed (the agencies in this case) are given pseudonyms. Interview numbers are assigned in order of interview. Figure 5.1 then illustrates the organisational coverage of the agencies and their linkage to the locality offices.

**Table 5.1 Provider Agency Roles**

<b>Name of Agency (Pseudonym)</b>	<b>Position of Interviewee (Interview number)</b>	<b>Main Role of Agency</b>
Premier Domestic	Operations Manager (1)	Domestic only (housework, cleaning & laundry)
Gainsborough	Operations Manager (2); Branch Manager (7)	Domestic & personal care
Norton Employment	Operations Manager (3); Branch Manager (10)	Domestic & personal care
Carlton Nursing	Branch Manager (4)	Bathing service
South Direct Service Organisation (DSO)	Operations Manager (5)	Domestic and personal care
North DSO	Operations Manager (North) (6)	Domestic and personal care
Care Solutions	Branch Manager (8)	Putting to bed & short-term night care
West DSO	Branch Manager (9)	Domestic & personal care



**Figure 5.1 Operational Coverage of Provider Agencies**



### **Initial communication with Care Managers at referral:**

A sequential approach on the process of referral, assessment, provision of services, and monitoring was adopted in the interviews, followed by specific areas of contracting with Parkside. The first section of the interview schedule examines the methods for communication with care managers at the initial stages of referral. These were still being developed, with the quality of referral details reported as varying from full to very sparse. This sometimes depended on the individual care manager, but there were also difficulties with the restrictive format of the form for referral details passed to the agencies. Carlton Nursing, the nursing staff agency providing the bathing service, regarded themselves as professional equals with care managers, and reported that her assessor colleague found that information they regarded as essential was missing, as it only consisted of one sheet for service user's name, address: '(...) and age if lucky. We want the next of kin, functional and social details'.

The Care Solutions manager, subcontractor for the North Locality Direct Service Organisation (DSO), also thought that details on referral were insufficient, or even incorrect. This was linked both to the relatively complicated contracting arrangements in the area and variability of practice among Care Managers:

Sometimes there is not enough information, especially from North. Care managers can't directly refer to Care Solutions, but have to go to North DSO first. They get the wrong number, and so on. It depends on the individual care manager. But, it is a 3-way process, and not as direct as with other contracts. (Care Solutions)

This perceived lack of information was a recurring irritation among the provider managers. Gainsborough, who had preferred provider status with South locality, were similarly irked by the lack of paper information, but also by perceived gaps in other information passed on by the locality care management team. For example, on the day of interview, Gainsborough staff found that another agency had visited one of their service users. In terms of written communication:

Shopping and cleaning is the worst. Some care managers are thorough, but compared with [a neighbouring borough], information is not so detailed. [The neighbouring borough] give more detail on their care plan, but Parkside don't send the care plan. (Gainsborough branch manager)

Reasons for shopping and cleaning referrals being 'the worst' in terms of information may have been due to it being seen as a 'simple' service that did not require more in-depth information. However, this was a perspective that was vigorously contested by the manager of Premier Domestic. This manager for providers of the housework contract was particularly expansive on the quality of the information received, and how there was a differential between referrals for low-intensity services (such as those provided by his agency) and more intensive personal care. He also wryly commented that all information came with the rider of '(...) and please start as soon as possible.':

We have a standard referral form which is very, very, very brief. Again, it goes back to, people tend to see assessment-type information roles as something that you do for high intensive personal care, as opposed to practical care. (...) I've questioned a couple of referrals. We had one referral which was for a particular need, where a service user needed somebody of a particular sex and language requirement and there's no point sending anybody if you didn't have that. [And that hadn't been noted?] Yes, it hadn't been noted but it would have been quite nice to even ask us. (Premier Domestic)

In particular, he highlighted the need for more functional analysis of task to be undertaken (a theme he would return to), rather than a model that more closely resembled a prescription for a dose of time. Thus, he appeared to prefer a task-centred orientation to a time-centred approach (Patmore, 2003), though this stemmed more from unrealistic expectations in the referral of what could be completed in the allocated time slots. Time-centred visits remained the usual method of purchasing services from independent agencies in Parkside. Nevertheless, he felt care managers could be more specific, which in turn would assist in clarifying user expectations:

Again, 'the person can come in and clean' is not a very descriptive way of going well this is about the service you can receive and the limitations within the services are (...) if you're going to visit somebody who's got a three-bedroom house and say we're going to provide you with a cleaner once a week. [So 'cleaning' is too vague?] Yes, it's too vague. It's about what can realistically be done within that time. I think that needs to be reinforced at the care management assessment side, because again it's loosely termed [...] from the realisation that they don't visualise what needs to go on within an hour. You know, I can just about clean my shoes in an hour, let alone clean a 3-bedroom house. (Premier Domestic)

In a later response, the same manager remarked that the issue was about managing expectations and being clear about what tasks could be expected to be completed from the outset, and having this in writing: 'You can't ask people to repair your wardrobe for you'.

The general lack of care plans raised earlier by Gainsborough was echoed by the manager of one of the Direct Service organisations, who again stressed variability among care managers for quality of communication. This manager was a former in-house member employee, and had a long history of contact with localities to arrange domiciliary care, and was familiar with the localities and their staff, and the work pressures on them:

Appropriate information depends on individual care managers, so sometimes it is full and sometimes not. We have deliberately cut down on the length of our referral form because of the pressures on care managers to provide detail. The problem is that our contract specification says each referral should be accompanied by the care plan. We very, very rarely get a care plan. (West DSO)

So this DSO manager was claiming that service specifications were not being met by care managers. As a former in-house manager, he had a good understanding of the format and content of care plans specified by Parkside.

The other DSO manager in the North team was also in agreement about the realism of some referral information, commenting on the increased distance now between the externalised DSO and care managers:

We used to be able to negotiate more with care managers. The information received is variable, and always depends on individual care managers. Care managers now know better what they have to do. Now they specify the times and length of visit. Sometimes this is realistic, sometimes not. The majority of the [North] team work to a high standard. If it is not appropriate, we go back and request more information from the Care Manager on services. There is a standardised format for information, still in draft but a long time in operation. We have to complete papers for a service plan and safe environment. Users should have a good idea what to expect. There is a long form on religious needs and choices: users must be exhausted. (North DSO)

The responses of both DSO and independent agency managers illustrates the multiplicity of terms for information received, with 'referral' form, 'service plan' care plan' being used without much distinction. For example, there was some confusion among some independent providers over what constituted a care plan, as the branch manager of Norton Employment (the independent sector

partner with West DSO) seemed to confuse the care plan with the referral request, illustrating how seemingly simple terms could have different meanings for different sector practitioners

The provider concerns about gaps in important information will be pursued further in Chapter 6, which includes content analysis of case file content analysis. The agency managers' views on the lack of care plans is buttressed by the examination of case files, where care plans were missing, and from the interviews with service users in Chapter 5, where none of the older people interviewed had received a care plan, despite this being a policy requirement.

### **Assessment: Whose role?**

Assessment of need matched to services was also an area of negotiation about changing roles in the mixed economy. The implementation of the purchaser/provider split under the NHSCCA 1990 had led to a decreased role in assessment of service users by provider agencies, as assessment became a care management core task. The following section examines some provider reactions to that development.

The manager of Premier Domestic continued with his topic quality of information by pointing out the situation with long-standing service users, whose entry into the care system pre-dated the implementation of care management:

A lot of the information which is held within care management is unknown information. We don't know whether they have any information on file or not, because some service users could have been receiving a service for years, and care management only came in in '93. So if there's anything pre-'93, there's no real assessment process. Before then, it was done on a very ad hoc basis and generally done by the local authority's own in-house team, as opposed to a properly care managed

service, so a lot of these people are unknown quantities.  
(Premier Domestic)

As will be seen in Chapter 6, this lack of historical information was evident in some case files. The operations manager of Norton Employment, the subcontractor partner with West DSO, felt that they did not have prior experience of assessment, as the agency had only recently moved into that area of work. This manager described an initial lack of confidence in the process. In particular, they felt inexperienced compared to West DSO, and hesitant in challenging decisions: 'At first, our staff were unsure whether they could query Care Manager assessments, for example about time allocations or priorities'.

This situation was improving as they became used to the process of both assessment and review of services. Norton Employment had a policy of carrying out their own assessment visit following the care manager assessment, and producing a service plan detailing specific care staff times and tasks. Such duplication added to the numbers of people entering the older person's home before the service had begun. In common with other providers, South DSO conducted their own assessment visit in order to produce their own service plan, thus adding to the paperwork generated by different sectors having their own, distinct procedures and definitions of what constituted 'assessment'. The Norton Employment operations manager also noted that they did not receive care plans from care managers following the locality assessment. Before the externalisation of services, the DSOs historically used to carry out their own referrals for the directly-provided home care service, but under the new care management regime, this role was reduced. As a consequence, long-established DSO home care staff felt that their level of expertise was devalued, as described by the manager of the West DSO:

Before, when we were providers, we were part of the department and we assessed for our own service, so our input was asked for more often than it is now. We have had to come to terms with not assessing now, though we are trained to do it. Staff felt de-skilled. (West DSO)

However, the manager of Premier Domestic was eager to stake a claim for his staff's expertise. He was more positive about the current role of provider agencies in assessment, an area where he felt they had more direct experience than some care managers:

I think that's about care managers not having any experience of providing, whereas we have experience of assessment. We are involved in the assessment process whereas purchasers are too rarely involved in the provision. You're part of that assessment process because you assess the service user in terms of the need. You're in daily contact with the service user in terms of need and adjustment, whereas care management are only purely involved in the assessment and the co-ordination, and maybe don't have any experience in providing certain services. (Premier Domestic)

This manager was linking his earlier point about breaking down time allocations into realistic tasks with monitoring (and adjusting) interventions on a daily basis. By highlighting the contrast to the less frequent contact from care managers, this manager was appropriating the functions of monitoring, review, as well as assessment of need. This confident assertion of role substitution with care managers chimed with the West DSO's statement regarding the under-used skills of the externalised home care staff. There appeared to be a struggle over the meaning of professionalism and role boundaries here, which will be returned to in the concluding discussion.



## **Forging new relationships in the mixed economy**

It can be seen from the previous discussions that communication between care managers and providers was still in a developing phase, as both sides of purchaser/provider boundary worked out their new roles. The operations manager of agency Gainsborough wanted to build closer relationships with staff in the South locality:

There are not enough regular meetings. The agency has suggested it in the past, but I think staff are too hard pressed. We want to set up a regular forum to meet with staff now that contracts are dealt with at a higher level. But I would also like more meetings at the local level. (Gainsborough operations manager)

This agency had had a difficult transition period when it did not win the contract for work in West locality. They complained in writing to the Parkside Contracts manager that one of their care staff had been told by a local care manager that they should leave Gainsborough and go to work for Norton Employment if they wanted to stay working in the West area. The staff member reported to the agency, asking why they had not been told that they were losing work. A letter had been sent out to Gainsborough's care staff from Parkside, but the details were very vague, which contributed to confusion and anxiety. Despite this unfortunate experience, the manager of Gainsborough reported good day-to-day working relations overall with the Care Managers in South locality. However, they had experienced some difficulties with streamlining their own complaints procedures with South's own procedures, and the central Parkside complaints system. This had also been the experience of Norton Employment, the agency taking over the independent provider contract at West locality:

There were difficulties with complaints, as it had not been thought about how serious complaints would be dealt with. There is a tripartite system between Norton Employment, the

commissioners and West DSO. There was difficulty over practicality. We have own complaints procedure that has to tie in with Parkside and West DSO. This got out of synch and over-bureaucratic. We don't want stage 1 complaints to clog up the process. (Norton Employment operations manager)

As with procedures over referral information and assessment, agencies and the local authority had to work out ways to streamline their own historic processes. Some of these difficulties were thought to be common to most local authority SSDs, however, stemming from care manager unfamiliarity with some of the administrative requirements of independent sector businesses, and the complexities of DSO/independent sector partnerships in particular:

Care managers tend to do things over the phone. But our Accounts Department do not like paying bills on telephone calls from Local Authorities, and insist on written records. This is a cultural thing. There has been more leeway historically for in-house providers. We have had care managers ring for care packages, and they don't see the point of faxing confirmation. We try to communicate to care managers that we are not part of Parkside regarding payment. There are too many assumptions made about information sharing, written information etc. Care managers understand West DSO well, but find it more difficult to understand that we are part of the contract, but as a separate organisation. But it's not a major problem. (Norton Employment operations manager)

However, the nursing agency Carlton Nursing complained that there were some lags in communication from care managers that could have more serious repercussions. Not being notified promptly on the death of service users was of concern, illustrated in the following examples:

We have had run-ins with the care managers over provision of service and quality. One of our registered nurses was visiting a lady who had sleep-in duty, an evening visit and Meals on Wheels. She was very unwell with her chest. We were very concerned, but the response from the care manager was

that 'you don't need an audience to die'. We withdrew the service. The client died and no-one told the next of kin. Another man had 3 hours care every evening. He needed help with meals, getting to bed and dressings. He was very dependent and needed our intervention. After a review, his hours were cut to 2. The care manager was new, and told him she would improve the service, yet cut the hours. The fact that the provider may have a view is ignored. (Carlton Nursing)

The first example demonstrated poor communication in a critical, sensitive area, as well as a startlingly callous attitude (if the attributed quote was accurate). The second example also foreshadowed the issue of resource restriction, which will be returned to.

The Gainsborough branch manager commented on the difficulty in reliably getting hold of care management staff in South locality, especially via the duty system:

From 12-12.30 the answer phone is on. We have devised a form to say if we can't get hold of the client. Sometimes we need to talk to someone on duty. But sometimes people respond to our fax about client non-response 2 days later. Is there a staff shortage? (Gainsborough branch manager)

This difficulty with getting swift responses if a service user's condition deteriorated was also found by the local branch manager of Norton Employment (interviewee 10), especially if the case was held on duty or unallocated. These managers were stating the case that quality of response and care was not solely a provider responsibility. However, the manager from Gainsborough also had a constructive suggestion for fostering more mutual understanding between care managers and providers:

Next week, a Care Manager from [a neighbouring local authority care management team] is coming to spend a week at our office and a day at our [...] branch to see work from the provider side. I'd like to do that in a Social Services office,

though it would get too much all round if there was a sudden surge of interest. (Gainsborough branch manager)

To emphasise the strengths of links, the manager of Care Solutions positively valued the direct contact the agency had with care managers, contrasting it to the way some other local authorities worked:

It's been extremely clear. We deal directly with Care Managers. Other boroughs don't seem to work that way. For example, in [a neighbouring borough], we have to go to a brokerage team who then go to the Care Managers. (Care Solutions)

The next section looks at how the agencies felt that services were experienced by older service users themselves.

### **Service provision and user experience**

Many of the providers' reflections on their services parallel the views on quality of care expressed by older people themselves in Chapter 4. The confusion felt by the numbers of different people entering the home is one example raised by the local branch manager of Norton Employment:

There are so many staff involved in care that it is difficult for the user. For new referrals, it is tricky if a user is not used to having someone coming into the home. They are sometimes not always aware what will be happening. They can't always handle the intrusion, and Parkside have been in there first. (Norton Employment branch manager)

This confusion over the multiplicity in staff stemming from shared care between providers was also raised by the manager of the agency subcontracted to North DSO:

North DSO share some carers, or North DSO use other agencies, so users can get confused who to ring. We have to explain that we are only responsible for evening visits, not other visits. It can make life more difficult. We try to avoid shared care but it's not always possible. (Care Solutions)

The West DSO was committed to inform people of any changes to the service, such as staff sickness. However, the manager stated that although the working day started at 8am, the office was often not told of care staff absences till 9am. This resulted in service users becoming anxious and telephoning the agency early in the morning. The manager of the South DSO proposed a policy of patience in dealing with some of the user frustrations and anxieties:

Sometimes users don't know what to expect. Often users are EMI. The day starts when they ring up to ask if their carer is coming. It needs staff patience to reassure them. (South DSO)

However, that patience did not seem to be so forthcoming from the nursing agency manager, who saw direct user contact as an annoyance:

The contract runs smoothly, but we get contact continually from clients. For example, at 9am, if the carer is 2 minutes late, the client will ring. I would not want clients to be given our number in future. (Carlton Nursing)

Here, some service users were regarded as problematic by the nursing agency. The proposed solution was to place further barriers between older people and those responsible for providing the services. The manager of Premier Domestic also acknowledged that punctuality was a user priority:

One of the top ten complaints is about staying the right amount of time, and being on time. And I think the thing about what people, staff, can and can't do. That's been going on for

year after year after year and still people don't know. (Premier Domestic)

The manager of North DSO subcontractor agency also made the point about unrealistic expectations from some service users, and was specific about those whom she felt were the most difficult to please:

Shopping and cleaning clients, especially those in [a wealthy district of the locality] are the most demanding and unreasonable, but their needs are the least. For example, this week we were asked to clean over 20 white cupboards in the hour available. Clients also don't understand that staff don't work 7 days a week, and they dislike having more than one worker. (Care Solutions)

The contrasts of poverty and wealth found in Parkside were sometimes mirrored in the relationships between care staff and the older person:

Many of the people we work with live in some very, very rich circles. Ranging from the area that we cover, you're looking at two wealth extremes there. Their expectations are very different about what they feel a care worker's there for - the cleaner, the char, polish the silver, compared to somebody who's extremely poor and lives in a fairly poor environment. [...] You get the more wealthy clients who are looking for a maid who can clean and dust the antique furniture and clean and polish the silverware. Polishing silver is actually part of the contract, believe it or not. (Premier Domestic)

He went on to speculate on why this might be the case, emphasising the loss of perceived status in having to submit to the unfamiliar public welfare processes (more commonly a preserve of those less wealthy), including the indignities of financial assessment:

They are very demanding because they've been in a position of authority to demand, in terms of wealth and in terms of outcomes with themselves throughout life. Certainly for them, number one, it's quite degrading having a service, having been assessed for a service. I also think in terms of outcomes for

service users for our more wealthy clients is a certain amount of resistance to information going to local authorities in terms of wealth, money, financial wealth, financial assessment. I think generally they're used to a lifestyle, they can't have that lifestyle any more, where somebody comes in and does all the furniture. It's a priority service which is really a vacuuming, bathroom cleaning, kitchen cleaning - you can't do everything. (Premier Domestic)

These themes of clashes of expectations and class-based attitudes to domiciliary care staff was also found in interviews with some service users (for example, Mrs Herman in Chapter 4) The amount of service received was also reflected in terms of user satisfaction, in this manager's opinion, echoing the observations made by the manager of Care Solutions:

I'd say that the housekeeping contracts as a whole are more prepared to complain because they're getting less services. You tend to find that people in receipt of a lot of services, like personal care in the morning, in the evening, tend to be very happy because they're getting a lot of service, they're getting a lot of input. Very few people complain. I know MORI did a poll in [a nearly local authority] of service users which bore out the percentages in terms of people who were likely to complain from receiving lots of service to people receiving small amounts of service. It bore out that people receiving small amount of service were more likely to complain, as a whole. (Premier Domestic)

The interviews with users in Chapter 4 partially bear this out, as the standard of domestic services was particularly subject to dissatisfaction and refusal or discontinuation of services.

Another issue that was highlighted both in the user and provider interviews was that of racism towards care staff. This was not a topic that was included in the original interview schedule, but it was raised spontaneously by providers. Agency managers agreed that there were particular difficulties faced by black and ethnic minority staff, who

comprised most of the workforce. Patmore (2003) found that ethnic minority workers comprised up to 80% of the workforce at some of the local independent agencies. The Gainsborough operations manager thought racism to be particularly prevalent in the area covering Parkside and a neighbouring authority:

[This] branch suffers more than any other branch in [the city] with racism, particularly with private clients, not necessarily service users, who show extreme racism. Users can't say so don't express it. We have an equal opportunities policy, and our carers are mostly from ethnic minorities. (Gainsborough operations manager)

The distinction was made here between 'private clients', who were paying for their care independently of SSD assessment and intervention, and the less powerful (and therefore, in this interpretation, less able to be vocal) SSD service users. Racism posed a similar picture for the nursing agency:

Yes. A lot of carers are black. A lot of users don't like it. We have equal opportunities, but will negotiate and change if staff are being abused. (Carlton Nursing)

Different agencies adopted different strategies to tackle racist attitudes against their staff. The manager of North's independent agency emphasised that such negotiation was not an option when it came to racism, however:

We are an equal opportunity employer regarding racism. We are clear with clients. It can be difficult, but we have to protect staff. Clients can refuse the service, and can complain. We have not needed to send a male worker to a female client, and can respect client choice in gender, but not ethnic origin. We try to look at every case individually. (Care Solutions)

While the operations manager at Gainsborough did not specify how an equal opportunities policy was implemented in practice if vulnerable



users were being racist, the agency's operations manager gave alternative strategies:

There is racism against staff. [The neighbouring authority] is the worst: we had to give a package back in one case. But often people settle down. I think care staff manage really well; they know they'll settle down. (Gainsborough operations manager)

The manager at Premier Domestic also made the point that care managers had some responsibility in tackling overt racism:

You can't just go in and do an assessment and come back and give it to the provider who's dealing with it and not dealt with the racism at source. Then there's going to be a continual problem when the provider goes in. Certainly my experience of this in service users is if there's been a tendency for a certain amount of racist behaviour then I've had to challenge it there and then. It seems a bit late in the day, because I'm sure that they've made it quite willingly known to whoever went the first time, because they're making it known to me now. (Premier Domestic)

The responses indicated variability in practices in attempting to tackle racism where it occurred. Consistency in implementing anti-discriminatory policies across purchasers and providers was still in development at the time of the interviews; part of the emerging process of alignment between the two. Similar variability was found in how providers and care managers approached monitoring services, as seen in the following section.

### **Monitoring and reviewing services**

In the exploratory study conducting interviews with service users in North Locality, users and informal carers commented on the apparent lack of monitoring the quality of service. However, in the larger study a year later, users were reporting annoyance at increased contact, with monitoring 'overkill' developing. On being asked about monitoring

and the agency Quality Assurance (QA) practice, the branch manager of the independent agency linked to South Locality confirmed her experience of user ambivalence over monitoring:

We also do QA visits yearly from a Gainsborough care manager. Some are now appointed specifically to do QA visits. Users get QA call more frequently by telephone, for example twice yearly. We used to do telephone calls from the office every evening, but users were not keen on being rung every few weeks, as they found it was too often. (Gainsborough branch manager)

The North DSO manager also found the monitoring role problematic, but had developed workable solutions:

Care managers had trouble with low to moderate dependency cases where they did not allocate staff on every referral, such as shopping or pension collections. We have a customer care manager. That person also does monitoring. No one wanted to do that work all the time. We initially put higher level of quality audits into the contract, but it's overkill if it happens every 3 months, and users get fed up. Now we have agreed monitoring every 6 months, but still do spot checks and other visits on complex cases. In the quality audit and review of service, there is a personal visit including review of the package and appropriateness. (North DSO)

The potential problem of intrusion was a feature of life for the housework contract manager, who undertook monitoring telephone calls to clients:

No, again, it's complete paranoia when you're ringing up: 'Why are you ringing up?' So you think you're doing something really positive and people should be pleased, perhaps, but - 'Why are you ringing up? I don't need you to ring up every three months to ask me how it was. It's the same as how it was three months ago. (Premier Domestic)

The changing status of monitoring from being an absent entity to an over-present one for users is likely to be an issue for continuous

review for providers. Another area of work that has come more to the forefront in social care is that of outcome measurement. This area is also dealt with in the next chapter on care management staff views, but the following section looks at some provider opinions on the topic.

### **Measuring outcomes**

Providers were asked about how they might measure outcomes of the services provided, a question also asked of care managers (Chapter 6). A feature of the responses below was the lack of unanimity on what might be entailed in evaluating service outcomes for service users, and what provider involvement should be. The operations manager of Norton Employment had a simple definition: 'If the user and the care manager are happy, it is working. (Norton Employment operations manager)

However, this does not consider that perspectives and interests may differ between care managers and service users. In contrast, the manager of the South DSO felt that they had no role in the evaluation of user outcomes. However the understanding of what outcomes might entail hinged on changes in the user's condition and changes in service levels:

We have no input into outcome measurement. Where changes occur, we are responsible for keeping the Care Manager informed and may initiate negotiations for increasing or decreasing services. (South DSO)

The depiction of outcomes as measuring deterioration was echoed by the manager of the provider partner for South Locality, who also elided outcomes with user satisfaction. The manager of the North DSO had arguably a more sophisticated perspective:

I think we have a role in outcomes. We have never separated ourselves from what the user wants, though we are not the instigator of the package. Whether it is a care management responsibility is another matter. But it's difficult not to look at it. [...] Outcomes in care service include dignity and choice for the user. (North DSO)

The nursing agency felt that this was not part of their role, but did hold an interest and professional knowledge:

Officially, we don't get involved as it's not our place. But as Registered General Nurses, we are able to talk about it. (Carlton Nursing)

This reflects a possibly greater appreciation and knowledge of evaluating outcomes as part of healthcare staff training. Overall, though, the providers interviewed were hesitant about their actual and potential role in this area, which was only beginning to be addressed at the time of data collection.

The next sections move away from the tasks involved in direct service provision to issues of staffing and training experienced by the agencies that have an impact of service quality.

### **Staff Recruitment**

A theme common to all of the providers was the fragility of recruitment and retention of experienced and suitable care workers in an unpredictable market. Recruitment and retention of staff in the wider City in which Parkside is located posed particular difficulties. High travel costs, high levels of migration of people over 30 from the city, coupled with low pay and status of domiciliary care work persisted over time (Robinson & Banks, 2005), and were an endemic problem for employers. Such difficulties were having an adverse impact on consistency, reliability, training and other quality issues,

with many agencies chasing a restricted pool of potential staff. The branch manager of Norton Employment reflected on the highly competitive nature of the market:

We aim to be local in our recruitment. But now we've exhausted the supply locally, and now look further afield. We are in competition with other agencies on pay. Care staff often register with more than one agency in what is a cut-throat market (Norton Employment branch manager)

The Norton Employment manager also felt that in the future, demand would increase as the local population need continued to be more complex:

A lot of users are low to medium dependency, but the population is ageing, so demand will be a problem. I think that a lot of low dependency people deteriorate to high; the difference between needing a service twice a week to 3 times daily. So we are likely to have problems with care worker demand. (Norton Employment branch manager)

As discussed in Chapter 2, this view of rising demand was prescient, as trends in provision have resulted in raised eligibility thresholds and increasing focus on fewer households and more intensive provision. The issue of increasing levels of need of service users, and the implications for staffing and numbers of people served, was also emphasised by the manager of the South DSO:

We began with about 550 clients. Now we have progressively reduced to about 420. I estimate this will reduce further in the life of the contract to about 200, as the infirmity of clients is increasing and the hours contracted remain the same. The emphasis is now away from cleaning and shopping to intensive personal care. (South DSO)

Such a change in care role towards more intimate bodily tasks had an impact in the availability of suitable staff. The manager of the West

DSO had tried local recruitment campaigns, but had to drop her sights, as the quality of applicants was poor. She thought that pay was not high enough and the job was more demanding:

We have problems with recruitment and retention, and it is deteriorating. I tried a poster campaign locally, and mail shots. I'm now discussing it with an advertising agency. But the calibre is poor; few meet the specification. We have lowered our sights, and dropped standards to look for potential. The demands of the job have changed, and money increases in line with inflation and no more, so expectations are now higher but the pay is less attractive. (West DSO)

A consequence of a volatile job market was staff turnover. This impacted on continuity for users and flexibility of services, as discussed by the manager of South's subcontractor:

We try to keep the same carers, as continuity of care is important. Peripheral carers move on, but the core stay on, as they have regular clients and want to stay. Often staff will move within the sector. There will be fewer staff available in the future. In the beginning, the private sector would provide what the in-house couldn't, but private operators picked up the service, as they were more flexible, and could go beyond 6pm. But we have other limits, as we can't afford 2 carers. Being a carer is low paid, hard with all the to and fro-ing; timings are getting tighter, as some authorities demand ½ hour slots. [The centre of the City] is unique as carers don't have cars, so there is a limit to what we can innovate, such as late bed times. There is a restriction on public transport as carers can't get home on public transport. (Gainsborough branch manager)

Prefiguring decreasing timeslot specifications, this Gainsborough branch manager went on to predict the increasing use of short, fifteen-minute 'pop-in' visits, which they claimed were starting to be used across Parkside. Patmore (2003) noted that cars were becoming customary for home care workers in the outer regions of the City, but not in the more central areas. The Carlton Nursing agency manager concurred with the difficulties of transport in the area: 'We can never

increase the carers hourly rate. It's not easy to recruit, and staff get fed up with walking'. North Locality's partner agency also highlighted local recruitment problems:

This is the most difficult area to provide a service in as we can't recruit enough local staff. It's difficult to get workers from other areas to go here. Parkside had a stable workforce, compared to other areas in [the city], but lost 50% this summer, which is unusually high. We had been recruiting more than normal, as there were lots of travelling Australians, but recruitment has now slowed. We used to get up to 300 calls generally per week from recruitment enquiries, but yesterday only it was only 2. Now it is difficult to be choosy. (Care Solutions)

The manager at North gave a DSO perspective on staffing problems:

It's been a hell of a learning curve. The past year has been demoralising because quality of service, especially for new users deteriorated because of the [failed subcontractor] collapse. They had poor quality agency staff provided; with allegations of theft and abuse. There were staff that I would not have thought suitable for the job. But Care Solutions are good: they treat staff well and do their own induction and training, so the situation is improving. (...) We had to reduce weekend conditions for our staff, who used to get pay at 1½ or double time, so many staff left, and we had problems with the Trade Union. I felt bad about doing it, but knew we couldn't compete otherwise. I think other private agencies should treat their staff better. (North DSO)

This highlighted the deterioration in pay and conditions that could be faced by former in-house staff faced with increased competitive tendering. The South DSO manager also needed flexible staff, but the market was not providing. He outlined the shortfall in pay with a striking (and shocking) phrase:

We ask for a 'caring attitude', honesty, and willingness to deal with human debris for no more pay than a shop assistant. (South DSO)

It was not entirely clear whether the 'debris' referred to human waste, or to the people themselves.

### **Staff Training**

At the time of the interviews for this study, there was an expressed desire from independent sector interviewees for joint training with the Local Authority. The operations manager of Norton Employment felt that the independent sector did not yet have as good a track record in training their staff:

There is a drive for training. The private sector still lags behind Local Authorities, who are traditionally good investors in training, but temporary staff agencies less are so. This is a big issue. The feeling in the industry is that the process that Local Authorities are looking for do not leave room for training. I think we should look at ways of pooling training with Local Authorities, and possibly the UKHCA [United Kingdom Home Care Association]. Competitors can share common aims, as there is such mobility of staff. We have developed training in-house for front line staff. We cover specialist areas such as lifting & handling and updates, plus opportunities for those interested to do more training in dementia or HIV. We are linked to NVQ in some areas, and trying to develop it. We also buy into Local Authority training, as it's more economic to do that than to set up from scratch. (Norton Employment operations manager)

The nursing care agency, however, bypassed local authority SSDs for the Health Authority, as a better professional fit for their staff: 'We no longer have in-house training, but we link with NHS Trusts and hospitals. Not usually with Social Services' (Carlton Nursing). The situation was not much different for the DSOs, as they also had to contract into Social Services training now:

Quality Standards are built into the price that would ensure basic training for all staff. We use Parkside training, and contract with them to get personal care training, lifting &



handling, Health & Safety etc. It is expensive. Casual staff need training, so they shadow a care worker for a week, then have 2 hour am and 1 hour p.m. on Saturday and Sunday. Staff find it not attractive, and not enough work and leave. Training cost £500 recently, with no return. (South DSO)

The changed position of DSOs in relation to the rest of the Social Services structure is examined further in the next section, dealing with provider experiences of the contracting process with Parkside.

### **The contracting process: Parkside as pioneers**

Providers were generally complimentary in their views on the contracting process with Parkside, given their positive attitude to the independent sector. This was in contrast to some agencies' experiences with other London Boroughs, as illustrated by the operations manager of Gainsborough:

Parkside was there right at the beginning with the independent sector, one of the few. It was great for us. We were inundated with work and there was not a lot of competition then and lots of business. (...) Parkside were pro-active in dealing with the independent sector. Some local authorities say they don't want to deal with the private sector as profiteers. Parkside are trying to be accountable to service users. (Gainsborough operations manager)

This point of view was also reflected by the operations manager of Norton Employment:

Parkside are at the leading edge regarding being an enabling authority. They have a set of values about doing it in a very transparent way without agendas, and without assuming the private sector are good or bad. I quite enjoyed tendering with Parkside. They were very professional and gave us no unnecessary burdens. (Norton Employment operations manager)

Joint independent sector/former 'in house' provider bids were commented on favourably for their creativity by the same manager, as Norton Employment were a beneficiary of this innovation:

Parkside were early into contracting; this was Norton Employment's first experience. It was very interesting tendering. North DSO had the view that to offer a mixed economy model would be considered 'PC' and seen as interesting as far as their winning the contract was concerned, by the commissioners. The subcontracting joint bid was unique to Parkside. Credit goes to [the Contracts Manager], who was very imaginative. He saw it would be attractive to the Local Authority and would give flexibility. (Norton Employment operations manager)

However, initial set-up problems and variation in contracting practices between boroughs did pose difficulties for some agencies:

I think all of the boroughs were going through a transitional stage set-up. I think sadly, this contract was historically badly done by the in-house team. The goal posts are moved some distance. I wouldn't say that is just a reflection of this borough, it's reflected in a number of different boroughs that do similar types of contracts. (Premier Domestic, 1)

The nursing agency in particular was disgruntled that expected benefits had not yet materialised:

There haven't been really any advantages for the bathing service. We are funding a nurse 18 hours a week to co-ordinate the service. There is a lot of administration and review; very labour intensive. It's not viable. It is not business sense to have a bathing contract; has not brought in other business as hoped for originally. (Carlton Nursing)

This was the agency that had been awarded the contract for a service previously provided free by the NHS. The pessimism about the future prospects illustrated the fragmented nature of the market, and prefigured future loss of providers and consolidation. The bureaucracy

of tendering was commented on adversely in particular by Gainsborough's operations manager:

Parkside were pretty thorough in what was requested. I was annoyed by having to supply six copies, not just documentation, but all of our policies and procedures. It cost about £160 to tender, which was not paid back when we were unsuccessful. In terms of questions, Parkside is standard, but they wanted the agency to do the paperwork. It was annoying and unusual to be expected to do all of the photocopying. It was hell trying to remember everything that had been put in when already submitted. (Gainsborough operations manager)

Unsurprisingly, the political nature of the borough was seen as a feature. It had been commented on in terms of the proactive stance in contracting with the independent sector, but here a more general point was made about the political practices of the council. As previously noted by providers, there was a trend to decrease time slots, and services were being reduced on review:

Parkside has got its own political intrusion into contracting. It seems to be very politically driven, very money driven, as opposed to service driven and I also find it's distressing from the person who has to deal with the people on the other end of the phone. You know, Parkside are now cost-cutting and the service driven in terms of cut the cost, make the service more, and that is quite sad to see. I certainly feel there is a lot of political bias within the contract. There's a lot of conflict within the borough. You feel that, you know, 'the members want, the members get' is a phrase which is commonly used, off the record! (Premier Domestic)

From the DSO perspective, aspects of the externalisation of services and need to tender for their service were an unexpected shock:

We had to go with 5 copies to City Hall and get a receipt. I asked for information from Finance, but they wouldn't give it to a potential provider. There was a 'Chinese Wall' all of a sudden. It was a level playing field, but we were made to feel throughout that bidding was a weird experience. (South DSO)

He went on to elaborate about the problems inexperience brought, and the emphasis on remaining competitive in the market:

In the first 6 months, we misunderstood some of the contract, for example the review system for domiciliary services. It was such a cultural change, particularly if we didn't deliver what we had said we would do. We would not get the income, then there would be problems for the budget and heads would roll. It strengthened the mind. We were failing to deliver initially at the reviews, as we didn't realise the format that was needed. I was summoned to meet Head of Contracts and got a dressing down, which had a salutary effect. We were not achieving the income expected at first because the hours weren't there. Now we are back on track and maintained the hours over the rest of the contract, but it's been touch and go in the last 2 months. (South DSO)

The sentiments of the West DSO manager were on a similar track:

The process was very involved and very stressful and pressurised. We all knew it would be difficult, and we were fighting for the right for it to stay in-house. No-one anticipated the amount of work; which went over the top. The tender documents were impressive, filling 2 large ring binders. We couldn't anticipate the detail needed for the specification. We had a consultant to help with costings for the tender, and had to look at the previous 3 years' costs (down to the stationery) to project budgets for purchasing and staffing. The biggest thing was looking at unit costs: 'down time' versus contact time. I had some experience of doing that locally for management organisation. Officially, we shouldn't have known who we were competing against. But pre-submission, people came to visit the properties and introduced themselves. It was secret who else was shortlisted. It was strange to call colleagues 'they': Whole relationships have changed (West DSO)

Nevertheless, this culture shock for the DSOs did help to convince independent sector providers that there was a level playing field in the contracting process:

When we sub-contracted with [the local DSO manager], he said he wasn't party to any special information because he worked for Parkside. He said he was on the same level as the independent agency. He did not have access to information from Contracts and there was no reason to disbelieve him. He is monitored just as closely as agency so is also accountable. This is great as it doesn't happen in other local authorities. (Gainsborough operations manager)

## **Conclusion**

The interviews with the domiciliary care agency managers provide a snapshot of the early days of working out roles and alliances soon after the implementation of the mixed economy culture. The responses from the service providers have illustrated some of difficulties faced in terms of recruitment of suitable staff, grappling with the complexities of the contracting process, and role boundaries and communication with Care Managers over issues such as referral and assessment. Nevertheless, and the potential for business opportunities were still appreciated by the provider managers interviewed. From these interviews, the role of Parkside at the forefront of the development of independent sector provision was evident. The trend indicated by interviewees towards rapid casualisation and turnover of staff, particularly in the independent sector, were congruent with contemporary survey findings by Ford, Quilgars & Rugg (1998). However, there was evidence of creative partnerships formed between DSOs and the for-profit independent sector, and the stimulation of more flexible services. These innovations were appreciated by both the independent sector and former in-house provider managers interviewed. As discussed in Chapter 2, Kendall *et al.* (2003) categorised provider motivations into four groupings. From these interviews with providers, the nursing agency (Carlton Nursing) appeared the most disaffected or 'demoralised isolates', but the majority still demonstrated the drive

and optimism of 'go-getters', despite the teething troubles' of an emerging organisational system.

Nevertheless, a pressing concern with quality control inter-related with recruitment issues that are exacerbated in the City where Parkside is located was highlighted in these interviews. The point of direct contact between domiciliary care staff and older service users was the lynchpin to user satisfaction, as demonstrated in the interviews with older people in Chapter 4. Difficulties in service flexibility, punctuality, reliability, consistency and competence were reflected in the provider interviews, also to the fore in the interviews with older service users. However, there was evident variation in the providers' ability to attain good levels of quality in these areas at a consistent level.

As noted in Chapter 2, the King's Fund inquiry into care services for older people in the city (Netten *et al.*, 2005) highlighted the fragmented nature of the market. This feature was also demonstrated in Parkside, with the proliferation of contracted agencies. In spite of such difficulties faced by the local authority, Parkside was praised in the Social Services Inspectorate report into its care services for older people (SSI, 2000), finding good working relations with external agencies and a number of interesting examples of joint working at local level. In addition, service users generally considered services to be helpful and good quality. Parkside Social Services continued to perform consistently well in the council star ratings brought in by the New Labour Government (1997-2010) and achieved the highest 3 star level in the first year (2005) that the regulatory body of the time (Commission for Social Care Inspection, 2005-2009) brought in an indicator system (CSCI, 2005). However, it is notable that the current provision of home care in Parkside has now reduced to only two

domiciliary care providers, both of which are leading national not-for-profit organisations, and neither of which featured in the fieldwork undertaken at the time of research.

Having examined the perspectives of the provider agencies, the views of care management staff in the three localities will be examined in the next chapter.

## **Chapter 6**

### **Practitioner voices and case recording**

#### **Introduction**

Disparities in practices between locality teams had been identified as an area for managerial concern in Parkside. This chapter presents findings and commentary from separate group interviews with the three locality Older Person's Team staff groups, conducted over a period of one month towards the end of the fieldwork period. In these group interviews, I sought the views of care managers (predominantly qualified social workers, with one Occupational Therapist in South locality) and their Team Managers on the operation of their care management tasks in relation to the provision of domiciliary services.

Firstly, this chapter reviews the rationale for the application of a realist evaluation framework discussed in Chapter 3, and outlines the organisational context. Secondly, as a specific application to the staff responses, the concept of street-level bureaucracy is reviewed in the context of social work practices and the scope of professional discretion in Parkside. The organisational context, the data collection processes and the thematic findings from the three locality staff group interviews are consequently discussed within these frameworks. Finally, the contents of a sample of written and electronic case files are analysed, to provide an insight into a different dimension of practice.



## **Applying the realist framework**

As discussed in Chapter 3, a realist theoretical approach is appropriate for the task of an evaluation of a layered and complex 'open system' (Houston, 2010). It is argued that the provision and receipt of domiciliary care services in Parkside, constitutes such a system, as a configuration of routine but rapidly-changing practice rather than a time-limited and more controlled 'test' intervention. Just one of these layers is examined in this chapter; the impact of staff practices. In this realist view, programme effectiveness can change with small changes in conditions, so that outcomes will not be uniform in different situations. Such a system may be subject to conscious managerial striving to regularise it and make it controllable. However, the attempt may be doomed to failure. This was evident in Parkside, which was subject to national policy drivers (as are all local authorities), and prone to dynamic changes on the local level, including reorganisation following a workload audit by external consultants, and industrial action in response. This was demonstrated in the research focus on the differences between the social work team practices in their different localities, with resultant effects on equity, which were of such concern to the Parkside senior management. However, it is these mechanisms that are of interest in examining how key participants in systems operate (within Parkside in this case) and hence, how the systems may change in the future.

In order to investigate and conceptualise the processes within Parkside, multiple data sources were collected, including here interview data and case records. These are used in this chapter to examine the role of practitioners' individual agency (Archer, 1995), in terms of their active interpretation and implementation of policies, and the interplay with organisational structures. The analysis in this

chapter couples this realist framework to Lipsky's (1980) concept of street-level bureaucracy and investigates this decision-making 'on the ground' within routine, dynamic practice. The application of Lipsky's concept in the context of Parkside is discussed further in the following section.

### **The impact of street-level bureaucracy**

Lipsky's work on street-level bureaucracy (1980) provides a subject-specific theoretical framework, focussing on those public service workers working at the interface between government and citizens, which here is exemplified by the care management staff in Parkside. The concept of street-level bureaucracy provides a linkage with the realist investigation of care management staff practices in Parkside by emphasising the significance of individual and group agency, and placing them in a new context of ideas (Danermark *et al.*, 2002).

By practitioners shaping their professional situations, there is scope for 'decision space'; the margins of freedom at the operational level of practice (Rycroft-Malone *et al.*, 2010; Rycroft-Malone *et al.*, 2011). In Lipsky's formulation, such workers act under competing pressures and with limited information, so simplify the nature of job and adapt it. In effect, they are the ultimate policy makers, as experienced directly by those receiving their services. The bureaucracies themselves are characterised by tensions between scarce resources, ill-defined organisational goals and high expectations of performance that may be unrealistic (Lipsky, 1980). Crucially, they are organisations in which: '(...) performance oriented toward goal achievement tends to be difficult if not impossible to measure' (Lipsky, 1980:28).

This has implications for attempts at evaluation of the efficacy of routine work in social services departments, which is itself an under-researched area. Ash (2011: 1), in her discussion of adult safeguarding in the context of street-level bureaucracy has noted the dearth of studies of: '(...) the day-to-day reality of social workers charged with implementing public policy'.

Professional discretion has to be exercised in order to cope with the job as it actually is; the gulf between social work ideals and practice realities, as Lymbery and Butler (2004) put it. Social Workers are therefore tasked with managing paradox, working with 'contending opposites' (Marsh & Macalpine, 1999:1). However, the use of discretion can be double-edged, as it can be: '(...) the lubricant in the public policy machine. But it is also difficult to control and could easily overheat the engine' (Evans 2010a: 3). The apparently uncontrolled nature of the discretion exercised in different ways by the different locality teams, with resulting inequities in service, had been the major impetus for commissioning the CASE studentship.

### **Data Collection Process**

As outlined in Chapter 3, I spent time with the teams; 'deep hanging out' in Geertz's terms (2000). I spent this time informally discussing processes with individual staff members, examining policy documents and case records (Hammersley & Atkinson, 2007) and visiting them in advance to discuss the research. A number of previous attempts at interviewing individual care managers and other front line staff had been prone to cancellation due to pressure of work on the staff. Competing pressures applied on the care management teams, with the immediate pressures of workloads not surprisingly accorded

higher priority than the demands of a postgraduate researcher of potentially uncertain allegiance from their viewpoint. The difficulties emphasise the centrality of practitioners as gatekeepers not only of access to services but also of access to evaluation of those services (Clark, 2010). The means of introducing the research had been by presentations to and discussions at team meetings, so the most efficient way of collecting the views of as many members of staff as possible was by the use of group interviews, given the time constraints on individual staff members.

Interviews were finally effected by arranging for an interview time for each staff group to be scheduled at the end of their regular, pre-existing staff meeting slot. The advantages were the ability to get as large a number of care managers as possible, given lack of staff time and staff turnover. The disadvantages were that the time available was restricted to 30-45 minutes, depending on the commitments of the team. The composition of the groups was also unpredictable, with, for example, the first team group (West locality) having forgotten that the time slot was arranged, resulting in a number of missing staff. In the other two locality teams (South and North), the senior care manager was also present. North Locality was the pilot locality for the implementation of the new electronic client information system (ECIS), and had the most representation. The preferred method for conducting focus group or other group interviews is to have a moderator who guides the discussion, and a scribe who takes notes of the proceedings (Frankfort-Nachmais & Nachmais, 2014). However, as a single-handed researcher, I did not have the assistance of an independent scribe, but used a tape recorder with multi-directional microphone and wrote contemporaneous notes. My own prompting questions are contained in square brackets where necessary.

Pseudonyms are used for all participants, with random changes of gender to further protect identities. Information on the source of each quotation, with speaker pseudonym and pseudonymous Locality team name, is given at the end of each speaker's contribution. The following Table 6.1 shows the composition of the group interviews. Those managers present were Senior Care Managers, or practitioners with some managerial responsibilities, who were also carrying caseloads.

**Table 6.1 Focus Group Participants**

<b>Locality West</b>	<b>Locality South</b>	<b>Locality North</b>
n=5 40 minutes	n=8 30 minutes.	n=12 45 minutes
Care managers: Phil Rachel Claire Jim Kate	Senior CM: David Care managers: Imogen Anne Helen Ellen Mike Jill (OT)	Senior CM: Sheila Care managers: Debbie Fiona Mary Sue Penny Amy

### **Interview Topic Guide**

The group interview topic guide (Appendix 6) covered the usefulness of existing screening and assessment tools, effectiveness of monitoring service quality, and views on outcome measurement. The themes followed the stages of care management, consistent with the approach taken with the interviews with users and providers. At the end, teams were also asked about areas of their work that they felt were done well, and improvements they would suggest.

## **Findings from staff group interviews**

The initial analysis of findings follows a similar thematic structure of the care management process structure as the user interviews for consistency and comparability, using these as orienting concepts (Layder, 1998) or the initial tools to organise data and develop theory. The structuring device of care management roles and tasks as defined at the inception of care management by the SSI (1991) provided an initial structure, though some of the tasks as originally conceived were not necessarily in the Parkside care managers' repertoire, as the analysis will demonstrate. The cross-cutting issues that were of particular interest within this structuring device are; why different locality teams operate in different ways; what team members thought about key elements of their work; how this impacted on their practice. These responses are analysed further to propose credible mechanisms, and what may enable or constrain a good quality domiciliary care services in Parkside.

## **Eligibility and screening**

The first questions centred on the ways in which practitioners tackled how current or potential service users were initially screened and deemed eligible (or not) for further assessment of services. The responses elicited for this topic illustrated confusion over what was deemed a care management task, and how care managers exercised professional discretion in their decision-making.

Over the previous eighteen months, Parkside had implemented an electronic client information system, (ECIS) which incorporated multiple 'pages' for different domains of information, such as assessed need, to be filled in by care managers. This also incorporated a screening tool for use in determining dependency and eligibility for services. This tool was used a scoring grid, placing potential clients in low, medium or high dependency bands, which would then be linked

to services. This system predated the Fair Access to Care (DH, 2002; DH, 2010) eligibility criteria for services determination. Following a pilot implementation project in North locality, the ECIS system had been extended to all localities in an attempt to produce the desired outcome of service consistency (from manager, older people and professional perspectives). In order to access the electronic records, I had undertaken a 2-day training course alongside care managers in the ECIS system, and found many of the care managers expressing fear and dislike about the use of Information Technology and the pressurised timescale to get to grips not just with the software, but also with basic keyboard skills; an essential competence in a period where written communication was still the norm, but which was not included in formal training. During earlier, informal discussions with locality teams when introducing the research project, the senior care manager of South locality had highlighted the unwieldy nature of ECIS, utilising a military metaphor for his experience of using it, likening it to: '(...) taking a Sherman tank to do your shopping at Sainsbury's'. (David: South)

Questions were incorporated into the staff group interview guide to ask how ECIS was being used one year on. On being asked for views on how ECIS was working, a West Locality Care Manager (Phil) replied bluntly: 'What is it? It's irrelevant to our work. It's just statistics' (Phil: West). Here, the eligibility tool was reduced to '(...) just statistics'. In Phil's view, older people and staff could be reduced to numbers, the social work role was itself demoted, and statistics (and hence the eligibility scale) were a meaningless and cynical managerial tool. This emphasises a disjuncture in aims between senior managers and staff. Although this view received general assent in the group, Claire noted the way that the hurdles to eligibility for services had been raised, and referred to registration as a disabled person under the Chronically Sick & Disabled Persons Act 1970:



(...) an awful lot of the clients coming here have got high needs. So we get so few with low needs it's the upper/moderate for most of the referrals. So there are very few that you screen out apart from at the registration stage, which care managers wouldn't be involved in. (Claire: West)

The process of decision-making at the stage of the first point of access enquiries to the locality teams was carried out usually over the telephone by staff who had held previously held administrative posts, and who were not qualified social workers. They carried out initial 'screening out' of queries before they reached care managers. These administrative staff therefore had pivotal roles as gatekeepers of services. As noted in Chapter 1, this process was not recorded systematically, so there was no database of how many enquiries from Parkside residents had been received, or how they were dealt with. It remains an unanswered question whether or how far those with perceived 'low' needs were being screened out by administrative staff before reaching care managers. Here, 'screening' was being identified as a different process (an administrative task) to that undertaken by care managers. Registration as disabled under the CSDPA 1970 was one of functions carried out by unqualified staff, and not seen as a care management task, as Claire acknowledged.

West locality had a high 'bombardment rate' for referrals. The upward shifting to higher eligibility bands also prefigures current trends to restrict eligibility for services to those with critical and high needs, eliminating low and moderate categories in many local authorities (CSCI, 2008; CQC, 2010; Age UK, 2011; Humphries, 2011). There remains the question of why there were so few 'low need' referrals in West locality. One answer may be the low numbers of self-referrals, as recorded in the electronic records. Instead, service users were being referred by other agencies (predominantly Health) when people were in crisis. Screening or assessment by telephone did raise some concerns for Imogen, a care manager in South locality:

I have to be honest and say that I have used it [ECIS] extremely rarely. Mainly as I've only had a training half day session and I haven't got to grips with it at all. I think it probably is a useful tool if one could do that. But I think one of my concerns is, and maybe this is just the way I work – I find it a bit arbitrary doing it over the telephone on a situation that you don't fully know, even on my own cases, looking at some of the boxes they could have fitted into. People could have come out at different levels. So again if it is a telephone referral I find that quite hard. I think I wouldn't want it used as taken as Gospel. (Imogen: South)

This expressed a lack of knowledge and confidence about the new system. This line of reasoning was taken up immediately by Ellen, followed by Anne:

On the telephone referral people tend to either over-emphasise what they can do. Like, 'I can do plenty', or under-emphasise because they think they might be seen quicker. So it's not really fair. (Ellen: South)

But then it can get used for future care plans, often. That's often taken that that is their level of dependency and we go on from there, whereas we actually haven't seen them. (Anne: South)

So ECIS could be misused and misleading, giving an inflexible 'set' position for care. Anne also elided initial screening and eligibility with a more comprehensive assessment of needs. The dislike of 'remote' tools that lacked face-to-face interaction with services users was clear, however. In North locality, where the ECIS system and eligibility grid were piloted there was more evidence of routine use. The following dialogue illustrates that in this locality too, there were differences of opinion as to whether initial screening was a care management task or not. The Senior Care Manager, Sheila, made a statement on how the grid should be used, in her view, as a tool to guide further action:

I use it for any new case that comes through. That's how I decide what's going to happen. Whether someone is moderate dependency and needs a particular service, or needs a full needs-led assessment. (Sheila: North)

So, it's an initial stage – it's not care management really.  
(Sue: North)

There is an issue here of definitions of care management, which Sheila, having a more strategic view, expressed:

It's actually supposed to be a tool for assessing dependency for the purposes of initial reaction to eligibility. What would be interesting would be to see how different people in different localities assessed the same clients with the same information. Because again it's quite subjective with the information you've got. When I'm on duty I use it. In theory I try to put them all on ECIS. (Sheila: North)

It would indeed have been interesting to pursue comparisons between the localities. However, it was not possible to draw firm conclusions regarding comparability as South and West localities in particular were not using ECIS consistently (detailed further in the chapter). This irony emphasises the difficulties of evaluation in practice environments where policy is implemented patchily or in unintended ways.

### **Assessment Tools**

Following on from discussion about the tools used for screening and eligibility, the staff groups were asked about the usefulness of the assessment tools they were using. In common with many other local authorities, Parkside was in a state of 'constant revolution' in piloting and streamlining new assessment forms. The authority was not alone. The 'Great Leap' to and fro in changing the tools of assessment has been amply documented from the implementation of the NHS&CCA 1990 (Crisp *et al.*, 2007). There was unanimity among the locality staff groups that were consulted about the format of the tools, but less agreement about which sections they thought had improved. In particular, there was an increased emphasis on inter-professional domains. This is an area highlighted by Challis *et al.* (2011) as a continuing area of concern, pointing to the poor level of coordination

between health and social care organisations in the management of people with complex needs. Whatever the reworking attempts to rework forms and tools, this is an example of a recalcitrant problem that has been resistant to change. This topic is referred to later by Imogen (South) in her reference to social workers' use of assessment instruments with medical or nursing or nursing origins. In West locality, Phil noted:

I think we've modified them, what, now for the second time. They are much more accurate in identifying certain needs. I think what is good is what's added to it in the medical & OT assessment. The medical assessment is something I think needs to be highlighted much more. (Phil: West)

However, Rachel felt that the forms did not adequately cover issues such as possible depression, a condition prevalent in community-dwelling older populations (Gellis *et al.*, 2008):

I feel a bit like (...) the current form gives a good reminder about all the different aspects, you know – finances, housing, care. At a superficial level, I think it reminds you about all those aspects. But the new form doesn't have a specific section on mental health, or the cognitive mood stuff. I think that's just general in the health stuff. And I think it's a worry because that can get missed. Sometimes you need a separate section on physical & mental. (Rachel: West)

There had been a number of re-jigging of forms in the local authority. This had variable results, as noted by Imogen in South locality, where she agreed with her colleague Rachel, but provided a different perspective to Phil in West locality. Instead, she felt that much of the health domain information was not sufficiently specific in the new forms:

My main concern is that on the issue of mood, mental health, the older forms looked at that better. The forms by tradition have been reviewed twice or three times. The one before this one was much better as it had questions, prompts relating to Barthel, Mini-Mental State test, getting some insights

into a person's cognitive abilities as well, while the new forms tend to rely on other disciplines. But as it's only a tool, it works well with the experience of the team. Obviously you use your tools to get your information, but I don't think as a team we solely rely on the form, as we have other skills that we utilise as well. (Imogen: South)

Mike in the same locality took up this theme of social work expertise, and emphasised the skills possessed by care managers that went beyond form-filling: 'I don't think that if you were to give Joe Public the form to do care management assessments that that's the only tool that you would need to do the job. I think it's important that point's stressed'. In West locality, Rachel summed up the difficulties of attempting to shoe-horn all eventualities into one all-purpose form:

I think it's very difficult to incorporate what is a great diversity of people, and great complexity of problems into one particular form. I do think that the time constraints that you've got in trying to meet the performance targets of getting it written down means you are sometimes writing things very early which maybe needs to be rewritten later on. And how do you work that out. (Rachel: West)

Here, the assessment tools and imposed timescales were seen as constricting individuality both for care managers and service users. Performance targets were not conducive to exercising professional discretion in these practitioners' views. Helen in South locality also felt that there were difficulties in trying to do an in-depth assessment in just one visit, with lack of time to assess:

For me I find a difference between doing them on a duty case as opposed to doing them on an allocated case where I'll often know the person better before you complete the assessment form. I personally find them a bit difficult to fill out fully on a visit where I've just met the person once for an hour. I think it feels at the moment that the prompts are less. But they are new forms, and I know that when the original ones came out it was like, oh my god, how do work your way through this, and now the new ones have come out you wish they were more like the old ones. So it might just be getting used to them. But there did seem to be more on the Aids to Daily Living and

activities and what people could and couldn't do, and sensory impairment seemed to be clearer. (Helen: South)

In both West and South localities, there was a discussion of recording ongoing change in case records. Time (or lack of it) again was a key factor. Phil in West locality stated:

You do the initial assessment, and then obviously lots of stuff happens after that, that tends to be in all the case notes, which obviously gets missing. You don't tend to, especially on duty cases, you don't get the opportunity to go back and redo an actual another assessment or a summary or updated thing in one place. (...) It's a time thing. You end up spending all your time monitoring & reviewing, you don't get stuff done. (Phil: West)

It was not made clear why '(...) stuff (...) obviously gets missing' in case notes, although there were evident gaps in consistent recording, as will be seen later in the chapter. In this narrative, the shortcomings of over-reliance on dealing with cases on a short-term, revolving duty basis (without a named, allocated worker) were also clear. Staff in North locality were not enamoured of the new form. Debbie in North locality was scathing: 'I think we identify needs in spite of the form, not because of it'. Fiona pinpointed what she thought was one of the problems, a point reinforced by Sheila, the Senior Care Manager:

It misses out a lot of peoples functional ability. (Fiona: North)

The last one has a score of 1-4 for functional abilities, and I thought that was quite useful really. That's gone. (Sheila: North)

However, a four-point scale for designating functional ability was a relatively crude device. Amy noted that a measure of social and support networks was now lacking, a crucial component which assessments are expected to incorporate (Smale *et al.*, 1993). This illustrates the atheoretical nature of the repeated modifications to

assessment instruments, with a constant cycle of omission, reinstatement, and omission again as the tools were refigured and either pruned or expanded: And there was also something about how often they saw people, because also that can be quite useful in making you see how often they did see people and what their social network was' (Amy: North).

Sheila indicated that North locality was tracking issues on the new form for future review:

What we are also doing is keeping a list of issues that come up about the form so that when it's reviewed we can see whether a) those issues are still live, as its difficult getting used to a new form, or b) whether they still really are issues and there's something wrong with the form. (Sheila: North)

Fiona in the same locality raised a fundamental problem with the perceived underlying approach of the assessment process. She highlighted two fundamentally divergent perspectives underlying social work with older people; emphasising dependency rather than strengths:

I think my main complaint about it is that the new one, you tend to look at the difficulties, and you don't get the side of the person's capabilities. Which checklists do – you then have to put down what they can do. As well as why they've been referred and what the difficulties are. (Fiona: North )

It is doubtful, however, whether it is an intrinsic feature of checklists to capture strengths. Rather, the key enabling feature resides in the attitude and training of the practitioner themselves. Mary agreed with the perspective of not concentrating merely on functional disabilities and tasks, expressing her dislike of task-oriented assessment. Unfortunately, this was the dominant practice paradigm, leading to a service-based approach:

It pushes you into doing things that are so much more task-centred, rather than looking at it in a holistic way. Because it says what are the problems as presented, and presumably you just find some issues to those specific problems that you find, and then that's the job done. (Mary: North)

Sheila took up a spokesperson role (as a Senior Care Manager), and summed up what she thought the thinking was behind the form (with the benefit of her involvement in the consultation group), and why it posed some difficulties with lack of specificity:

The old form was very focussed on the elderly service. This form is supposed to go across other services. And that's actually one of the reasons it shifted in the way it did, because it's supposed to encompass the whole of assessment & care management, not elderly services. It's why some of the offices don't like them. (Sheila: North)

Despite this rallying call excusing the forms, practitioner dissatisfaction remained clear.

### **Carers and Assessment:**

From the interviews with older people (Chapter 4), I had found that, where there was a carer, none had had a separate carer's assessment, despite the implementation of the Carers (Recognition & Services) Act 1995, and the inclusion of assessment of carer needs in the original policy guidance for community care, Caring for People (DH, 1989). From the staff group interviews, it became evident that no staff in the three localities were offering separate assessments, and that there was a degree of confusion over what they were meant to do. In West locality, this was justified in terms of pre-existing practice:

It's part of the assessment to identify the carer's needs within that assessment anyway, so no. (Phil: West)

It's always been part of our practice. (Rachel: West)



There were no dissenters from this view in West locality, yet in effect, legislation was not being adhered to. In South locality, there was, inevitably, a discussion about whether the appropriate assessment form existed, though there was more interest in the subject. In the following discussion between team colleagues, lack of tools was raised as a key issue in the assessment of carers, repeating the emphasis in the preceding section, and again conflating the ends of good practice with the means of the recording devices:

We still haven't got a form, David, am I right?  
(Helen: South)

No, you may well be right. (David, Senior Care Manager: South)

I think we haven't even got the form, though I've requested it on several occasions. (Helen: South)

We've done it on an informal basis, but not being really sure what one should be doing. (Anne: South)

We were supposed to be using the same form that we were using for clients, the old format, but it doesn't really cover it. (Helen: South)

It's one of those things where the team has been doing carer's assessments as part of the assessment of the client. It hasn't been recorded in a separate manner. Except perhaps on those assessments where the carer's needs are influencing the care plan significantly, i.e. where the carer is perhaps giving up that role. Or is no longer able to fulfil certain functions. (David: South)

Or there have been conflicting interests. (Anne: South)

Despite more discussion of the issue in South locality, the conclusions were the same as in West locality; separate carer assessments were not being completed, but subsumed under the service user assessment. In North locality, similar issues were raised, but with the Senior Care Manager acknowledging the limitations of defending this

'informal' approach to carer assessment. A lack of knowledge of the law was evident, as well as the familiar recourse to 'lack of tools':

I'm not sure if we are supposed to offer carers an assessment, a formal assessment. I've never done one - I don't even know if we've got a form to do it on. (Sue: North)

There used to be a section on the old form from for carers, but there's only a little bit on the new one. (Penny: North)

I think if you do a carer's assessment, you could almost do with a new book in its own right. I think we are moving towards doing more carer's assessments. It's like everything. At first people said well we do this everywhere, but actually when you do a focussed separate assessment, you realise that all you were doing was saying they do need a bit of relief some of the time from this person. Which is a bit different to looking at what they do and don't need. Whether or not we can provide it is another issue. (Sheila, Senior Care Manager: North)

Here, Sheila sums up what carer assessments should comprise, while pinpointing the lack of resources available to realise them. Nevertheless, the discussions across the localities seemed to be focused on how 'tools' and 'forms' (the latter being the twelfth most frequently-used word in the group interviews) actually seemed to be driving practice. Since these interviews, further legislation has been enacted (Carers and Disabled Children Act 2000; Carers (Equal Opportunities) Act 2004) in attempts to strengthen carer rights. Nevertheless, the practitioners' confusion over how to implement existing legislation and guidance demonstrates how there can be time-lags in the accomplishment of policy objectives.

## **Monitoring**

In the exploratory study interviews undertaken with older service users and available carers in North locality a year before (see Chapter 4), older people had commented adversely on the apparent lack of monitoring of domiciliary care, whether by providers or care managers, and with the concomitant impacts on service quality. This

topic in the group interviews revisited the subject of whether monitoring was carried out, and if so, by whom. In West locality, Jim took a very broad definition of monitoring, but linked it to the unstable nature of the cases he was working with:

I feel that most of the cases are in constant crisis. Monitoring is daily. Formal monitoring is something very rarely used. If it is, it's a case that is taken away from you, because it's safe. (Jim: West)

However, Phil felt that more formally scheduled reviews, with invited participants did have a valuable role to play: 'In those that you do 6 or 3 monthly reviews you can be a bit more proactive when you do visit them, and not just reacting to crises. Sometimes that can be helpful'. Claire, who had returned to the locality after a short period of working in another office, liked the system of reviewing cases, and contrasted it with the previous impetus to close cases speedily:

That's new, because when I was here before, before if everything was stable it got closed. Now they get put on 3 or 6 or 12 monthly review. How much actual difference it makes I don't know, but I think as a formal system to put in place it's good. And it gets the people known, even if sometimes they say 'What are you ringing me for everything's fine.' I think people don't always understand that process, but it's good for them to see that we are following up and checking. (Claire: West)

In South locality, the staff group were asked their views on how well they felt provider agencies monitored their own work. David, the Senior Care Manager, gave a comparatively lengthy explanation of the current situation, to general nods of recognition and assent from the rest of the staff group:

I think there is increasing evidence that our clients get short-changed, and that there is not a sufficiently strong monitoring aspect that the agencies have taken up. That may be for two reasons. One is that they are not particularly interested in the monitoring, they are just interested in the provision of the work, or, as I know has some credence, that we have given

some of the agencies so much work that they are actually buckling under the strain. The monitoring of the service is actually the easiest thing to get rid of so that they can concentrate on the provision. [How do you know?] It's phone calls to duty saying the carer hasn't turned up, and when you ring the agency, they say... 'really?' Or that the carer hasn't turned up for several weeks, and the agency wasn't aware. There are cases where we have recorded that there are concerns of the carer not staying the full whack of time. The agencies haven't monitored that despite protestations that they would. (David, Senior Care Manager: South)

The boundaries of accountability for 'cases' between purchasers and providers are very blurred here. It was seen in Chapter 5 that provider agency managers took a very different view of the effectiveness of the respective roles in the monitoring process. David went on to discuss the quality of the contacts between the care staff and users, which led into a dialogue with Helen about the vulnerability of their users and the suitability and skills of their front-line home care workers:

There's also the issue of quality of time that is spent. We have one client who has dual sensory loss, and the carer that was sent to them was wearing a Walkman. So you wonder how much communication is possible to go on for someone for whom communication is actually more important at that particular point. (Helen: South)

It's also something that we've said for a long time, that we deal often with very vulnerable people who have dementia, and don't have carers or neighbours or whatever, and we know there is no feedback as to whether agencies come in. [General assent] I think going back to start of care management, I might be wrong on this, but when they were talking about having monitoring & review officers within SSDs there was a thought that they would be reviewing out of hours care packages. But in fact what has ended up happening is that they are solely reviewing residential placements, so we have no one on the purchasing side monitoring either. (David, Senior Care Manager: South)

This chimed with an issue raised in a discussion I had with a commissioning manager in my early orientation period in Parkside, where it became clear that whereas my intent was to discuss the

regular monitoring and review of domiciliary care packages, he was exclusively focussed on reviewing residential placements. Care managers in South locality were concerned about the incidents that they did not get to hear of:

When people phone, say through duty, then often admin workers say, you know, 'Here is the number of the provider', and so even some of the calls don't filter through and nothing's done about them. I think heaps of calls go direct to the provider anyway. And then we don't hear anything at all, because obviously they don't want to tell us what problems they're having. (Helen: South)

This provides another example of the 'screening out' of service users was happening at an early gate-keeping process, with no accurate records kept of how often this was happening. Mike thought that, as well as service users bypassing the care managers due to the relationship they had with their home care staff, there was a practical difficulty in getting through to locality staff:

It tends to work on an informal, easy-going basis, until something happens that they can't resolve between themselves, and then we get involved as kind of schoolteacher. Then we try to resolve them. Though we do try to encourage them [users] to make contact with us, because we are the purchaser, and they should be making contact with us. It doesn't always work that way, because of the carer's relationship with the client. They may feel better in contacting the agency direct. I think as well another problem is the bureaucracy involved with our duty system if there isn't a named worker, that they may dial the number six, seven times and it will be engaged. (...) So that's the deficiencies within the system, I think. (Mike: South)

This had been raised in the interview with the Gainsborough agency local branch manager (Chapter 5), who asked if there was a staff shortage, such had been the difficulty in getting through to South locality care managers. The point was immediately taken up by Helen, who emphasised the potential fear of complaining felt by service

users, coupled with the effects of low expectations. This sparked a number of instances given by other care managers:

I think some clients are too frightened to report their carer. (Helen: South)

As well, yes. That's one aspect. (Mike: South)

They don't want to complain." (Helen: South)

There is a very sorry end to this strong issue of vulnerability." (David: South)

I actually had a client say to me yesterday – 'I would like the carer to do the laundry, but I don't want to upset her so don't bother asking because I know she won't want to do it'. That's outrageous really. (Ellen: South)

I think another problem that I've had so many clients say to me that the carers go in and just complain about how busy they are and how many people they have to see, and then they don't just feel guilty about the carer but they feel guilty about other clients. I've asked agencies to ask their carers specifically not to talk about how much work they've got. (Anne: South)

Even without home carers explicitly talking about their excessive workloads, it was still evident to some service users that 'their' carers were stretched. Mrs Bugno (Chapter 4) had seemingly excused the rushed nature of her home care visits, by commenting on how tired 'the poor girl' was. David, the Senior Care Manager, felt that the providers were attempting to fit too many clients into the available time, thereby breaking their contracts:

The issue for us is that we book them for an hour, and they shouldn't be running from one client to another except for the travelling time aspect. So if they are trying to fit 2 or 3 clients into an hour, then we are getting short-changed. (David: South)

Anne felt she had a solution, though it hinged on having copies of care plans (an issue that will be returned to in the subsequent section):

One way of getting around that is to write it in –‘Have a conversation with the client’, and then because the client knows that was part of the visit, then they didn’t feel that as soon as the practical things were done, they could leave, and they could actually refer to their care plans to say this is what you are supposed to be doing as well. (Anne: South)

She went on to say that the whole complaints procedure needed rectifying:

I don’t think the structure is actually there for people to feed back. I think there needs to be a change to the tools and structure. They need to be given standard letters of complaint, so that’s its easier. Unless they are particularly vocal they won’t complain. (Anne: South)

Mike stressed what he saw as the differing professional and ethical differences between market-led providers and the care managers, demonstrating some lack of trust in the motives of the agencies:

I think one of the difficulties with the agencies is that for us all we see is the shop front, and that’s all they want us to see. And so it’s very difficult to work to some common goal with them. I’ve often said this, that I don’t know what goals or what work practices they’re working towards, other than what they are contracted to do. So, it isn’t like a nursing profession where they have their own work ethics and do on, agencies are, for me, employment agencies. And I think perhaps a bit more work from the council needs to be done to improve the quality of contracts they are setting up. And unless emphasis is put on solely the money there has to be good quality as well. (Mike: South)

However, Helen raised the point of the relatively low costs of the competitive tendering system in operation:

I think some of the agencies might disagree with you there. We don’t pay a lot of money. We go for the cheaper contracts, presumably, and that’s what we get. Within their own agencies I think they would have their own standards. (Helen: South)

Jill, who was an Occupational Therapist care manager, felt that joint training was needed:

The issue of training is absolutely huge. From the South Project side<sup>4</sup>, one of the bees in our bonnet is that of lifting & handling. We've come across so many carers who aren't trained in lifting & handling, who are using equipment like hoists, that aren't trained and it's very dangerous. There is one carer I spoke to who had been employed for two years and been using all sorts of lifting & handling equipment, and had no qualifications. That was a very clear example of where they have stated that they will train their staff. I'd be interested to know if there is a timescale, because they are not keeping to it. (Jill: South)

In North locality, the issues of vulnerability and variable quality were also apparent, in the context of problems of monitoring services:

Providers are monitoring, but we can't monitor them. (Debbie: North)

If you have an alert carer or the client is mentally alert, then they will ring in, but what they tolerate is sometimes an unreliable service. They usually don't like to bother you, so they ring up after they haven't had a carer for 4 days or something. I'd love to have them clock in and clock out. (Mary: North)

Sheila emphasised the need for good quality services, provided routinely:

Users would rather have someone there for the full hour than someone ringing up monitoring and saying 'How are you'. They actually want the care that was agreed to. There is a problem about power, and how powerless the users feel to complain. To criticise your carer is quite a difficult thing to do. (Sheila: North)

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<sup>4</sup> A joint health and social care team based in the locality.



She went on to outline consultations they had had with their local preferred provider about reliability of care staff, that developed into a dialogue with Mary:

We've asked [the care provider] to work on informing users that they are going to have a change in carer. It's one thing if you know the carer, and they are going to be a bit late. You know they are busy, but they know they are going to come. But it's this awful feeling of 'who is coming, what time will they come?' (...) We are waiting for people to inform us a lot of the time. We do set telephone reviews. But with the best will in the world, you can't go and visit three or four hundred people. We are having to rely on providers to do that, and users to call in to us when there is an issue. (Sheila: North)

We are certainly concerned about the more vulnerable people, because it's actually impossible to know what's going on. That's a bit scary really. When we do hear some of the horror stories, we know that could be happening ten times over. We don't even know – you almost think you could do with a television camera in there. A bit like they've started doing with some childcare, so we could have a monitor back in the office tuning in. (Mary: North) [General laughter]

But we are using communication books a lot more, in clients' homes. You know there is an issue of money as well. Steve<sup>5</sup> has a client who has accused his carer of stealing money. In fact, it's been resolved now, but where there is an issue of money, we need to set up a really good system of protecting both the user and the care worker. Signing in and signing out for money, and receipts and all that. (Sheila: North)

Gavilan (1992) was an early chronicler of the capacity for 'institutionalisation at home' of older people receiving domiciliary care services. A significant feature of care provided in the home is the isolated and private (sometimes to the point of isolated) nature of the interactions, compared to the semi-public setting of residential care. In that private space resides the potential for an under-regulated, under-observed, under-skilled, underpaid and overworked home care

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<sup>5</sup> A North locality Care Manager not present in the group interview.

workforce to inflict harm as well as impart benefit, as the examples cited from the practitioners' experiences graphically illustrate. Mary was only half-joking in her suggestion of closed-circuit television monitoring. Without robust monitoring systems in place, the onus remained on service users to report adverse interactions with home care workers.

### **Care planning**

Care plans as a means of clarifying expectations of tasks for care staff and users was raised in the previous section. However, from the interviews with older people (Chapter 4), it was clear that copies of care plans were not being given to service users. From the examination of case records, the use of care plans was also inconsistent. Confusion over what constituted a care plan was apparent in the interviews with the staff groups. In South locality, there was a general debate over whether the weekly service chart was the care plan. In fact, in the Parkside policy, the care plan was intended to be a separate document stating the summary of the assessment, aims and services, that is meant to be signed by the care manager and user, and a copy retained by the user. In West locality, three of the staff appeared clearer about what the care plan was, but admitted that users were not routinely given copies of their care plans:

We are trying to get that done, but it's a bit inconsistent."  
(Kate: West)

It's on request. Quite often people turn round and say they don't want to see it. (Phil: West)

They might not always exist. I'm talking personally here.  
(Claire: West)

Phil drew a distinction between allocated and duty cases in drawing up care plans:

I think the care plans are used more on duty. For picking up things you don't know well, the care plans are very useful. Generally if you haven't done it on your own active cases, it's because you know in your head what's going on. (Phil: West)

However, this view centred on staff perspectives, and did not take into account the 'need to know' of either the user or other relevant parties. Having information 'in your head' would not be seen as sufficient if an adverse event occurred. Phil went on to describe how he adapts existing document formats, taking a very functional view of care planning, conflating it with the weekly service plan or timetable of tasks to be completed:

I think the care plan is just the structure, the timetable for the week. I just use the statement of needs for my care plan, to be honest. You attach with that how you are going to meet those needs, which would be the care plan. I don't necessarily follow the actual form. (Phil: West)

This argument was taken up by Rachel, who indicated the lack of useful meaning the care plan had for her:

You use the same phrase on every single plan. The only useful part of the care plan is the grid. (Rachel: West) [General murmurs of agreement]

You are just duplicating what you've done in your assessment. (Phil: West)

Other colleagues in the team echoed this feeling of unnecessary duplication. However, these views did not acknowledge the intended owner of the care plan; the service user:

If you've done a good assessment, then it's the assessment and the timetable is all you need. You don't need to rewrite all the other wordy stuff. (Claire: West)

The statement of need could be attached, so that you've got the statement of needs and then you've got the care plan, saying how you are going to meet the needs - like you were saying - to be defined how they are going to be met, then have the care chart. Because it is repetitive. You fill out the statement of need, then you repeat it again, because on the care plan it's got 'statement of needs'. But you should just have how the needs are going to be met; by whom, the tasks. We are looking at ways to streamline it. (Rachel: West)

Here Rachel reiterated a common view, conflating service plans with care plans, and needs with tasks. In North locality, there was a debate about the purpose of care plans, as well as whether they were given to users as a matter of routine. Sheila adopted the role of a mildly chiding manager in the following dialogue with Sue:

Sometimes they are done and sometimes not done, I'd say." (Sheila: North)

Well, I wouldn't give a written care plan to someone who couldn't see. If it's not going to make any sense to the person, I wouldn't give it to them, because it seems a waste of time. I may give it to a carer if it's relevant. I wouldn't give it routinely unless I thought it had some meaning. Maybe I should be, probably should be. (Sue: North)

There are other professionals that need to know." (Sheila: North)

Well yes, obviously. I'd probably send it to the GP or other people involved, but I wouldn't necessarily... I would think about who it had meaning for. (Sue: North)

You are supposed to." (Sheila: North)

I know. Sorry Sheila. (Sue: North) [General laughter].

Following this exchange, Sheila brought out an internal statistical report by the Parkside Policy & Research Unit, based on the regular monitoring of performance indicators. It showed that only 48% of care plans were going out to service users. This was not surprising, given the functional view of care plans, and the confusion with as service

timetable of tasks held by care managers across the localities. Care managers were selecting those aspects of procedure that made sense to them, and eliding those that did not. If they found procedures repetitive, they tended not to use them.

### **Outcomes:**

Staff in each of the localities were asked for their views on outcome measurement in their work, as the Department of Health was consulting during the period of fieldwork on how outcomes could be introduced into routine care management with adult client groups. It was notable that care managers took outcomes to be a reflection on their work, a managerial monitoring tool rather than a reflection of what service users wanted. Staff were asked how they knew if what they were doing with service users was working. In West locality, the first answer was succinct, and greeted by general laughter and nods of agreement: 'If you can close it and it stays closed' (Phil: West). This was clearly intended as a light-hearted comment, and taken as such by the team. Nevertheless, it indicated the pressures on the team members to quickly assess, close the case and move on to the next one; a type of rapid throughput deemed 'conveyor-belt social work' in child care settings by a social worker and Trade Union witness to the Climbié Inquiry (Laming, 2003). This was elaborated on in the ensuing discussion, with more serious viewpoints, including from Phil, expanding on his initial comment:

But it's risks, isn't it. You are looking to see whether you can make the risks safe, and make clients satisfied. Those are the sorts of thing you're working through aren't they? (Kate: West)

Yes, but really the only way we get to measure that once that's all been done I feel it's successful if you've done all you can do, and they are happy with it, and that means you can close it. And then it stays closed, providing everything's OK. (Phil: West)

A key point was the estimation of risk, so that '(...) everything's OK'. The prevailing ethos was about getting cases through the system and meeting the targets (operationalised into statistics) rather than doing the work that needed to be done. Claire had worked in another setting, and had more experience of structured outcome measures:

I've used outcome measures in another authority, but only with part of the care plan. And that was very effective in actually measuring the value of the service we were purchasing. Because it gave us a tool that enabled us to measure it. [What was being measured?] It was much like the dementia support workers here. People doing that sort of work. And for each particular client, we decided we outlined their problems, and we decided what we were targeting, and then we measured whether it was successful, whether we achieved our target. And it was quite a valuable structure. [Could it transfer to work here?] I think people do it, I think it's actually incorporated into the way people think. It's just not formalised. I do think it's the way we work. (Claire: West)

Kate echoed this:

I do think that the way people work...they just don't necessarily use the language of outcomes. We are very focussed on what we want to achieve for this client, and that highlights areas we want to focus on. So it is the preferred style, I think. (Kate: West)

Here, Kate expressed the power inherent in the care manager relationship with service users, where the objectives are those identified by the professional assessor. Rachel also thought they did keep some track of linking outcomes to needs, albeit in a task-oriented manner:

We do summarise. Especially when we are closing we do write and say what the initial problems or concerns were, how these were met, if these were met. That gives you an indicator of the initial referral & needs. (Rachel: West)

However, she went on to say how the care managers could feel restricted in what they could provide to meet needs:

It's difficult to interpret quality of services and things for clients. Basically if someone needs home care, then our only option is to provide them with a standard dom care service. Which can do an often very good, but quite set limited number of things. Now for some people, providing that service makes a huge difference, and that suits them, and they get a really good carer that they click with, and all of that. So for them that comes through as successful. Maybe exactly the same services for someone else because of lots of individual things isn't nearly so good but we don't have any option. We can only provide that same service. I guess we would record that we'd provided that service, so we in that way we'd met that need, and it was successful. But we don't have any option for making that particular service any more successful for the person it doesn't suit. (Rachel: West)

This experience of what could be provided by the 'set list' system of providers is more akin to a service-led provision, where service users have to 'fit in' with the available choices. Jim concurred, stressing the importance of personalities of home care staff:

I have several cases that hinge on working on the personality of the particular carer they've got. If that carer is ill or goes on leave, the case collapses. Somehow [the preferred provider for West locality] have never been able to get to grips with that particular issue, finding alternative carers who can work with this particular client. It almost becomes a fact of life that you know there will be periodic crises. (Jim: West)

This concurred with the importance placed on good interpersonal relationships with their home care worker by the older people interviewed (Chapter 4). These care manager views tended to focus on issues of the process of the delivery of services as being the most important factor for users. In South locality, stability and satisfaction were key components of successful care packages:

By putting the care plan together, you are aiming to give them some kind of consistent lifestyle, and not continually reach

crisis point, say wandering out at night, or whatever. So if you are achieving that, then the care plan has been successful. If you're not, it needs to incorporate other things. (Jill: South)

Mike felt that the initial assessment of need was crucial, and that it was user feedback that told care managers whether the package worked or not. However, this prompted discussion over the difference between 'wants' and 'needs':

The person most qualified to let you know whether it's working or not is firstly the client or the carers, because those are the needs we are assessing, that have been identified needs that we are trying to be met. Their need overrides ours. We should only give ourselves a pat on the back if they are happy. (Mike: South)

Need and want are not the same thing, are they. So though we may be maintaining the quality of life at a certain level, the level they need, they may not be happy, because it's not the level they want. I can think of a case I've got. If we are giving them a life based on need, it may not be a level they want. So they may not be happy, but we are still maintaining them in the community in their home with their level of need. (Anne: South)

Indeed, wants and needs are not the same: The NHSCCA 1990 s47 stipulated that it is the responsibility of the local authority to determine needs, which are further filtered through the eligibility criteria system. However, this distinction may be far from apparent to service users, as seen in the user accounts (Chapter 4), where views on the quality of some services were equivocal, to say the least. Finally, this debate finished on the subject of the impact of budgetary restriction on service provision:

We also work within budgets, and we may be trying to set up care packages that we know don't meet our assessed needs, because of the financial constraints. That's very hard as well. It's not cheap, effective community care. (Ellen: South)



In North locality, the Senior Care Manager gave her view on what constituted success:

I suppose basically your aim is to keep someone at home and they stay at home. And they are well when you look at them again – they haven't deteriorated, they've improved, - you have to assume something's working. (Sheila: North)

Care managers in this staff group also raised the issue of what could be expected of older service users in general:

You can see if someone's deteriorating. But that may be nothing to do with the care. That's just the client group we are working with. (Debbie: North)

Consulting the original aims of the care plan was discussed, although its usefulness as a tool was questioned:

But on the actual care plan it says aims of care plan, and I don't know about anyone else, but my aim is always very, very general. It might be something like 'help to remain at home in reasonable safety and comfort' [General assent] and it's very general. If you look at how minute the detail is that residential care plans go into, like to get someone's toenails cut in the next 6 months, that's interesting, but I don't think we've got the space and the time for that out in the community. (Sue: North)

This appeared to be lip-service to care planning; fulfilling a requirement by filling the form. The Senior Care Manager was explicit about her dislike of the concept of outcome measurement in their work. However, her response indicates a restricted, bureaucratic interpretation, based on a conception of measurement for the benefit of the organisation, rather than for users:

I have a problem with the word outcomes. I'd hate for us to go down the line of having to be measuring outcomes for our clients, because I think people here feel here that there are enough bureaucratic forms for them to fill in for everything now, that to start to look at specific outcomes, unless it's something that can really be incorporated into the work rather than

something that is seen as an add-on and doesn't actually doesn't help the client. If it concentrates our minds, fine, but if it's seen as another statistic, then no. (Sheila: North)

Again, the mantra was repeated of 'another statistic', as an icon of suspicion and uselessness. She continued with issues of limitations of budgets and role:

I think also you've got to be realistic. I remember discussing this with the placements section, about shouldn't we be asking more from nursing homes rather than just that people are all right. Shouldn't we be asking that they improve? I actually think if you think about how much we're cutting back, and how much money there is to go around, we've got to be realistic. We can only keep people going in a fairly comfortable way, but we can't actually rehabilitate them at the same time. We haven't got the time or the money, and it's not our profession. So outcome measures are a bit difficult. (Sheila: North)

Sheila did not see rehabilitation as part of a social work role; she designated this as a medical-allied task, appropriate for a nursing home, yet did acknowledge the scope for working towards improvements in older people's conditions, rather than the limited ambition of 'keeping people going'. She also highlighted the lack of time and resources that limit what staff can achieve. 'Keeping people going' in a 'fairly comfortable' way may be a constraint on ambition and creativity; a self-imposed block to anything more than routine maintenance work. Nevertheless, Sue felt that outcomes could be measured for informal carers. However, she did not extend this to older people as service users:

That's something we can do with carers. We can measure outcomes for carers and our support of them. Our client group, ultimately the outcome is that they will die. (Sue: North)

Yes. A happy death is a good outcome. (Debbie: North)

That isn't for us to be fixing up. (Mary: North) [General laughter]

In the midst of the humour, this indicates a bleak view of working with older people, echoed in earlier exchanges. It does not indicate a nuanced view or consideration in depth of shorter-term (whilst still breathing) maintenance or change outcomes, or the process outcomes that all contribute to quality of life and wellbeing (Nocon, 1996; Nicholas, Qureshi & Bamford 2003; Patmore, 2002; Patmore & McNulty, 2007; Glendinning *et al.*, 2007; Glendinning, 2008; Andrews, Driffield & Poole, 2009) It is precisely these 'process' outcomes (which reflect the service user experience of the services) that are the subject of discussion of satisfaction or frustration in interviews with older people. Sheila changed the subject emphatically:

We don't want any more money to be spent on groups studying things. We'd rather they gave us the money to provide the care. [Others: 'Exactly'] We are getting really cheesed off with the groups meeting and talking when our money keeps disappearing and we are having to cut people's care packages and what have you. It is a current irritation here at the moment. We had a long argument about whether or not to give someone who was dying a telephone or not because they happened to be in sheltered accommodation, and he didn't deserve- that's the wrong word - he didn't qualify because he was in sheltered. But we were actually cutting him off from everyone he knew if we didn't provide it. And that was 60-odd pounds, really, wasn't it. (Sheila: North) [Others: 'Yeah']

The 'groups' referred to here include the external consultants that had been commissioned to review workloads, whose report was contributing to the impending reorganisation of locality teams. It was difficult not to feel rather uncomfortable with this reminder of my own position, however. Concern about lack of money, or it being wastefully expended on things that did not matter, was clear. Although swiftly self-corrected, the elision between 'deserving' and 'eligible' is telling. Nevertheless, the impetus to invest a relatively small sum of money in order to provide a much greater level of social connectedness is clear. Fiona and Sheila had the last word:

Outcomes are fairly clear. What users really want is a reliable, consistent care. Well, let's find a system providing that, and then worry about all the other bits. I mean that is known. That has been known for a long time about what users want. The same carer or maybe two carers, who arrive on time, do what they are supposed to do, and don't go early. (Sheila: North)

And do get a decent wage. (Fiona: North)

Sheila pinpointed 'what users want'; the deceptively simple attributes of both low and high intensity services that are valued by service users, but which seem so resistant to delivery. However, Fiona placed this in its market context and concerns that home care workers were a poorly-paid group.

### **Areas that worked well**

Finally, the staff groups were asked about where they felt they were working well. The intention was to end the focus group discussions on a positive note and on perceptions of effectiveness. However, this appeared to cause some consternation in West locality: [Long pause] 'Silence'. (Claire: West) [General laughter]. The team could be construed as under-selling itself. It was a similar picture in South locality. Here, the Senior Care Manager took charge when others were reluctant to speak, and proposed:

[Long pause] Shall I say something? I think that we face a number of problems in getting out to our clients, and providing them with an assessment & service. I would say that any client that is allocated to a worker gets an excellent service. And that's not because I'll get stabbed in the back if I say anything else, in front of this team [General laughter] and I think as far as the limitations go, they get an excellent service from duty as well. But I have to recognise there are limitations around that, in the sense of how easy it is to respond. The level of assessment is skilled, highly skilled, and pertinent. I think that the

coordination of services is very good as well. [General laughter] Jaws hitting the deck there! (David: South) [Others –Play that one back, please!].

It seemed very difficult for the teams to point to their achievements. This may be false modesty, or acute awareness of the restrictions under which they work, so that what they would like to achieve and what they are able to accomplish seem a long way apart. Echoing a contribution by Sheila in North locality, Helen in South expressed her dissatisfaction with lack of time and resources to enable staff to feel that they were doing a good job. This theme was taken up by other care managers:

The frustration always seem to be a lack of time, wanting to do more, specifically on duty. We are very aware you are trying to plug and patch the gaps, and if there was more time, more staff – the usual bleats. You know, you could offer a better quality service. We do a lot over the telephone, I think which isn't always helpful. (Helen: South)

To be fair, we are spread very thin, Michele. It's robbing Peter to pay Paul. (Anne: South)

The Peter and Paul analogy was reiterated by the Senior Care Manager:

It depends on which way you look at it. If you look at it from the team's viewpoint, yes we're down in numbers. If you look at it from the greater team, i.e. the South locality, duty is not quite so pressurised, it is able to respond slightly more flexibly, and absorbs slightly more pressure. So I think as we've said, we are constantly robbing Peter to pay Paul. It depends on who's wearing the Peter or Paul badge, is who gets robbed. That's part of the problem. I've got one other comment. If we look at the stability of the staff group, certainly in the South locality, I don't think it reflects the pressure that we are under. The staff group has remained exceedingly stable. The turnover is quite small. Very low. I think we've got good workers. And there may also be another aspect to that, which is Parkside still has money to throw at care packages. Where else is there in [the City] to go to? (David: South)

Parkside indeed did have 'money to throw at care packages' at the time of fieldwork, as exemplified by the 24-hour care package provided for Mrs Herman. Services were still subject to resource limitations, nevertheless, and benefitted from stability in staffing. Staff in North locality were also reticent in saying what they felt they did well: 'We are not used to blowing our own trumpet'. (Debbie: North). Sheila, acting as spokeswoman again in her role both as a middle manager, but also a practitioner with a caseload, encapsulated the mood of the team:

The main issue for us is getting reliable, consistent carers for our users. If we could crack that one, everything else would follow. (Sheila: North)

Reliability and consistency are the service criteria that research consistently itemises as valued highly by service users (Clark, Dyer & Horwood, 1998; Raynes *et al.*, 2001; Clark & Raynes, 2006; Raynes, Clark & Beecham, 2006; Clough *et al.*, 2008); a fact not lost on Sheila as Senior Care Manager. This closing comment presents a bridge between staff views and those expressed by both users and service providers in previous chapters. All were in agreement on the centrality of service users experiencing good quality services, though were unwilling to couch this in the language of user-focussed outcomes (Patmore & McNulty, 2005; Glendinning *et al.*, 2006; Glendinning *et al.*, 2008; Andrews, Driffield & Poole, 2009). Thus outcomes were not perceived as acting in the interests of service users, but as a means of managerial monitoring; a resistance to performance measurement also noted by Lipsky (1980). The next section turns to the examination of case recording by staff in the localities, another domain where staff exercised discretion, thus continuing the theme of discontinuities between policy and practice.

### **Case file analysis: The missing user voice**

Case recording can be seen as the poor relation of frontline social

work; an afterthought after the 'real' work of personal interaction with services users has taken place. Taylor (2008) suggested that written documents in social work such as case files and care plans are afforded little detailed or theoretical scrutiny by either practitioners or researchers. O'Rourke (2010) concurred in her empirical study of adult care case records; they are both taken for granted and neglected, whilst being viewed negatively as a bureaucratic exercise. This section presents an analysis of a sample of case recording, focussing on written and electronic case records from the three major locality offices. The authority used a mixture of manual recording and an electronic database, ECIS, which pre-dated the Single Assessment Process, proposed in the National Service Framework for Older People (NSF) (DH, 2001b).

### **Sampling the case files**

As discussed in Chapter 3 on the methodological approach to the research, 30 paper case files from each of the 3 social work localities were systematically randomly sampled (n=90), taken from referrals that had resulted in an assessment within the previous 6 weeks. 'Assessment' was defined in a broad sense, to include telephone assessments as well as home visits, hospital assessments etc. by a range of practitioners. These assessments were chosen as the most likely to produce information on user and carer progress through the care management process, although they would not necessarily include 'lower-level' contacts that did not result in further investigation, as these were not recorded systematically. This informal and unscrutinised (by managers) level of screening-out constitutes a major omission in the data record maintained by the organisation.

Other researchers (Hayes & Devaney, 2004; Hayes, 2005) have commented on barriers to accessing case files in light of data protection legislation and research governance (both of which post-date the Parkside study), with a plea for greater cooperation with

researchers. However, for the purposes of this research, as noted in Chapter 3, access to written and computerised records was freely granted; a privileged position for a researcher. The choice of these records was within my control more than the selection of interviewees, as the case files did not have gatekeepers excluding me from contact. However, the procedure for collecting the data was not free from practical difficulties, as fieldwork diaries chart hours spent in the locality offices searching for sampled records that were not to be found in the expected filing systems. The categories of written case file content analysis focus primarily on the availability and quality of key information, which track the progress of the service user through the care management process, but, unlike the SSI (1999) checklist on good practice in recording, also include outcomes. A recording sheet was devised to provide a structure of key variables that was checked against each case file. These components were chosen as essential information that could be reasonably expected to be included in social services case files, in the absence of local or national guidelines on good practice at the time of data collection. The key variables are set out in the following table, and how far the information represented was present or not in the files will be evaluated at the end of the chapter.



**Table 6.2 Case File Key Variables**

BASIC IDENTIFIERS	Site				
USER DETAILS	Gender	Date of birth	Ethnicity	Religion	
CASE STATUS	Allocated	duty	closed	Other	
ECIS ELIGIBILITY CRITERIA GRID SCORE	High	Medium	Low	Total Score	
REFERRAL INFORMATION	Who by	When	Why	Events leading to referral	Method of referral
ASSESSMENT INFORMATION	Assessor	When	Where	Who with	What assessment tool
OTHER STANDARDISED SCORES	Description of Functioning	Activities of Daily Living (ADL)	Barthel (Nursing needs)	Any other tests (e.g. Mini Mental State)	
CARE PLANNING	Presence of care plan	Identified aims	Copy to user	Signed by user	Record of participants
SERVICES PROVIDED	What service	Agency	Frequency	Hours	
OUTCOMES	Recorded outcomes of intervention				
CARER ASSESSMENT	Assessment details	Carer involved			
REVIEW	Planned				
SUMMARY	Presence of summary				

As to be expected in written case files, both ordinal and categorical data were collected. Demographic details such as age, standardised

eligibility and functioning tests are presented as ordinal data. Details of referrals, assessments, care planning and service provision are qualitative and descriptive. The data collected were entered into SPSS, for comparative analysis. As will be seen, the opportunities to perform inferential statistical analysis were limited by the amount of data that was missing from the files.

### **Basic demographic information**

For all three localities, gender was identified consistently. This is the minimum information that could be expected. However, it is the only variable consistently included in the case records. Other demographic information was less easy to access, or not present. For example, in the selected records from both West and South, one date of birth was not recorded. North had 5 files with no information on client age, and 3 recording age alone, rather than precise date of birth. This made tracking client ages over time more difficult, and introduced ambiguity over identity where names were similar. No systematic information on ethnicity or religion was written into the case records. In the ECIS computerised database, ethnicity was not a required category, despite being a standard (number 28) in the early SSI benchmarking (SSI, 1999). The reasons for this non-recording were unclear. It may have reflected some difficulties in the sensitivity of collecting such information, although self-definition would be an option. Some information could be gleaned obliquely from other notes in the case files (such as references to services provided by a local voluntary organisation specialising in care according to religious and cultural heritage). In other comments, the ethnicities of three older people were specified in West files (as African-Caribbean, Austrian and 'Asian'). In the latter file, it was noted that the wife spoke Urdu only; her husband translated for his wife. This translation included her apparent wish to continue to care for her husband. Awareness of a

potential conflict of interest was not indicated in the record. This lack of systematic information may also have had implications for the provision of culturally-appropriate services, as it was unclear whether such needs were being met at the time or in relation to planning for future commissioning of specialist services. No files were structured to prompt for such information, or for other important circumstances such as household composition or wider networks of support.

**Standardised measures of need and eligibility criteria:**

**Presence of the ECIS scoring grid**

North locality had been the pilot office for implementation of the ECIS scoring grid to determine eligibility for services and provide consistency between localities (see Chapter 2). At the time of data collection, all localities were expected to have implemented the system. The following Table 6.3 illustrates the percentage of case files that contained complete or partially-completed grids, or absence of any grid.

**Table 6.3 Presence of ECIS Grid**

<b>Locality</b>	<b>Grid Complete</b>	<b>Grid Incomplete</b>	<b>Grid Missing</b>
North	43% n=14	10% n=3	47% n=13
West	27% n=19	10% n=3	63% n=19
South	7% n=2	0% n=0	93% n=28

These case files provided the least information in the ECIS format. Of the two grids completed in South locality, one gave a score of 22 (moderate), and the other a score of 29 (high). In addition, there were one further case noted as high, and one as moderate, but neither had supporting ECIS information. As North had been the ECIS pilot locality, the high proportion of missing information can be seen as surprising, with nearly half of files not containing any required grid. None of the localities appeared to be consistently using the tool that had been sanctioned by managers at Assistant Director level. These omissions made it difficult to evaluate the levels of need at initial contacts, and thereby to track progress. None of the records held any information of re-scoring at review or at the end of contact. The grids were used as crude eligibility screens, but inconsistently and without clear correlation to outcomes.

**Measures of need and ECIS scores**

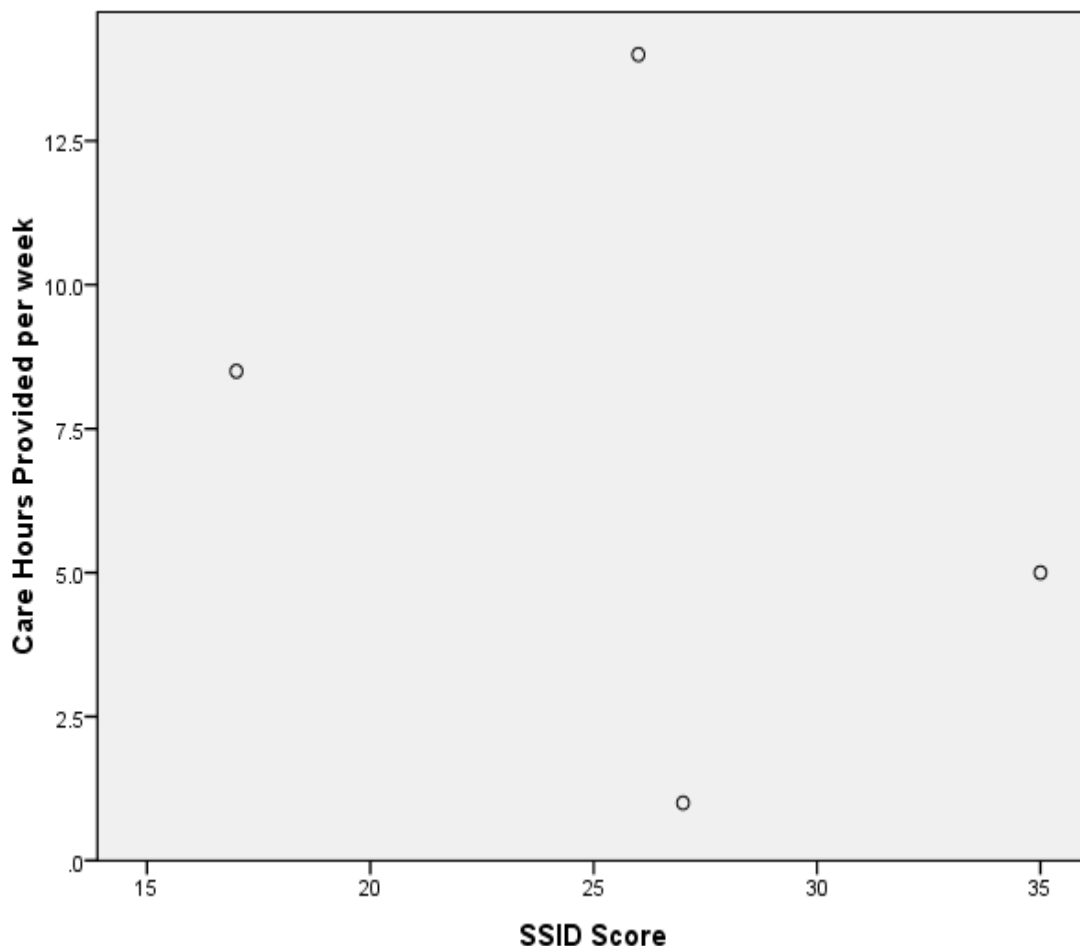
The ECIS grid acted as a tripartite measure of perceived dependency, based on a deficit model of what people could not do rather than on people’s strengths. The scoring system banded service users into three categories of needs: 4-11=low; 12-25=moderate; 26-40=high. In West locality, information was missing in both domains of raw ECIS score and eligibility banding in 19 of the 30 case files samples. The distribution of dependency scores in West locality is illustrated in the table below:

**Table 6.4 Distribution of ECIS Dependency Scores**

<b>Locality</b>	<b>High</b>	<b>Moderate</b>	<b>Low</b>	<b>Missing</b>
West	6	2	1	21
South	2	2	0	26
North	2	11	1	13

In SPSS, scatter plots were used to attempt to chart any association between the variables of dependency score and care hours recorded in the case records, based on a prediction of increased care hours where dependency levels rise. However, the data points were restricted due to the lack of recording of both variables for each case, rendering further claims to analysis invalid. In West locality, only six case files recorded both variables. As expected, one case recorded as low dependency received a low number of care hours per week (one). However, one case scored 18 (moderate) received 24 hours care per week, a greater input than other cases scored higher on the ECIS grid. North locality had four case files recording both ECIS score and care hours. It is worthwhile including this scatter plot to illustrate the lack of evident association between score and hours provided.

**Chart 6.1 North Locality Recorded ECIS Scores Against Recorded Care Hours Provided**



In the South case files, only two cases contained information on both the dependency score and the hours of care provided; clearly no conclusions regarding associations can be drawn from that data. From this information, it can be seen that there is no clear association between the two chosen variables; case numbers are too low, and the range of variability is high.

The use of the ECIS eligibility grid, with its relatively crude tripartite banding, illustrates an attempt to mirror apparently 'objective' standardised measures of older people's functioning used within

medical or nursing contexts, such as the Barthel Index (Mahoney & Barthel, 1965). Although the range of ECIS scores in the 3 localities tallied with the local guidance given on matching raw scores with the three bands of low, moderate and high dependency, there was insufficient contextual information contained in the written records to explain on what evidence the scoring judgements were made by individual assessors. Despite jealously-guarded distinctions being made in social work practice between 'medical' and 'social' models of care (Oliver, 1990; Swain *et al.*, 1993), these grids can be seen to emphasise dependency at the expense of strengths, and display a reductionist approach to individual needs.

### **Referral Details**

All of West locality case files contained some written details of the reason for the referral to the team. However, only eight noted the need for further assessment, whether for a needs-led assessment by a care manager or specifically for home care services (which is more akin to a service-led model). Four files simply stated what service was needed (without further assessment). The rest briefly stated circumstances, such as; 'Wife unable to go on'; 'Not been out since November', but devoid of further analysis. In South locality, referral details of any kind were missing in three case files. Again, direct requests for further assessment were scant ('full OT assessment/Day care'; 'For allocation'). In North locality, all files contained information about referral reason, or events leading to referral. Two contained request for assessments; others were statement of areas of need or a presumption of what services were required ('requires cleaning, laundry, not personal care or cooking, shopping') In all of the localities, Activities of Daily Living (ADLs) were mentioned in files, but not necessarily specified or quantified.

## Sources of referral

This information demonstrated the relative lack of self-referral by older people themselves, which was also highlighted in the interviews with older people. The volume of traffic from the two major teaching hospitals within the West and South catchment areas indicated the potential high levels of crisis at referral.

**Table 6.5 Sources of Referral**

Locality	Self	District Nurse	Local hospital	Other hospital	GP	Relative	Other	No details
West	2	3	8	3	1	0	13	0
South	14	0	2	2	3	5	8	6
North	2	0	2	0	6	2	13	5

## Assessment

Just after the implementation of care management within adult care services in 1993, the Social Services Inspectorate noted in their inspection of assessment in community care (SSI, 1994) that assessments mainly focused on whether individuals qualified for a particular service, rather than establishing needs first, then adapting the service to them, and that user choice was not central to assessment process. Assessors often presumed that their role was to go beyond the presenting demand to the actual need, implying superior judgement, and there was no attempt at user self-assessment. Assessments did not specify desired outcomes, so no means of measuring effectiveness of interventions. Therefore it was not possible to evaluate whether objectives and priorities were being met. Different assessment procedures for each service resulted in duplication, instead of integrated needs-based systems. Lack of common language and philosophy impeded multi-disciplinary assessment. The following discussion of data highlights that many of



these concerns were still identifiable from the Parkside case files analysed.

### **Participants in assessment**

Table 6.6 shows how the participants in assessment were recorded, notable for the missing information.

***Table 6.6 Participants in Assessment***

<b>Locality</b>	<b>User</b>	<b>User &amp; carer</b>	<b>OT</b>	<b>Home carer</b>	<b>None specified</b>
West	9	1	0	0	20
South	2	2	1	1	24
North	3	3	0	0	24

### **Assessment tools**

At the time of sampling, a new assessment tool had been introduced. However, Table 6.7 show the variety of recording methods in use during the sampling time frame. Where another form is indicated, it is used as a substitute for an authorised assessment tool, and includes referral sheets, individual care plans, home care forms, and diary sheets.

***Table 6.7 Assessment Tools***

<b>Locality</b>	<b>Old form</b>	<b>New form</b>	<b>Other form</b>	<b>No form</b>
West	4	27	5	13
South	6	4	8	10
North	2	2	1	25

## **Assessment Details**

Details of the assessment process were very brief in the case records. Where they existed, they were no more than two lines, and focussed on existing medical conditions and existing or projected services.

***Table 6.8 Missing Assessment Details***

<b>Locality</b>	<b>Missing Assessment Details</b>
West	12
South	7
North	17

Gambrill (1997: 478) discusses '10 ways to fool yourself and your clients about the degree of progress', including not gathering baseline data on the frequency of behaviours, thoughts, or feelings of concern to client before the service is provided. Notable by their absence in the written details given on the assessment process (whether recorded on a standardised form or more diffusely through the file) are details of user opinions or self-assessment. ADL needs were only quantified in one case record in North locality, so they could not be correlated with services or other variables. Three cases in South locality gave Barthel scores. This did not necessarily just refer to nursing tasks as the service users had been assessed by social work Care Managers (one based on the community, the other in hospital). This may have indicated the influence of the locality interdisciplinary project, which brought together qualified social work care managers with nurses and OTs.

## Care planning

Findings from the exploratory project in North locality detailed concerns arising from interviews with older people and carers about the lack of care plans shared with them. In the course of discussions with managers in West locality during the same period of exploratory fieldwork, it was additionally made clear that practice in that locality had developed where it was the norm for care plans not to be signed by service users, who would not receive copies for their own reference. However, reasons for this were unclear. This was a 'creep' in practice, noticed by senior managers, but not challenged or addressed. The following table demonstrates the inconsistency in including written care plans, sometimes reduced to service plans or statements of need (designated as 'other form').

**Table 6.9 Care Plan Inclusion**

<b>Locality</b>	<b>Care plan signed</b>	<b>Care plan unsigned</b>	<b>Other form signed</b>	<b>Care plan absent</b>
West	6	5	1	18
South	6	10	0	14
North	4	0	1	23

### **Case file stated aims**

It is difficult to discuss outcomes of intervention of agencies if there are no clear aims for that intervention. As seen in the table below, the majority of care plans gave no aims for further intervention, whether agreed with user and/or carer or not. Most of those that were recorded appear instrumental, confusing services to be provided with an indication of what is hoped to be achieved. Reference to notions of independence were scarce, and may display ageist assumptions of lack of capability (Butler, 1969; Bytheway & Johnson, 1990; Cuddy & Fiske, 2002; Ray, Sharp & Abrams, 2006). It may not be perceived as being worth having aims or outcomes for intervention with older people when expectations are predominantly limited to maintenance and risk aversion.

**Table 6.10 Case File Stated Aims**

<b>Locality</b>	<b>Service-based</b>	<b>Outcome-focussed</b>	<b>Mixed</b>	<b>Aims missing</b>
West	5	4	2	19
South	5	4	3	18
North	5	1	0	23

### **Service provision and provider mix**

In North and West localities, half the files did not record who the service providers were. The number of care hours also had to be estimated, as, for example, only 14 of the case files in South locality gave an explicit total for hours.

**Table 6.11 Range of Provider Agencies by Locality**

Type of agency	North (n=15)	West (n=15)	South (n=26)
Direct Service Organisation (DSO)	14	13	14
Private care agency	6 (3 providers)	3 (1 provider)	18 (4 providers)
Day care	3	1	6
Private carer (paid)	1	1	1
Informal carer	1	0	0
Voluntary agency	0	1	1
Nursing agency	0	0	2
Meals at home	5	3	2
Respite	0	0	1
District Nurse	1	0	1
Combination providers	13	6	0

The combination of DSO and private agency partnerships is an example of the flexibility of provision that was a hallmark of the Parkside mixed economy of care.

### **Carer Roles**

No carer assessments were recorded in any of the files. Where carers were mentioned in files, the relationship was not always specified, but reduced to tasks undertaken or hours. One file stated the carer role to be 'the rest', and four mentioned carer stress, though without further elaboration.

**Table 6.12 Carer Representation in Case Files**

<b>Locality</b>	<b>Carer mentioned</b>	<b>Carer not mentioned</b>
West	9	7
South	11	6
North	7	7

### **Reviews**

The disparity between locality teams in explicitly scheduling the three-monthly case reviews directed by Parkside policy was stark, but unexplained except in terms of informal practice 'drift'.

**Table 6.13 Review Dates Recorded**

<b>Locality</b>	<b>Review Dates Recorded</b>
West	18
South	27
North	9

### **Case status**

The following tables demonstrate the different practices between the localities in how referrals were distributed to staff for further work. Allocation would ensure (as far as possible) consistent application from one named social worker. Keeping referrals within the initial referral system of 'duty', however could result in a multiplicity of different staff carrying out the required contacts and work.

**Table 6.14 Case Status**

Locality	Allocated	Awaiting allocation	Duty active	Duty pending	Review	Closed	No information
West	0	0	12	18	0	0	0
South	6	0	7	8	6	2	0
North	0	4	15	8 (HC)	1 (HC)	0	2

It can be seen here that West locality was practicing non-allocation, holding cases within the duty system. South locality actively allocated a greater proportion of its cases than either North or West locality. North locality showed the most variation of systems of work distribution, including a separate system for dealing with referrals for home care services. An implication of this is that a further needs-led assessment would not be carried out in these cases, exemplifying service-led practice.

### **Complaints**

Complaints or dissatisfaction from users and carers were recorded incidentally in diary sheets. In North, three episodes of dissatisfaction were indicated. One centred on unhappiness with uncomfortable assistive equipment, but the other two involved unhappiness with poor standards of care. In one case, meals on wheels, laundry and home carers had not arrived as planned. In addition, a male home carer had been sent, contrary to expressed wishes. The other case was one of the few to include direct service user quotes; 'I know what to expect & what not to expect' in relation to the timekeeping of the home carer. This resulted in the service user not receiving timely assistance with getting up and going to bed, and the carer only reportedly staying for 20-30 minutes in an hour slot. In South locality, a service user felt that young carers '(...) can't get out quick enough at night and she doesn't like being rushed'. However, it was not clear what further

action had been taken in response to these two expressions of dissatisfaction. In the same locality, a service user reported a night carer asking for their fare home illegitimately from the service user. The provider agency investigated the allegation, and as a consequence suspended the worker and changed the service users' home locks. In West locality, a service user complained about different home carers arriving, and not always getting breakfast or cleaning properly. Again, no outcome was recorded. A clearer outcome was present in one of the West case files where a 'formal' complaint had been lodged about delayed discharge from hospital due to home adaptations not being provided in time. This resulted in a network meeting to discuss the complaint and organise services. What differentiated a 'formal' complaint (acted upon) from an 'informal' complaint (unclear whether acted upon) was not specified. Crucially, it is not clear how far older people were made aware of a distinction.



**Table 6.15 Case File Key Variables: Have They Been Addressed?**

Colour code legend: Red: Data missing in all files;  
Green: Data present in all files;  
Orange: Data inconsistently present.

<b>LOCALITY</b>	<b>North</b>	<b>SOUTH</b>	<b>WEST</b>
Client Details: Gender			
Client Details: DoB; Ethnicity; Religion			
Case Status			
SSID eligibility criteria score			
Referral Information			
Assessment Information			
Other Standardised Scores			
Care Planning			
Services Provided			
Outcomes			
Carer Assessment			
Carer Involvement			
Review			
Summary			

This table summarises the level of consistency across localities in recording the key variables outlined for data collection in Table 6.2. Gender is the one constant; all other domains demonstrate lack of consistency in recording.

### **Electronic Records**

As a snapshot of the locality workloads, records of enquiries and referrals received in a three month period and logged in the Parkside

computerised information system were also examined. In total, 534 ECIS case entries from the 3 localities and one local hospital social work department (supplying referrals to North locality) were examined with the aim of gleaning further information not contained in the written case files, such as outcomes, reviews, care hours and costings (which were not consistently present in the written records). The electronic database (ECIS) contained multiple separate navigable screens for the worker to enter in this information for each 'case'.

**Table 6.16 Electronic Case Records by Locality**

<b>North</b>	<b>West</b>	<b>South</b>	<b>North Hospital</b>	<b>Total</b>
155	133	196	50	534

Prior to examining these records, I had undergone training in the ECIS system, on one of the regular sessions for social work and allied staff, and was able to access the database on site in each of the localities and from the office space allocated within the local authority for my period as a researcher. Whilst on the training course, other social work staff participating expressed hostility to the database and to Information Technology in general: 'I hate computers'. They did not feel they had the time to practice, some did not have basic keyboard skills (which was not included in any training programme), and felt frequently baffled. The Joint Review of Parkside (Audit Commission & Social Services Inspectorate, 1999) noted that at the point of the introduction of the database, staff were generally optimistic that ECIS would work and support their practice. However, the Joint Review reported that this was tinged with scepticism over whether this would come to fruition. The most important issue for the department to address identified by the Joint review was the credibility gap that

existed in some parts of the department about the relevance of ECIS for their own work.

These entries for the first locality (South) were examined initially in the presence of a locality team manager, who had expressed an interest in an overview of the content of the electronic case records. However, as the case entries from the previous three months were brought up, the 'hidden' screens behind the front screen containing basic demographic detail were found to be almost exclusively empty. The manager had been unaware of the lack of use of most of the available resources in the database, and expressed great surprise. This exercise was repeated from an office connection away from the localities, with similar results. The case records are interesting for what they do not say, as much as for what they do say. For example, the only outcome recorded in all of the electronic records is 'died'.

### **Conclusions: Autonomy not automata**

A caveat should be sounded in terms of the validity of focus groups in general, as they are not replicated and suffer from observer dependency (Frankfort-Nachmais & Nachmais, 2014). This was particularly the case in this series with Care Managers, where I was not a researcher external to the agency, and fulfilled the double role of moderator and scribe. Nevertheless, despite these limitations, the group interviews provided a snapshot of the professional opinions of the staff on their care management roles within Parkside policy and service delivery.

It was notable that prior to the arrangement of these interviews, Parkside had undergone a workload review exercise, carried out by external consultants, in an example of top-down management in action (Hogwood & Gunn, 1984). The resulting decision to reorganise

localities had provoked a period of industrial action spanning a number of weeks. After this unrest, the teams' attitudes towards outside researchers (including myself) had shifted subtly to being slightly more suspicious of how far I was allied to senior management. As a consequence, I became a more liminal, or ambiguous, figure. My role became more compromised, moving from designation as 'emic' or insider (with the same professional background as a qualified social worker) to 'etic' or outsider (Headland, 1990; Padgett, 2008). As a social researcher, and an agent in my own right, I influenced the social interactions under study. Nevertheless, staff expressed some satisfaction at being asked their views when the focus groups were completed, as they felt that communication with more senior management levels could be poor. I could therefore be a potentially useful bridge in this communication route, though could also be seen simultaneously as a potential threat. In the interviews, this wariness seemed to manifest itself in the Senior Care Managers making declarations of support for their staff. In spite of this, the transcript extracts demonstrate healthy debate on potentially contentious issues. However, different team cultures led to different ways of working, illustrated by the greater use of the ECIS eligibility grid by North locality, which had been the pilot for implementation.

The contributions to the discussions demonstrate staff pride in their professional expertise (David: South), but also frustration with budgets (Ellen: South; Sheila: North) and provider quality (Sheila: North). Despite management attempts to regularise work practices, the interviews show a number of areas where staff were defiantly protective of what they regarded as their autonomy and construction of professional identity (De Montigny, 1995), seen, for example, in their resistance to the ECIS grids. This could work for the benefit of service users, but it could also lead to lack of consistent care planning (Sue: North 29), lack of carer assessments (David: South 13) and the

aim to close cases as quickly as possible. Frustration with unwieldy systems was also evident, with hostile (and militaristic) analogies used, such as the 'Sherman Tank' (David: South). Attempts by senior management to impose consistency had resulted in the unintended consequence of resistance through staff recourse to a vaguely articulated professionalism. Tools for consistency were derided as 'just statistics', and therefore anathema to a profession priding itself on inter-personal skills.

The crux of social work is the interaction with service users. Although the value of strong interpersonal bonds between home care workers and service users was emphasised, this concept of relationship-based care (Nolan *et al.*, 2006) was not extended to the relationships between the care managers themselves and service users. Instead, management of risk, making sure cases stayed closed, were the prevailing concerns, throwing a spotlight on the distance between care managers and service users post-assessment. The dominant 'script' that care managers worked to was entwined with this procedural approach, where dependency and what people could not do was a major focus of the assessment process (although disliked by some). Staff were curiously hesitant in proclaiming their own successes. Some of this may be explicable by the 'Blitz' mentality of staff working under high caseloads, time-poor, harried by repeated changes in assessment tools, and liaising with service providers of variable quality. The debate on continuation of professional discretion versus curtailment may be expressed as that of autonomy versus automatons. This dichotomy simplifies the complexities of professional practice greatly. However, it can be used as a starting point to look at emergent properties and potential generative mechanisms in greater detail. The staff participating in the focus groups demonstrated aspects of both ends of this continuum in their responses. However, they support a continuation view of discretion overall in practice,

exemplified by the different work sub-cultures between the localities, despite attempts to regularise them.

In their research in North Wales, Parry-Jones & Soulsby (2001) discuss the conceptual difficulty faced by social work staff in differentiating between 'needs-led' and 'need for a particular service'; a difficulty exemplified in the Parkside case records. Olaison (2010), in her discourse analysis of sixteen older people's case files in Sweden, found that fact-oriented recording using 'objective' language contrasted with event-oriented, more personal depictions of the older persons. Interactional elements of the assessment were lacking overall, and physical and medical needs were privileged over social needs, and provided the predominant rationale for provision of home care services. Care managers within the authority appeared to exercise passive resistance to attempts to implement new systems, later echoed in Dickinson's (2006) study of front line staff resistance to the implementation of the Single Assessment Process for Older People (SAP) in England (DH, 2001). In Parkside, service-driven, terse accounts that focussed on deficits substituted for person-centred reports that could be explanatory, where a good outcome was summed up as a closed case that stayed closed.

Considerable efforts had been applied in Parkside to regularise assessment forms and introduce standardised systems, such as the ECIS eligibility grid. Despite this, the evidence from examination of the case records demonstrates lack of consistency, and staff exercising individual variation and discretion (Howe, 1991; Evans & Harris, 2004). The Joint Review (Audit Commission & SSI, 1999) findings tally with those found in this data collection. They found that it was not always possible to tell from the case files how closely the

care package met the assessment of need. Sometimes this was only confirmed when Reviewers met with users. However, their main concern was with inconsistency. Some files did not appear to have had a risk assessment; there were others where the initial enquiry was not evident; some files were not up to date and some care plans could not be found, while costings of services were not always clear. Tanner (1998) found that practitioners used normative (professional) and comparative (eligibility) criteria in assessment, rather than user-defined need: Parkside practitioners appeared to be doing the same. This means that further holistic view of service users can be seen as a luxury, as the prevailing focus is on risk, which is nonetheless imprecisely defined.

From the analysis of the Parkside paper and electronic record, key issues can be highlighted. Basic required information was missing in files. Where care plans were included, the stated aims were overwhelmingly functional and service-led, based on deficit models of dependency. From the sample of older people interviewed (Chapter 4), none had a copy of their care plan. There was no systematic recording of ethnicity or religion in the paper records, and neither category was a requirement in electronic records. No outcomes focus was discernable in the records, whether practitioner or user-defined. The needs of carers were not routinely included within the records of assessments, apart from detailing their contribution. Most of the information facilities in the electronic recording system were unused by staff. Managers at team level and higher had been unaware of the details of the lack of consistency in practices across the localities, including gaps in care planning, eligibility grids & electronic records. The individual user voice was missing overall. The lack of baseline information and consistently recorded details of services or outcomes in the records made evaluation of efficacy impossible.

The staff making the recordings were operating in an environment of rapid change and uncertainty in the arena of changes in assessment tools and eligibility criteria, wider uncertainty in terms of proposed restructuring, a climate of inevitably limited resources, and lack of clear local or national guidelines. Lipsky (1980) argued that such conditions facilitated the informal (and inconsistent) discretion of street-level bureaucracy. Care managers appeared to be making individualised decisions about what was important to record, within diverging professional cultures of practice across the three locality teams. Common to all of the records, however, was the prevailing focus on user dependency and a deficit model of ageing (Woodward, 1991). The records can only act as an abbreviated, incomplete proxy for the interactions that took place during the assessment process. Nevertheless, further inferences can be made regarding care management practices that operated in relation to older people. These social work practice models are discussed further in the concluding chapter, bringing together for analysis the triad of the narratives heard from professional staff, providers, and the people themselves as recipients of services.



## **Chapter 7**

### **Concluding Discussion: Articulating the key components of home care**

#### **Introduction**

In this thesis, I have examined a case study of one Social Services Department's practices in the routine provision of domiciliary social care with older people, and highlighted the implications for current and future practice. I argued in Chapters 1 and 2 that there were substantive concerns regarding the provision of domiciliary care services that had persisted over three decades. In this chapter I return to the rationale for the research approach adopted, how that paradigm changed, and the implications of the empirical findings presented from the perspectives of older service users, care managers and provider managers that were detailed in Chapters 4, 5 and 6. These arguments are broken down into the following themes.

Firstly, I discuss the evolution in conceptualisation and research methods used in the case study, and the move away from an effectiveness paradigm to a realist evaluation framework. Based on the empirical findings, I propose mechanisms for how they articulate, or interact in a complex, shifting system, and how this is operationalised from the empirical data.

A feature of this thesis has been the ability to draw on a longer timescale, to provide a perspective on the operation of policy and practice governing community care with older people. This thesis originated in the period within four years of the implementation of the NHS&CCA 1990, with care management the operating practice

system. Care management, based on assessing need and then commissioning appropriate services, continued to be the dominant paradigm for the next thirty years. However, although the concept of personalisation as enhancing person-focused choice has been part of the policy and practice discourse since the White Paper *Valuing People* (DH, 2001b) concerning learning disability, the application of personalisation in terms of cash for care systems within the mixed economy has not been embedded in legislation until the Care Act 2014 in England.

I go on to identify what contribution to knowledge in social work the thesis makes. I discuss the strengths and limitations of the research, and reflect on the process of researching in Parkside. Finally, I discuss areas that may be fruitful for further research.

### **Evolving Methods: Life beyond effectiveness**

The following section presents more detailed discussion of the evolution of the methodological approach, and how this shapes the analysis. The thesis was originally formulated within an effectiveness framework (Macdonald, Sheldon & Gillespie, 1992; Gambrill, 2012), traditionally addressed by attempts to manipulate closed systems through Randomised Controlled Trials or, more usually in social care settings, quasi-experimental non-randomised methods, based on the premise that the target intervention causes the expected outcomes. Hence, the original research question was:

*How effective are Parkside Social Services' domiciliary care services in meeting the needs of older people?*

This question made the assumption that the care managed system of assessment of need did generally lead to matching services and

resources to meet those assessed needs, in order to enable older people to remain in their own homes for as long as possible as the preferred alternative to long-term residential care settings. The schedule for interviews with older people was designed with such a framework in mind, including provision for a further interview after a six-month period, to apply a pre-test (six weeks after assessment), post-test (after a further six months of service provided) design. However, Parkside was (and is) a complex organisation, open to external influences at local and national level, and which changed constantly for the duration of the research. Organisational changes would have occurred without intervention from myself. However, the conditions of the studentship called for interim reporting on findings, which in effect changed the methods into action research through feedback loops, not conducive to pre-post effectiveness research methods. Additionally, older people themselves are far from passive recipients of care services. As Milligan (2012) points out, although power appears to reside in the hands of social and health care professionals, the care relationship is not simply uni-directional but instead older people exercise agency, including resistance and reciprocity, in sometimes unpredictable ways that a linear model of service provision does not reflect.

As detailed in Chapter 1, as a result of the small-scale preliminary study commissioned by Parkside, it became apparent that the administration, recording and gatekeeping practices would not provide the data baseline to sustain a quasi-experimental approach that focussed on outcomes and how far they were effectively mapped to needs assessment in a linear and causal process. The identified gaps in record-keeping informed a subsequent theoretical change to a realist case study that combined quantitative and interpretative methods, suitable for comparing how programmes work differently in different localities. The research design and analysis therefore shifted

to a multi-faceted approach, accounting for multiple perspectives of care managers assessing for and commissioning domiciliary care, older people receiving such services, and those agencies providing it. Realism as proposed by Pawson & Tilley (1997), and latterly Pawson (2006; 2013), is both methodologically based, and pragmatic. Therefore the emphasis is on proposing why interventions in specific circumstances may or may not work as much as describing what happened, thereby providing a richer and more explanatory picture that includes interactions between organisational and social structures and agency exercised by key actors. The research question therefore became:

*What works in domiciliary care in Parkside, for whom, and under which circumstances?*

To reiterate the argument from Chapter 1, realist evaluation tests the efficacy of the intervention theories by exploring how the intervention components may induce a change in practice and responses (known as mechanisms), the environmental factors that impact on these mechanisms (known as contexts) and how combinations of both link to the outcomes observed. Explanations are produced through the configurations of contexts, mechanisms and outcomes which can be applied to Parkside as a case study of a complex system of constituent parts that work in relation to each other, and which cannot be fully understood in isolation.

### **Formulating a programme theory: Parkside's policy on domiciliary care**

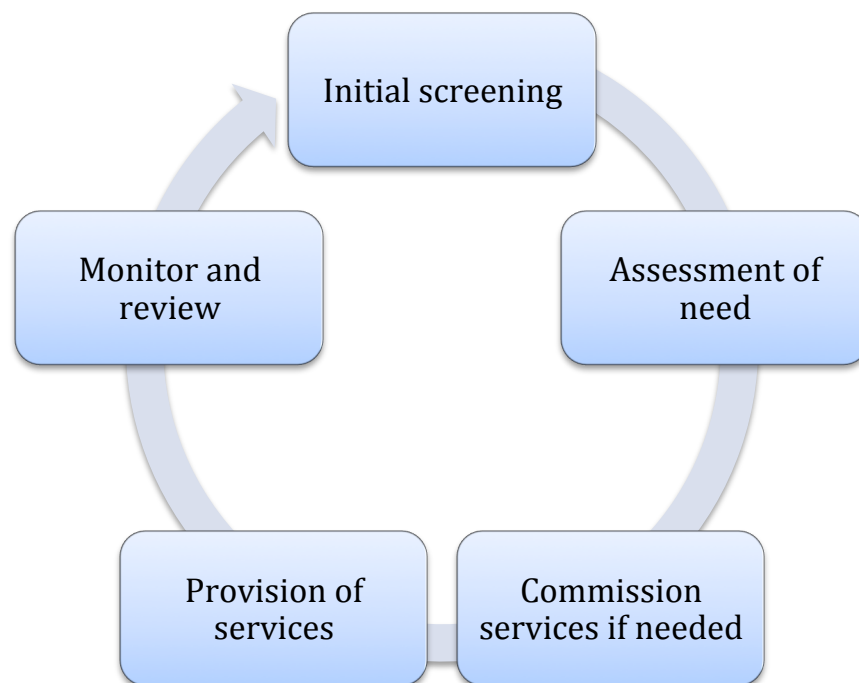
A feature of realist evaluation is framing policy and its implementation

as being theoretically driven, however implicitly; this is known as the programme theory (Pawson, 1996). Greenhalgh *et al.* (2015:2) usefully summarise the position: Programmes 'work' by enabling participants to make different choices (constrained by individuals' previous experiences, beliefs and attitudes, opportunities and access to resources). In order to make and sustain different choices, there needs to be a change in reasoning, such as values, beliefs, attitudes and decision-making, or the resources available to them (which can include information, skills and support, as well as material resources). This combination of 'reasoning and resources' is what enables the programme to 'work' and is known as a 'mechanism', and will work (or be 'triggered') in different ways for different people, in interaction with the wider contexts. With so many potential interactions, interventions cannot simply be replicated with the same outcomes from one context to another. As Pawson and Manzano-Santaella (2012: 178) put it: 'Why does a programme work in Wigan on a wet Wednesday and why does it then fail in Truro on a thunderous Thursday?'. This question also highlights the emphasis on searching for explanations for the ways interventions may work, so that potential underlying mechanisms can be identified and applied to other interventions in similar or different contexts.

For the case study, I therefore formulated the relevant programme theory as being centred on what Parkside wanted to achieve in its domiciliary care provision, and how it measured how it was achieving this. Although referred to by Pawson (2006) as 'programme theory', it is unlikely that Parkside managers or policy-makers thought of provision of home care in terms of a theory. Their drive was for results in a most cost-effective way. As seen in Chapter 2, all domiciliary care was provided within the framework of care management under the NHSCCA 1990, with emphasis on needs-led assessment and commissioning of services within the mixed economy of care. In this

sense, national legislation was a non-negotiable constraint. However, it has been seen in the analysis of care manager responses and case records in Chapter 6 how carer legislation (at the time of data collection, the Carer (Recognition & Services) Act 1995) was effectively ignored by care managers immediately post-implementation. The stages of the traditional 'care management approach' (Law Commission, 2011) that guided practice (in principle, at least) were also followed in the structure of the interview questions, following the sequence of the cycle of Care Management, adapted from the SSI practice guidance (1991):

**Figure 7.1 The Cycle of Care Management**



### **What were Parkside's aims?**

In order to investigate how well or otherwise Parkside was implementing its domiciliary care for older people, there are a number of potential sources of information about its administrative thinking

(how it implemented the national legislation and associated practice guidance), some explicit, others less so. The most public statements were in the Parkside Business Plan and Community Care Plan (Parkside, 1996) and Business Plan (Parkside, 1997) for the period. Efficiency in use of resources, choice, meeting both national priorities and local needs, whilst recognising budgetary constraints were key themes. These objectives would not be out of place in current local policy statements. The Social Services Business Plan for the period of fieldwork (Parkside, 1997) was presented to the Social Services Committee and set out the aims and core values of the services provided to the residents of Parkside. As discussed in Chapter 1, the four core Committee aims (Parkside, 1997:3) were to:

1. Protect those at risk of significant harm;
2. To assess and meet the needs of service users and their carers;
3. To enable people to live as independently as possible within their homes or within a family;
4. To listen and respond to service users' views.

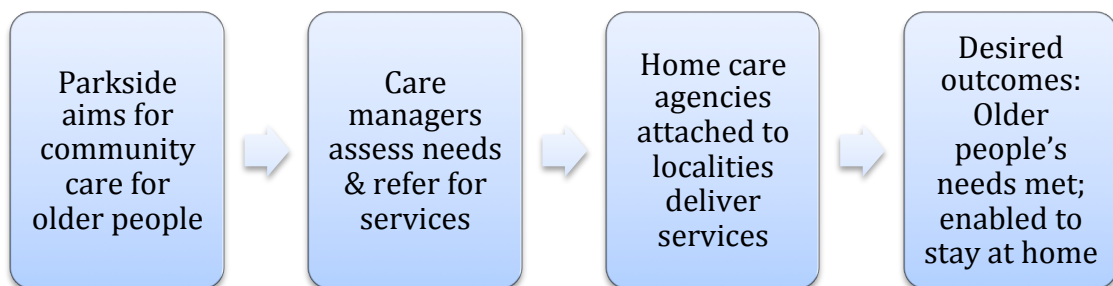
In addition, the Business Plan set out core values for the authority, which included developing a '(...) high quality mixed economy of care through the (authority's) enabling strategy', and ensuring residents services provide 'best value' (Parkside, 1997:5). This 'enabling strategy' had led to 64% of services being purchased from the independent sector in 1997/1998, and 23% from the authority's Direct Service Organisations, with the remaining 13% from other Business Units (dealing with aids and adaptations, for example) that had been set up in the authority. The Plan also lists targeting services at the most vulnerable, 'who meet our agreed eligibility criteria' as targeting

enables the authority to '(...) manage effectively the increasing numbers of referrals to the services whilst maintaining control over the budget, thereby achieving best use of available resources'. It should be noted that a further aim, to assist service users to purchase their own care, was not investigated in this thesis. At the time of fieldwork the Community Care (Direct Payments) Act 1996 had just been implemented, with an aim in the Parkside Business Plan to conduct a pilot scheme by the end of 1997. However, this had not been evaluated at the time of fieldwork, and Direct Payments did not feature in the interviews with service users, practitioners or providers. However, cash for care schemes, including Direct Payments and Personal Budgets (in England) constitute a central plank of contemporary personalisation in social care, exemplified in Section 28 of the Care Act 2014, whereby all adults eligible for support must be offered a Personal Budget, which may include a cash for care component.

From these public aims, it can be clarified how far there is a Programme theory underlying the provision of home care. In other words, how Parkside formulated its approach to implement its services and thereby to effect change. There is little explicit theory informing the delivery of home care services (Ceci, 2012). Parkside followed the standard care management cycle that has been in operation since the NHSCCA 1990 implementation (SSI, 1991). This involves an implicit chain of implementation, illustrated in Figure 7.2 below:



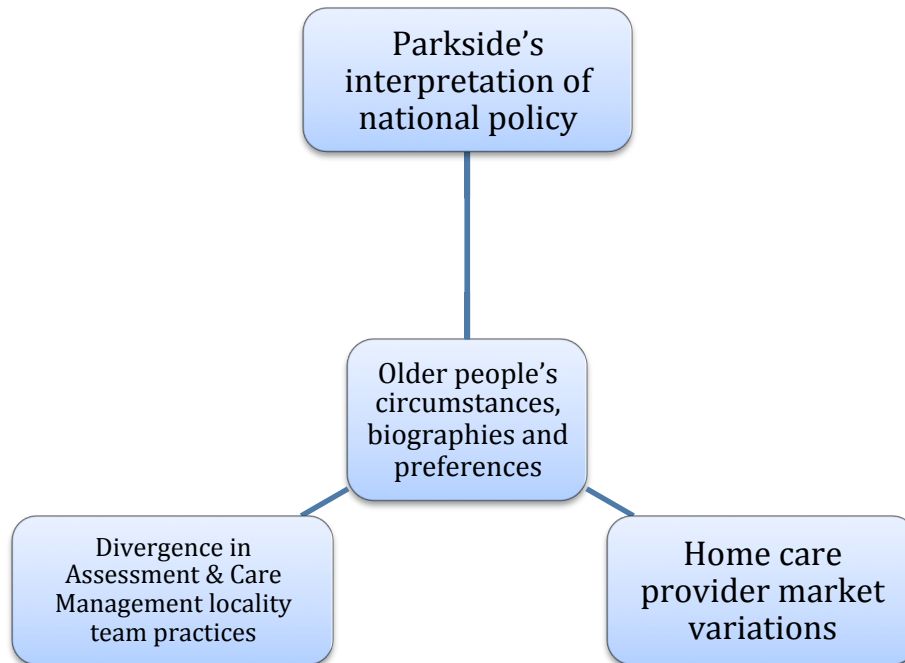
**Figure 7.2 Idealised Implementation Chain**



This '1990 Act approach' has been criticized by the Law Commission (2011) as being service-led rather than needs-led, and by the Welsh Assembly Government as '(...) outmoded - conveying a sense of control by the service, not by the citizen.' (WAG, 2011: 24). This is a view supported by the empirical findings in this case study. As discussed in the analysis of findings in Chapter 4, there is not a simple linear matching process of services to needs. This thesis has argued that the provision of home care is context-dependent, with inherent variation that emanates from the complex responses of the key agents (designated in the Parkside study as the older people in receipt of services, the care managers and providers). The following section outlines the relevant characteristics of such variation in contexts,

mechanisms and outcomes as manifested in Parkside. These will be discussed further from the three perspectives investigated in the case study' as illustrated in Figure 7.3:

**Figure 7.3 The Enactment of Home Care in Parkside**



### **The realist model: Contexts**

To recap the realist evaluation model originating with Pawson & Tilley (1997) of 'what works for whom in what circumstances', there are three major components; contexts, which interact with mechanisms to generate outcomes. Contexts are conceptualised by Pawson (2006) as the conditions that constrain the choices available to key stakeholders in the system (Pawson, 2006), and which 'load' their choices towards success or failure according to their characteristics and circumstances. Contexts are integral to the analysis, rather than 'confounding' factors

to be controlled, as in an effectiveness paradigm. Pawson (2013) further elaborates contexts as individuals, interpersonal relations, institutional settings, and infrastructure. These are diverse and broad categories, and some of the debates about where contexts overlap with mechanisms will be discussed further in the next section. In this case study of domiciliary care, I identify relevant contexts at the macro and organisational level rather than the level of individual characteristics. This includes the national legislative and policy parameters, as well as conditions that are local and particular to Parkside, such as the infrastructure of the locality teams and contracted provider agencies, and the services offered as a result of assessment. Following on from this, the contexts that can be identified initially in Parkside are national legislation and policy at the macro level, as summarised in Table 7.1, below.

**Table 7.1 National Legislative and Policy Contexts**

National Framework of Community Care			
Guiding Legislation: NHS & Community Care Act 1990		National Policy Principles	
Enable people to stay in own homes for as long as feasible	Assess needs; decide on matching resources	Operate in mixed economy of care	Implement through Care Management

At the intermediate level are Parkside’s own policies and implementation aims as outlined in their Business Plan (Parkside, 1997), summarised in Table 7.2.

**Table 7.2 Parkside's Organisational Aims**

Parkside Aims for Community Care for Older People				
1. Protect those at risk of significant harm	2. Enable people to live as independently as possible	3. Assess & meet needs of service users and carers	4. Ensure all care services meet high quality standards	5. Meet social care needs by working in partnership with other services and independent sector
6. Listen & respond to service users' views	7. Work in partnership with users, carers & Service providers	8. Provide services that treat people with respect, ensure confidentiality & avoid discrimination	9. Achieve best use of available resources	10. Develop high quality mixed economy of care

Also within this meso level are the ways in which services were organised locally in Parkside, into the three distinct Assessment and Care Management teams in the North, South and West locality offices, and their associated provider agencies.

### **Mechanisms: The interactions of structure and agency**

I have discussed how programmes or interventions in social work and social care are complex entities, acting on individuals in complicated social situations. It is people that make interventions happen, and people can act in unpredictable ways, and in ways that do not conform to the intended aims of the intervention. As Pawson (2006:24) points out: '(...) programmes work only if people choose to make them work'. How the programme's resources impinge on people's reasoning, and their responses to it, is how Pawson & Tilley (1997) originally conceptualised 'mechanisms'. Mechanisms thereby generate context-dependent tendencies or patterns of behaviour, rather than determinative certainties, and have explanatory power. Crucially, these underlying mechanisms may operate in the domain of the real, where, they may not be directly observable (in contrast to a positivist approach to observable entities in the domain of the empirical). However, the term 'mechanism' has a long history in social theory, and is one that can become mired in semantic confusion, a point made by Merton in 1968, and again by Astbury and Leeuw in 2010, and Porter in 2015. Blom & Morén (2010) critique Pawson & Tilley's (1997) interpretation of realist evaluation, consisting of Context + Mechanism = Outcome as an explanatory device applicable to social work and social care settings. Since this model does not account for agency explicitly, Blom & Morén emphasise the role of actors and how they interact with social work interventions into their model of mechanisms. These authors do acknowledge that that such roles may be implicitly incorporated in Pawson and Tilley's model of

mechanisms, but are diffuse, and that more specific highlighting of the role of individuals is appropriate for evaluation of person-focused interventions such as social work. Dalkin *et al.* (2015) argue for understanding the impact of mechanisms as acting along a continuum, rather than acting as an on-off switch or trigger. They also highlight the analytical conundrum that can exist for researchers in deciding how to categorise which elements of an intervention as contexts or mechanisms. For example, they argue for more explicit disaggregation of mechanisms into resources (the components introduced by a context) and reasoning than originally proposed by Pawson and Tilley (1997). In this case study of domiciliary care in Parkside, I have characterized these mechanisms as how the levers of reforms or policies worked in practice locally, as a result of the interaction of the resources available and the reactions or reasoning (which may not have appeared 'logical') in response to the resources or services offered.

The specific conditions and characteristics of the three identified participant groups in Parkside are important here. For example, there were identified differences in practices in the three locality teams, different types of providers, including the newly-constituted Direct Service Organisations, and there were different user characteristics. In terms of the implementation of Parkside's aims for care management and the provision of domiciliary care for older people, how far were these policies embraced, distorted, ignored or rejected by those assessing for services, those providing services, and those receiving them. Given the complex nature of domiciliary care in any local authority, there will always be paradoxes and tensions, so that what may be a successful outcome for one group may be more equivocal for others operating within different contexts, whether individual characteristics, resources, or organisational climates. So changes may be activated for only some of the intended target subjects.

Mechanisms, the reasoning, choices, preferences and reactions to differing contexts will also be multiple, resulting in different outcomes for different people. Such factors are generally hidden.

## **Outcomes**

In a realist evaluation framework, outcomes are probably the most straightforward concept, and although they are the end points of interventions, can act as the starting points for evaluation and analysis. At an early stage in the case study, it had been established that a pre-test, post-test research design was unfeasible. However, it can still be asked what changes, and for whom, did the organisation and delivery of domiciliary care (the interventions) bring about in Parkside. In the context of social care, outcome measurement can be politically charged and linked to performance measurement in local authorities, as was apparent in the commissioning of external consultants to perform a performance review in Parkside at the time of fieldwork. Outcomes can also have different meanings for different people, demonstrated by the perspectives of what constituted a good outcome for the respective groups interviewed in the case study. There can be both intended and unintended consequences of policy implementation. The Parkside Business Plan (Parkside, 1997) identified what they termed outcomes for assessment, with targets for initial screening assessment times of fourteen days for older people, and thirty-five days for care management assessments. Parkside had thereby elided outcomes (impacts on people who received assessments) with outputs (the targets of implementation) in its Business Plan. Such targets were apparently easily measurable. However, the content analysis of case records revealed no consistent recording of dates of completion of the assessment process.



## **Key points in process of delivery and receipt**

The analytic structure adopted here of evaluating how well domiciliary care is operating is to examine the policy formulated by managers and councillors, and map how this is implemented in Parkside, linking the chain of contexts, mechanisms and outcomes as defined in the previous sections. The Parkside Business Plan provides a table of policy, implementation and intended outcomes. Crucially, this model of implementation assumes that each service component is successively causal; that the intervention (domiciliary care) will cause the intended outcome (enabling more people to remain in their own homes for longer). However, all implementation is reactive, as Lewis and Glennester (1996) found in their study of how community care was put into practice immediately after the introduction of care management in 1993. Policies that originate as 'top-down' are subject to reactions and changes, and become 'bottom-up'; a feature examined by Lipsky (1980) in street-level bureaucracy. In a complex system with multiple layers of personnel and interactions, there are multiple opportunities for such changes to be enacted, which may have both intended and unintended consequences. However, these decision points may be poorly articulated or unrecognised. Greenhalgh *et al.*, (2015:3) note that:

(...) realism sees the human agent as suspended in a wider social reality, encountering experiences, opportunities and resources and interpreting and responding to the social world within particular personal, social, historical and cultural frames.

This purports to explain why people respond differently in different settings, even where circumstances appear the same. The challenge in realist analysis is to propose how contexts, mechanisms and outcomes (C-M-O) once identified, link together in Context-Mechanism-Outcome configurations (CMOCs). As discussed earlier, a key feature of

mechanisms is that they are context dependent, so that interventions may not be amenable to replication between different locations, for example, as the contexts in which they operate may act on mechanisms differentially. Outcomes may therefore also differ, to the consternation of policy planners. Jagosh *et al.* (2015) point out the semi-permeability of these constructs, so that in some circumstances, outcomes themselves become contributors to contexts for other outcomes, providing a chain of interlocking reactions, in what they term a 'ripple effect'. This has implications for generalising beyond Parkside, but also for examining processes within Parkside. In order to examine this more closely, we can return to the Parkside management's initial concerns about equity of service across the three locality offices. The next sections examine how far Parkside's aims for domiciliary care were achieved, from the three core perspectives, and how the CMOc framework may be applied to providers, care managers and older people.

## **The triad of perspectives**

### ***The perspectives of the older people on their home care services***

I have argued that the care management approach or cycle tends to simplify the characteristics of services users as needs to be assessed. However, the responses of older people interviewed in the case study demonstrate variation that goes beyond simple matching services to meet assessed needs. Levels of need did indeed differ, as expected, though the services provided did not always match these needs in a linear way (see man in wheelchair with no services, and LDS self-reported data). Individual preferences were very important, as older people exercised their individual agency as seen in a spectrum from compliance and satisfaction to subversion (for example, Mrs Wieder's attempts to complete again the paid carer's domestic work), refusal,

or exit from services. Meals at Home also elicited strong responses, including the remark that they were '(...) a good thing for poor people, who haven't got the money' (Mr Stewart). This reflects the heterogeneity of the people placed into the category 'older people' (Iliffe & Manthorpe, 2004), that serves as a convenient organisational label for ordering social services. Older people receiving care are notable for expressing satisfaction with services overall, as Ware *et al.* (2003) found in their examination of the files of fifty-five older people. However, the authors also noted from their interviews with older people that their levels of expectation of services was low. In the findings from the interviews with Parkside older people, three expressed complete satisfaction with their home care services, but of the twelve remaining for whom this was applicable, four said they received not enough home care services, four that the services were of poor quality, two said they received excessive services and one received services that were unwanted. It is also notable that ten older people had refused or withdrawn voluntarily from services, without self-funding the purchase of alternative services. This is an area that could merit a study in its own right.

The following Table 7.1 summarises the C-M-O configurations from the perspectives of older people who were interviewed about the services they received at home:

1. The contexts are given as Parkside's stated aims from their Business Plan;
2. The outcomes are derived from qualitative and quantitative data from the interviews, presented in Chapter 4;
3. The mechanisms relate to resources provided to meet these aims, and responses of the older people interviewed to them.

In particular, the pivotal role of human agency has been emphasised beyond Pawson & Tilley's original proposition, as seen earlier in the

work of Dalkin *et al.* (2015) in their analysis of palliative care. This separation of resources and reasoning has very practical implications for the provision of domiciliary care, as resources are issues that service commissioners and providers may have some measure of control over (financial restrictions notwithstanding). People's responses, on the other hand, are less amenable to prediction, let alone change, although there are key and repeated lessons about older people's wishes for consistent, reliable services that include low-intensity services (Raynes, Clark & Beecham, 2006; Ismael, Thorlby & Holder, 2014). Having cautioned against the idea of linear mapping of needs to services and hence to outcomes in the care management model, it should be noted that the use of tables is a useful summary device, rather than implying that the relationships between proposed components are themselves linear and subject to the inevitability of constant conjunction causality. Pawson (2013) is critical of tabular lists, as the components can appear arbitrary. Nevertheless, the following Table 7.3. provides a synopsis of how far Parkside's stated aims that impacted specifically on older people were achieved. The table uses a colour key for intended (green) and unintended (red) outcomes.

**Table 7.3 Parkside’s Aims and Outcomes of Home Care for Older People**

Parkside’s aims	Resources offered	Outcomes and examples
1.Protect those at risk of harm	Provision of a range of home care services	All older people (N=24) enabled to live at home at time of interview, including 2 on verge of entering residential care Older people at risk (5 from main study; one from preliminary)
2.Enable people to live as independently as possible	Provision of a range of home care services	All older people (N=24) enabled to live at home.
3.Assess & meet needs of service users and carers	Provision of locality Assessment & Care Management teams	No services as screened out; Needs unmet: (Table 4.2); No carer assessments; No written information provided (21/24)
6.Listen & respond to service user views	Assessment, review and consultation	Satisfied with most aspects of services; Life better or mixed (13/24)
8.Provide services that treat people with respect, ensure confidentiality and avoid discrimination	Staff training, including buy-in options for provider care staff	Provision of tailored services. Refused, discontinued or subverted services; Dissatisfied with most or all services (2/24); Given unwanted services (9/24)

In terms of protection and safeguarding (Parkside aim 1), some examples came to the fore as presenting obvious risks. Mrs Wieder (interviewed in the preliminary study) was at risk of falls due to her re-cleaning regime after her supplied home carers had performed the tasks. Mrs Herman in the main study, who used a wheelchair, was in effect imprisoned within her own home by a disgruntled agency live-in carer commissioned whilst her usual personal housekeeper was in hospital. Mrs Grant (who received assistance within the home once a week) would open her ground floor flat window to give money to ask passers-by to get errands for her. Mr Wilder, who was blind, made accusations of theft against home carers, which were being investigated but not substantiated at the time of interview. Mr Smith had had his regular home care services withdrawn because of an incident recorded as aggression with a new carer attempting to assist with transfer from his wheelchair. The withdrawal of services to Mr Smith had left his spouse caring for her husband whilst working, when he could have been in need of 24-hour care. Mr Garfield was suspected to be at risk of financial exploitation from a purported relative.

All of the older people interviewed were living within their own homes (Parkside aim 2), rather than in residential care, although Mrs Yates's relative had requested residential care due to her cognitive impairment, and Mrs McTaggart entered residential care on a six-week trial soon after interview. All had received some level of assessment from the respective locality teams (Parkside aim 3), although it was not clear when this had taken place or who conducted the assessments. 58.3% of those who were interviewable could not remember an assessment taking place. The levels of need varied, as did the level of services, as seen in the self-assessment data in from the Lambeth Disability Schedule, compared to specific services provided (Table 4.2). The services provided did not always match

recorded levels of need, though the recordings of these were very inconsistent (Table 4.3). Monitoring had been highlighted as an area of improvement by provider managers and care managers (Parkside aim 6: Listen & respond to service user views). However, there was scope for confusion between care managers and providers over whose role this was, as shown in the respective interviews, and it was reported that the process of monitoring contacts became burdensome for older people. Confidentiality and discrimination were not obvious areas of concern from the interviews with older people, however (Parkside aim 8). Parkside was also attentive to the cultural needs of their residents, in the commission of specialist services from third sector organisations operating in the City that were run by and for Chinese and Jewish elders.

### **Context-Mechanism-Outcome (CMO) configurations relating to older people**

Having summarised how far the outcomes derived from the empirical findings from interviews with older people actually matched Parkside's stated aims, a series of CMO configurations can be proposed as cumulative and transferable lessons from the local evaluation (Pawson & Tilley, 1997). The first of these proposes the situation where Context 1 (C1) consists of the resources made available by the process of assessment of need by locality care managers and the commission of services to meet those needs. Mechanism 1 (M1) is the response of older people where their perceived needs align with the care manager assessments, and provided services meet those needs. This response is one of acceptance, and the outcome (O1) is being enabled to live at home with support, and satisfaction with the services.

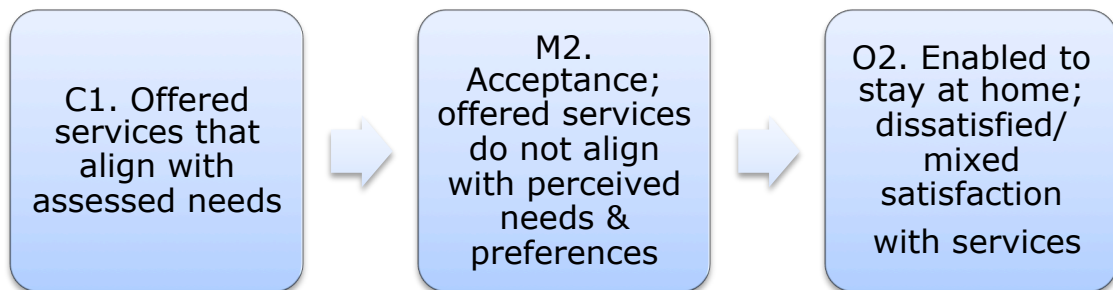
**Figure 7.4 CMO Configuration 1: Satisfaction with Services Provided**



However, from the interview data from Chapter 4, it is clear that whilst this outcome is clearly the desired consequence from the viewpoint of all protagonists, there can be multiple responses leading to different outcomes. The second CMO configuration (Figure 7.5) has the same context C1, but the responses or mechanisms differ (M2), as does the subsequent outcome (O2).

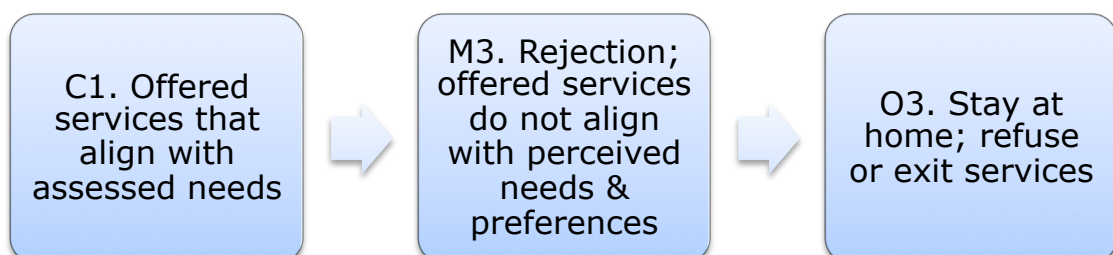


**Figure 7.5 CMO Configuration 2: Dissatisfaction with Services Provided**



The third CMO configuration (Figure 7.6) is where offered services again do not align with perceived needs and preferences, but the older person exercise stheir choice to reject or exit from services.

**Figure 7.6 CMO Configuration 3: Exit From Services Provided**



The context for the latter two configurations could also vary in that services offered may not align even with assessed needs; the responses and outcomes may be either dissatisfaction or exit in such cases. The factors that help shape these contexts that form the direct interface with the older people interviewed in Parkside are the actions of provider agencies, the resources available to them, and the decisions of care managers who assess needs and commission their services. These will be examined in turn in the following two sections.

### **Provider perspectives**

Parkside was a high-profile pioneer in Conservative local authorities, and aimed to provide services at demonstrably low cost to its local taxpayers. Its intent was to increase market choice while retaining value for money through its contract tendering process. Privatisation of local authority care services has been a major trend since the mid-1990s in the United Kingdom and Europe (Taylor-Gooby, 2004; Kröger & Leinonen, 2012). Parkside was proactive in 'outsourcing' delivery of services to the independent provider sector, and this flexible approach to the mixed economy of care is reflected in the study findings. There had been some retrenchment after high spending at those most at the margins of entry to residential care in order to delay their entry which carers in particular objected to (Chapter 4). From the views of home care recipients and their commissioners and providers, the thesis demonstrates the fragmentation and variable quality in such services, as well as examples of flexibility and stimulation of new services.

The issues raised by provider managers in Chapter 5 show concordance with trends in the care markets in the United Kingdom in terms of difficulties in recruitment, training, low pay, transport, and, a pattern of small-scale, and recently-formed companies (Allan &

Forder, 2012). There were also communication problems and role confusion with care managers, in terms of assessment criteria and practices, and specifying task-oriented time slots and unclear tasks. However, in other ways, Parkside presented more distinctive features, such as the demographics of its older population in terms of more older people living on their own, and a mix of wealthier 'clients' with more educated backgrounds than their home care staff whose views of their home carers were less focussed on companionability or relationships, but orientated to a market or service transaction with paid care staff, with such personnel even seen as 'servants'.

Table 7.2 summarises Parkside's aims relating to provider agencies (again, designated as relevant contexts), and how these were operationalised in practice, drawing on data from the interviews with provider agency managers in Chapter 5. From the older people and care manager interviews, ensuring all care services meet high quality standards (aim 4) could be variable. The providers also acknowledged that the quality of personnel was not always reliable, and there was a limited pool of suitable recruits. The outsourced former in-house providers, now DSOs also made alliances with the independent sector in order to meet social care needs by working in partnership with other services and independent sector (aim 5), to the extent that West DSO made a joint bid with Norton Employment for the contract with West locality. Third sector specialist organisations were also contracted e.g. Jewish care agencies. However, difficulties in communication with care managers was raised by all of the managers interviewed. For the independent sector, there was a mutual lack of understanding of processes of assessment with care managers in the localities, as evidenced by Care Solutions, Gainsborough, Premier Domestic, with additional confusion over whose roles covered assessment and review and monitoring. The DSOs understood care

management better, given their previous insider status, but were still frustrated by the lack of care plans as specified in the contracts.

In attempting to achieve the aim of the best use of available resources (aim 9), providers did find margins of fees squeezed, and there was cutthroat competition between agencies to attract workers. Nevertheless, providers were also appreciative of Parkside's stance towards independent providers, and had found the alliance with the DSOs innovative and fruitful, even if it had been a steep learning curve for the outsourced home care teams. Parkside were seen as at '(...) the leading edge of regarding being an enabling authority' (Norton Employment manager), in their aim to develop a high quality mixed economy of care (aim 10), and achieved diversity and flexibility. A fragile balance was maintained between flexibility to respond rapidly to changing circumstances, and the scope for stability to enable long-term planning. This balance was achieved by a mix of spot and block contracts. The majority of the contracts awarded by Parkside were on the block contract model, with a fixed price for a set number of hours. Providers tended to prefer this arrangement, as it gave them security, and it was seen as good practice. However, Gainsborough were contracted for additional spot hours, to provide flexibility for unforeseen circumstances. New services had been commissioned by Parkside; specifically the handyperson service, bathing service (Carlton Nursing), putting to bed service (Care Solutions) and domestic care contract (Premier Domestic). Premier Domestic wanted task-oriented service plans, not time-oriented slots. Their contract was for domestic tasks primarily, with less emphasis on personal care, so it is more understandable that this would be their stance, as their role was more akin to cleaning staff who could work at a distance from their clients. That this domestic service, although newly commissioned, was already looking a thing of the past was suggested by the South DSO manager, who had noted the increasing

levels of need in service users, and corresponding decline in numbers of people served. The trend was seen as moving away from cleaning and shopping towards intensive personal care, as noted by the manager of Premier Domestic. Carlton Nursing also had not seen the expected benefits of their contract materialise. What may have been expected to be a profitable area of work was not necessarily being fulfilled.

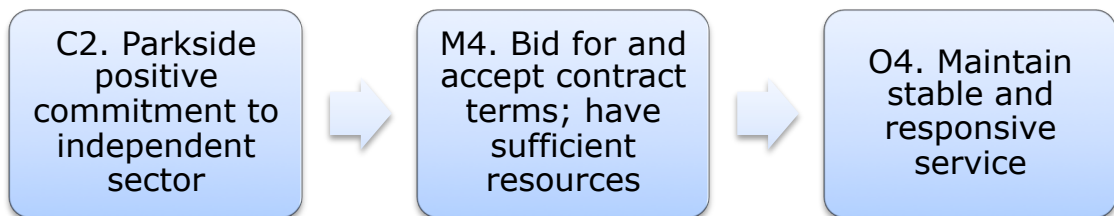
As with Parkside's aims for older people discussed in the previous section, their aims targeting home care providers are summarised with the outcomes derived from the empirical findings from Chapter 5 in the Table 7.4 below, followed by Figures illustrating two contrasting outcomes for provider agencies.

**Table 7.4 Parkside’s Aims and Outcomes with Providers of Home Care**

Parkside’s aims	Resources offered	Outcomes and examples
1.Protect those at risk of harm	Provision of a range of home care services	All older people (N=24) enabled to live at home at time of interview, including 2 on verge of entering residential care Older people at risk (5 from main study; one from preliminary)
2.Enable people to live as independently as possible	Provision of a range of home care services	All older people (N=24) enabled to live at home.
3.Assess & meet needs of service users and carers	Provision of locality Assessment & Care Management teams	No services as screened out; Needs unmet: (Table 4.2); No carer assessments; No written information provided (21/24)
6.Listen & respond to service user views	Assessment, review and consultation	Satisfied with most aspects of services; Life better or mixed (13/24)
8.Provide services that treat people with respect, ensure confidentiality and avoid discrimination	Staff training, including buy-in options for provider care staff	Provision of tailored services. Refused, discontinued or subverted services; Dissatisfied with most or all services (2/24); Given unwanted services (9/24)

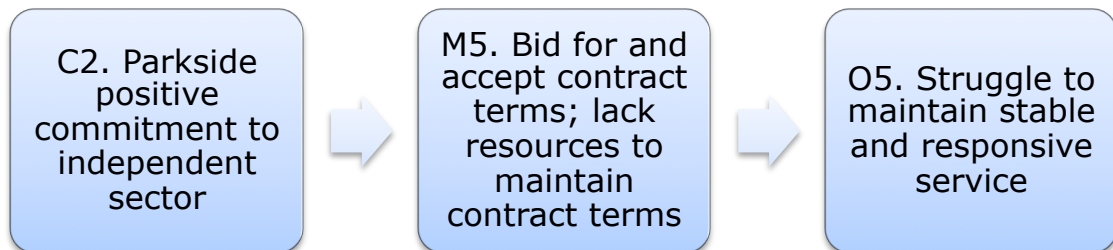
**Context-Mechanism-Outcome (CMO) configurations relating to provider agencies**

**Figure 7.7 CMO Configuration 4: Provider success**



In contrast, Figure 7.8 illustrates a different outcome, based on the resources available to the agency to maintain a viable business in Parkside, and representing those agencies who were struggling to cope with their contract conditions.

**Figure 7.8 CMO configuration 4: Provider failure**



Where provider agencies were unable to fulfil their contracts (and withdrew abruptly in one case), or fulfilled them inconsistently, it was older people who suffered from the disruption or poor quality service, and care managers who had to intervene, heightening a degree of mistrust that existed amongst the practitioners. It is their perspectives that are considered next.

***Practitioners: The exercise of professional discretion***

The locality team care managers are key actors in the interpretation of national and local policies, and thereby how service users experience processes and services. As discussed earlier, programmes operate (not necessarily intentionally) by enabling people to make choices. Chapter 6 also placed the actions of the care managers interviewed into the theoretical context of professional discretion debates and street-level bureaucracy. It was seen that the care managers in the different locality teams did exercise discretion, both within the locality teams and between them, as will be discussed below. This lies at the



heart of the paradox for the practice of these care managers. On one hand, they are expected to be responsive to individual need, but are also mandated to provide an equitable service.

In order to consider the question of what works, for whom, and in what circumstances it has to be considered that some mechanisms may benefit one group, whilst acting against the interests of others. This is examined from the responses in the group interviews. The position expressed by the Senior Manager in West locality gained general assent in the team: 'If you can close it and it stays closed' (Phil: West Locality Team). This is more than an expression of a job well done; it is what it 'feels like' to be a care manager, and reflects what can be a relentless, task-oriented sequence of completing assessments. It also illustrates a self-preservation tactic to manage an otherwise unpredictable, frustrating and uncontrollable workload. Lymbery (Lymbery *et al.*, 2007; Lymbery, 2010) has championed the role of qualified social work practitioners in their role with older people, and Manthorpe *et al.* (2008) have commented on older people's perceptions of their care managers' roles as appearing reductionist, unclear and variable. Referring to professional activity, Schön distinguished between the:

(...) prevailing idea of rigorous professional knowledge, based on technical rationality, and (...) awareness of indeterminate, swampy zones of practice that lie beyond its canons (1984: 3).

Care manager staff in Parkside demonstrated the necessary pragmatism for survival in the swamplands. The individual social worker's professional knowledge, skills and values were also contextualised by the freedoms and constraints they experienced

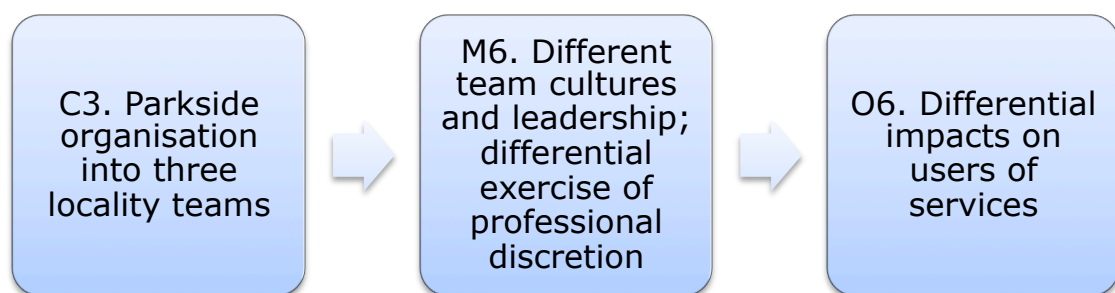
within the UK-wide policy and legislation bounding community care, and the particular demographic, social, policy and resource impactors in Parkside. Table 7.5 summarises the aims, resources offered and outcomes achieved from the perspective of care managers.

**Table 7.5 Parkside’s Aims and Outcomes of Home Care with Care Managers**

Parkside aims	Resources offered	Outcomes and examples
1.Protect those at risk of harm	Locality Assessment & Care Management teams serving local areas	Services provided to minimise risk; some older people living with high levels of risk (see Table 7.3)
2.Enable people to live as independently as possible	Locality Assessment & Care Management teams	Flexible response to local needs; knowledge of local networks and services; differential practices across locality teams in allocation and recording; inequity between localities
3.Assess & meet needs of service users and carers	Professional skills and values of care managers; provision of local services	Assessment identifies needs; appropriate services commissioned; changing assessment form formats; lack of consistency across localities; information lost (no carer assessments); focus on disability and deficit; incomplete recording
7. Work in partnership with users, carers & service providers	Professional skills and values of care managers in working with individuals and provider agencies	Commitment to user-focus as a positive impact of discretion and skills; flexibility; innovative partnerships with provider agencies; poor communication with providers; some mistrust of providers

The core mechanism operating to produce such diversity of outcomes can be simplified to that of the exercise of professional discretion, forming the mechanism in the following CMO configuration.

**Figure 7.9 CMO Configuration 5: Care Manager Perspectives**



This figure only summarises the multiplicity of the ways in which care managers (both front-line staff and their team managers) may exercise such discretion, but which are demonstrated through the findings from the interviews with care managers and the analysis of case records, as illustrated by the exemplars in the following discussion.

It is argued in this case study that the tasks originally envisaged as part of care management had been modified in practice within the Parkside locality offices. Enquirers could be screened out at the initial point of telephone contact by administrative staff, who were not trained or qualified in social work. Such encounters were not recorded, so there was no data available for the authority to monitor the impact

on enquirers. In the group interviews with staff in care managers, another example was given of telephone calls from service users being dealt with directly by administrative staff without referral on to care managers.

There was considerable variation in practices between the three locality teams. This exercise of discretion by both frontline staff and their team managers was seen in the analysis of written and electronic case records in Chapter 6. For example, West locality team operated almost solely on a duty system, rather than allocating to a single, named care manager. Charismatic managers were identified as being key drivers of local policy. For example, during informal discussions in the initial period of orientation to Parkside, a Manager from North locality informed me that the Senior Care Manager of West locality Assessment & Care Management team was known to colleagues as 'Mr Duty', as he set his stamp on the ways the team operated. No solid rationale was gleaned for this reliance on the system, and its favouring over allocation to longer-term named workers. It is not clear from the interview and case record data what impact, if any, this variation may have had on outcomes. This variation was seen by the Parkside senior management as inequitable for service users, and had been the impetus for commissioning the CASE studentship. Data from the case records in particular demonstrated that this continued to be an issue during the period of the study, with information missing differentially across the locality teams. The external consultancy company commissioned to undertake the audit that prompted industrial action near the end of the fieldwork period (Business Consultancy<sup>6</sup>, 1996) also identified the entrenched nature of these differences, as an external reinforcement of the thesis findings. In their one-day census, they also found that the proportion of cases

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<sup>6</sup> A pseudonym

allocated or managed on duty varied considerably across the teams, with West locality team holding a third of cases on duty compared to 10% in South locality team. The Business Consultancy report went on to query whether this reflected 'bombardment' rates, or historical factors. My analysis indicated that although bombardment rates were acknowledged to be high, they were high across all locality teams, and that distinct team cultures that had developed over time were recognised within the teams themselves as being key factors in the variation.

There was animated discussion between care managers in the group interviews about whether the new assessment forms helped or hindered them in their work. As forms were revamped, so information was added, but some that had previously been included was also lost. Despite the time spent by local authorities on changing assessment forms in pursuit of the perfect form, care managers in all of the locality teams brought the emphasis back to essential practitioner skills that could not be reduced to form filling. Caldock & Nolan (1994) reported that such focus on developing the tools, rather than the participative role of older people, had been a feature of assessment since the implementation of the NHSCCA 1990, which continued into the introduction of the Single Assessment Process (Abendstern *et al.*, 2008; Weinberg *et.al.*, 2003). This debate has continued to the present and extended beyond adult care, with recording processes criticised for their 'descriptive tyranny' (White, Hall & Peckover, 2009) and subjected to formal evaluation as part of a government commissioned review of child protection. In this review, Munro (2011) placed restrictive and rigid recording systems into a wider context of bureaucratic and prescriptive rules imposed on practitioners that can stifle professional judgement. Whatever the version of the tools used, whether forms were actually filled out or not was a point of great debate within Parkside from practitioners to senior managers. None of

the older people interviewed had received a care plan, and there was considerable variation in how far the ECIS grid was actually being used (See Table 6.4, Chapter 6), as the majority of files sampled in West and South localities did not contain the grids. The care managers' use of the ECIS system was fraught with suspicion and non-compliance, as demonstrated in the level of domains in the electronic records that had not been completed, discussed in Chapter 6. Since the fieldwork took place, supported self-assessment has become more prominent in policy, and is mandated in the Care and Support Statutory Guidance issued under the Care Act 2014 (DH, 2014). How practitioners apply policies in their practice has been the focus of research and discussion in the context of street-level bureaucracy and the exercise of professional discretion (Evans, 2010; Evans, 2013), discussed in Chapter 6. An additional example from an area of practice not examined in the case study (as legislation had only recently been introduced at the time of fieldwork) lies in the variable implementation of Direct Payments (WAG, 2007; Davey *et al.*, 2007; Ellis, 2008), whereby care managers applied their own filters of who they assessed as 'suitable' rather than 'eligible' for cash in lieu of services. In addition, as seen in Chapter 6, no carer that I interviewed had received a carer assessment; another example of the time-lag in implementation of legislation, and of care managers not necessarily conforming in their practice to the policy or legislative contexts of their employment. The senior managers in Parkside had made attempts to regularise these variances in practice across the locality teams, Indirectly, and unintentionally, I became part of this managerial concern with the commissioned research.

In conclusion, none of the CMO configurations from the three respective standpoints that have been discussed operate in isolation. They signify the separate components for data collection that were represented in the empirical design of the case study. However, as

indicated in Figure 7.3, these components, and hence their mechanisms, interact reciprocally and interlock as essential sub-systems within the overall provision of home care.

### **Continuities in policy and practice**

The thesis has located domiciliary care at the heart of the UK policy of ageing in place, diverting older people away from institutional and long-term care settings, as discussed in Chapter 2. The case study is acknowledged to be situated in a particular political and practice historical moment in the period following implementation of the NHSCCA 1990, with the implementation of care management as a universal system of provision of social care, focussing on assessment of need and commissioning services in the landscape of a mixed economy of care that was emerging at the time of fieldwork. Nevertheless, the thesis highlights continuities from the implementation of the NHSCCA 1990 (in 1993) to the present policy drive of personalisation, under the Care Act 2014 in England, and I argue that its lessons have resonance for current practice as well as future trends in social work practice with older people and care at home. The timescale has enabled more reflective commentary and linkage to continuities and discontinuities in policy and practice with the benefit of historical perspective, with implications for future directions of social care. The topic retains its relevance as the phenomenon of poor service delivery in home care within the mixed economy has been reproduced over time, and remains an apparently intractable problem, as evidenced by studies across the United Kingdom devolved nations over two decades (Godfrey *et al.*, 2000; Patient and Client Council of Northern Ireland, 2012; EHRC, 2011; Care Quality Commission, 2013; Older People's Commissioner Wales, 2012)) and internationally (Purkis, Ceci & Bjornsdóttir, 2011; Vabø, 2012; Rostgaard, 2012). Such studies agree that domiciliary care



provides crucial care for many older people, but some aspects are in desperate need of improvement. These include repeating issues of reliability and quality of care, and concerns about market instability and recruitment in a low pay employment environment, lack of training and skills among domiciliary care staff and lack of continuity of care. Whilst acknowledging the expressed value of home care to older people, these flaws in service manifested across studies as complaints about inconsistent, unreliable, task-driven, rushed and unskilled care are reiterated in the voices of older people in this thesis. Norman Lamb, Health Minister in the United Kingdom Cameron Coalition Government (2010-2015), warned in advance of a summit with care providers that home care could be the next scandal to erupt, citing low wages and a system that incentivises poor standards of care. This proved prophetic, as scandals have erupted over the practices of 'clipping', or shaving time from the allotted visits to the home because travel time between appointments has not been factored into the home carer timetables. Such practices, brought to light by whistleblowing to Corporate Watch (2015), also resulted in home care staff not being paid the minimum wage. In Wales, this has resulted in another review of the quality of home care by the regulatory body Care and Social Services Inspectorate Wales (CSSIW), commissioned to report in 2016 by Mark Drakeford, the Minister for Health in the Welsh Assembly. It remains to be seen whether the conclusions of this review will differ in any major respects from previous reviews highlighted earlier.

### **On the cusp of a (r)evolution?**

Chapter 2 considered the cultural shift in British organisation of social care produced by the NHSCCA 1990, not least in the role of care markets in sharing provision with directly-provided local authority services. This thesis has traced the impacts of mechanisms such as

the operation of quasi-markets, variability in social work practices and the individual responses of older people. In this, it demonstrated matches and mismatches between the 'programme theory' or aims of the implementation of the domiciliary care system as imagined by Parkside local authority and its, and its actual implementation in routine practice.

Home care suffers from chronic structural underfunding, driving eligibility criteria higher so that only those with highest levels of need are able to access publically-funded care. A notable difference in the climate of services from the period of my research is that domestic tasks are now rarely provided routinely. However, this may change with Personal Budgets or the increased use of Direct Payments as people have potentially increased flexibility to choose what is most important to them. Lymbery (2014) has critiqued the ways in which the rhetoric of individual choice and citizenship in personalisation may be distorted by restrictions on the ability to exercise that choice, particularly in a period of financial austerity. Indeed, Duffy, the architect of the Resource Allocation System (RAS) used in England issued an apology in 2012 for the negative consequences of the over-bureaucratisation of the system. Ironically, the United Kingdom is now at a tipping point in devolved social care policy, with the Welsh and Scottish Governments moving away from atomised consumer interpretations of the principles of personalisation, to a citizenship model of social care (WAG, 2011; Duffy, 2013). However, it remains to be seen what this approach delivers, as it is influenced by the same drivers of decreasing resources post-recession and demographic pressures as the rest of the UK.

The way in which good intentions can be distorted by the need to ration resources has been detailed in this thesis. This may also prefigure how personalisation will be operationalised in future. Older

people may be faced with a message of self-help when in greatest need (Ray & Phillips, 2012), in the name of greater self-determination of choice, when a major driver is one of conserving funds and placing responsibility back onto the individual for their care. Tanner (2009), writing in the period of Modernisation under the New Labour Government of Tony Blair, made a point that still applies, that it is improving the quality of life of older people that should be the central concern of SSDs, rather than the improvement of services as an end in itself. Lloyd *et al.* (2013) defend the continuing role of social work in identifying community networks and promoting active ageing with older people, in contrast to individualised (and potentially blaming) solutions. The organisation of social work teams has not changed significantly in adult care, up to the point of writing. The study thereby retains theoretical relevance for practice as the debates on outcomes, professional discretion versus curtailment, street level bureaucracy (Lymbery, 2000; Evans & Harris, 2004; Evans & Harris, 2006; Evans, 2010) and concerns about the de-professionalisation of work with older people are still current. However, it is clear that the care management model of working with adults in general is changing, as people who are supported by services, rather than professionals, are placed at the centre of the process, and the language of policy foregrounds well-being and individual outcomes. The original model of care management has come to the end of its life, branded an outmoded concept by the Welsh Government (WAG, 2011), in a policy paper that also rejects a consumer-led model of personalisation. This policy emphasis on citizenship emphasises community cohesion, and prefigures a different role for social work, the consequences of which remain to be seen.

## **The implications for domiciliary care provision in other settings**

Parkside is necessarily unique in many of its local contexts. Some of the organisational factors, such as the arrangement of locality teams, the political composition of the administration, the mix of provider agencies and its demographic characteristics were specific to Parkside. Yet Parkside, then and now, shared with other local authorities the difficulties of operating within the conjunction of care management and markets of care. The findings from this case study can generalise to other local authorities that continue to struggle with the quandaries of maintaining services that help older people in areas of need, that are of the quality and compatibility that they want, and which are affordable in a climate of financial restriction. The preceding discussion has proposed that different local contexts will affect the outcomes of domiciliary provision. Nevertheless, responses and interchanges between key groups have been identified from the Parkside experience that provide lessons for other settings. As a carer in the preliminary study said about the services provided at home to her mother:

There is no in-between. Either it's a success or a complete failure. When they are good, they are very good. When they are bad, they are horrid. (Mrs. Goodwood)

Like the little girl with the curl in Longfellow's poem, domiciliary care continues to show these antithetical characteristics, as discussed in Chapter 1. There appear to be fine margins in distinguishing a valued service that makes a significant difference to older peoples' lives (CQC, 2013) from one that threatens human rights (EHRC, 2011). So the question remains of where the crucial points lie in the chain of implementation that can make or break the service. In Parkside, interlocking mechanisms that relate to each of the triad of key agents can be identified as older people's responses to services that are in

turn influenced by their individual biographies and circumstances; the state of maturity and fragmentation of provider markets; and both team manager and front-line staff discretionary space resulting in different working practices in the different localities.

Overall, the older people interviewed acted as active agents, exercising choice in their acceptance, rejection or subversion of the services offered; this is further broken down into the acceptability of quality, reliability, appropriateness and compatibility. In turn, the interviews illustrated how this can be influenced by user characteristics of personal taste; class (for example, in the attitudes towards care staff demonstrated by those interviewed who were from wealthier backgrounds); having the power of exit through being able to manage without the services offered, or the financial ability to purchase alternatives (which was not demonstrated in the interviews). Whether these services were accepted uncritically, with reservations or not at all was in turn influenced by provider agency characteristics that included the personal qualities and reliability, availability, suitability and skills of individuals in the workforce available for recruitment. Agencies were also impacted by local authority commissioning practices, types of contract, and the level of fees that impacted on training and contracts. All provider managers were under pressure to remain solvent in a cut-throat market, where they were competing amongst each other for staff. The volatility in the market can be seen in the changes since the period of fieldwork, where the pattern of small, sometimes recently-constituted agencies has been replaced (at the time of writing) by two large, national, not-for profit providers, who are also involved in other areas of welfare and housing. The reason for such changes, particularly in the commissioning of not-for-profit providers has not been examined in this case study, however. As the manager of Premier Domestic noted, cleaning services were still being provided in Parkside, but the writing

was already on the wall for such provision as individual needs increased and budgets were reduced. Norton Employment and Carlton Nursing both formed alliances with statutory bodies, (the local authority and NHS respectively) to jointly access training as they did not have the resources to provide it themselves. The South DSO manager nevertheless pointed out that despite stipulated quality standards for training, casual staff did not find attending training a viable economic prospect, and chose instead to leave their employment and move elsewhere.

Older people's expectations of services were not necessarily linked to levels of need and could be pitched at a comparatively high level by some (for example, Mrs. Wieder, Mr Sergy, Mrs Bugno), with complaints about the quality of staff and work. These older people highlighted their own backgrounds of high levels of education and social status in their interview responses. However, others were more compliant, where low expectations were identified by care managers as a general trend among the older people they worked with, and which conforms to findings by others (Clough *et al.*, Bowers *et al.*, 2009; Blood, 2010). The sample of those older people interviewed reflected some of the diversity of the wider population within Parkside's boundaries in terms of the complexity of social identities and biographies that intersected with the primary categorisation used by the SSD; that of 'old age'.

Despite policy statements about providing choice, older people had to make do with what they were given, which appeared to be at odds with the range of providers. The rhetoric of 'consumers' at the start of community care did not match reality (Baldock & Ungerson, 1994; Lymbery 1998; Harris 2009); the choice to find services funded by another authority did not (and still does not) exist. Harris & White (2009) traced the movement from the administration of public

services (including social work) as an entity with distinct values to the management of social work within a neo-liberal business model that stretches back to Conservative Governments from 1979 under Margaret Thatcher, and which continued under the New Labour Government of Tony Blair. It is debatable how far the contemporary model of personalisation will reinforce the rhetoric of consumerism, as responsibility for the management of care falls back onto the individual, but within an economic context of reduced funding, and an uncertain and unregulated state of the novel market in personal assistants. The older people interviewed did not tend to ask for someone different to be their home carer (with the exception of Mrs. Herman, with disastrous results), though they might complain about the standard of care.

The research in Parkside was conducted during a period of optimal conditions for domiciliary care providers. The Conservative government of the time, and Parkside itself, actively encouraged the growth of a diversity of care markets. However, an ageing population with complex needs has continued to rise, with the projection of an increase of 17% from 2013 to 2025, representing an additional 1.5 million people over the age of 65 (Health and Social Care Information Centre, 2014). Although chronological age is certainly not an essentialist determinant of long-term need, the growth in the proportion of an ageing population At the same time, finances available to Social Services Departments continued to decline. The ADASS (2015) budget survey for 2015 reports on the impact of five years funding reductions that have totalled £4.6 billion (31% of net budgets). The report estimates that an additional £1.1 billion would be needed to provide the same level of service as in the previous year, taking growth in numbers of older and disabled people into account. Such cuts in finances have an impact on the fees that councils offer provider agencies in their contracts. In turn, 56% of social services

directors reported providers in financial difficulties, as well that as well as concerns about quality of care. Skills for Care (2015) analysis of the National Minimum Dataset for Social Care (NMDS-SC) highlights that whilst there is increased demand for social care staff the care sector also has high staff vacancy and turnover rates. The latest issue concerns the Living Wage, established under the UK Conservative Government under David Cameron at the time of writing, due to implement (from April 2016) a higher rate of pay than the previous minimum wage (Living Wage Foundation, 2015). Whilst a commitment to low-paid workers has been welcomed by the United Kingdom Home Care Association (UKHCA, 2015), this organisation has also warned against a potential crash in the domiciliary care market if home care remains underfunded and local authorities fees do not cover the additional costs of meeting the Living Wage, predicting a £753 million shortfall.

Commentators have discussed the importance of relationship-based practice in direct care work (Nolan *et al.*, 2008) and especially in dementia care, in the work of Brooker (2006) and Sheard (2007), the founder of Dementia Care Matters. The King's College Longitudinal Care Work Study (Social Care Workforce Unit, 2014) also discusses 'compassionate care', a term parallel for social care with the compassionate care in nursing advocated in the Francis Inquiry 2013 report in the wake of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013), and how the term 'compassionate' has its origins in moral panic, and may be used as a stick to beat staff with. The value of 'getting on with' the individual's home carer was reinforced, in part, by the older people's responses in Chapter 4. However, this cannot be assumed, as not all of the older people valued what would be seen as the essence of 'relationship-based care'. Such attributes of friendliness, informality and warmth, may indeed be highly valuable when carrying out the tasks of personal



care, notoriously undervalued, and which is reinforced in the CQC's characteristics of good care as being well led, responsive, caring, effective and safe. The home care agency chosen as an exemplar of an outstanding provider of home care services was chosen for its strong caring values of 'more than just a job' (CQC, 2015:17). However, some of the older people interviewed in Parkside equated their care workers as the equivalent to tradespeople with whom they would not wish to have more conversational contact. Some were more dismissive, seeing them as 'girls' or even servants, and were resistant to accepting care based on characteristics such as the ethnicity and perceived class of paid carers. A warm personality may not be enough, and may even be seen as intrusive. Perceived generational incompatibilities, such as those highlighted by Mrs Wieder ('They are sending me children'), and educational and cultural differences also need to be accounted for. For some, the home care relationship was transacted on a business level, not to be confused with the desire for a 'relationship'.

### **Strengths and limitations of the study**

Manzano-Santaella (2011), in her analysis of the operation of delayed hospital discharges, notes that programmes evolve inexorably from their original design. In other words, they do not stand still for evaluators or other researchers. This was certainly true of Parkside, which presented a moving target as policies and practices changed over the duration of the research, a feature of the messy realities of routine social care organisation and delivery. The case study approach that I adopted in response to what I encountered when first observing practice in Parkside has its strengths in providing a context-specific analysis in depth (Yin, 2013; Yin, 2014). However, this also can have limitations in terms of external validity and generalisability to other social phenomena. As a means of strengthening explanatory power,

Yin (2014) discusses the use of examining within-case configurations of interventions and outcomes, as employed by Byrne (2013) in his analysis of complex social interventions. This approach to complexity is also congruent with the emphasis on examining specific contexts, mechanisms and outcomes in realist analysis (Pawson, 2006; 2013). For example, a complexity-consistent approach within a realist framework has been employed by Westhorp (2012; 2013) in her small-scale evaluation of an Australian family support programme. Hammersley (2009), in a general theoretical critique of realism, and McEvoy & Richards (2003) in the context of a nursing evaluation, counsel against certainty in drawing conclusions about the best courses of action in developing practice. As the domiciliary care system in Parkside was constantly changing, characteristic of a multi-layered open system, findings do not lay claim to absolute predictive power to other social services contexts. Nevertheless, in investigating the persistent phenomenon of the reproduction of poor service delivery in home care, the thesis identifies not only what may be specific to Parkside, but also where there may be commonalities with other organisations providing domiciliary care services. The scope of the research was very wide ranging, and by examining Parkside from the perspectives of the three core stakeholders encouraged a breadth of analysis of how these perspectives interlock together. Inevitably, some important groups such as 'informal' carers lacked specific focus, although important findings regarding their lack of assessment did emerge. There was also a lack of systematic focus on safeguarding, although individual adverse events and risk factors were discussed and incorporated into the analysis. Nevertheless, the research design

The mixed methods approach enabled the collection of both qualitative and quantitative data derived from oral and written sources, and standardised measures. This multi-method approach

thereby provided triangulation of data, as discussed earlier. The standardised measures such as the Lambeth Disability Schedule that were used in the interviews with older people were grounded in the original PSSRU model (Challis & Davies, 1986; Davies & Challis, 1986) that enabled some baseline comparisons to be made. These provided a useful indicator of disparities between perceived and assessed needs (Bradshaw, 1972), and indicated the non-linearity of the relationship between matching needs and services that is at the heart of the care management model. The views expressed by care managers in the three group interviews could also be compared with the unobtrusive approach in analysing the contents of the case records, which was fruitful in uncovering disparities and gaps in written and electronic recordings. Although originally considered a strength, the case study's initial 'what works' paradigm, resulted in a structured framework of questions in the interview schedule, tailored for the collection of data that was also suitable for coding for further quantitative analysis. This data was illuminating in itself, and was a necessary correction to more insouciant attitudes to grounding practice in evidence. However, this structured approach lacked flexibility, and sometimes missed opportunities for encouraging richer narratives of how the services were experienced by older people.

An apparent initial limitation that later emerged as a strength was the length of time between the start and completion of the study. This conferred an (unexpected) historical perspective that emerged in retrospect, and enabled a view of historical continuities from the first wave of marketisation in the implementation of care management to contemporary developments in individualised personalisation within a devolved landscape of governance.

Contemporary research grant bids are now likely to ask for evidence of partnerships with the people who are the focus for research, including a reference group for example. If I were to undertake such a study now, I would be doing so within a more collaborative framework, both to frame and guide the initial direction, and also to check back with those people interviewed about the empirical data gathered. The involvement of stakeholders is one of the precepts of realist evaluation (Pawson & Tilley, 1997), as well as being a sound ethical principle of research. In this case study, I was involved with consultation with and feedback to employees, both practitioners and managers, as stakeholders within the local authority, through the expectation of feedback as part of the studentship. However, this was not formalised into a structure such as a consultation group.

My own professional background as a qualified social worker was central to my interest in researching the area of community care delivery, with particular reference to older people. As a local authority inspector of residential care homes for older people, I had witnessed the initial period of implementation of care management under the NHSCCA 1990, and the organisational confusion and staff turnover that ensued locally, as an unintended component of the cascade of organisational change identified at the point of implementation by the Audit Commission (1992). This privileged knowledge of a practitioner, coupled with access to records and facilities, eased by managers' and staff goodwill, was of benefit in that I was familiar with structures and terminology. However, it could also be seen as a disadvantage, in making shared assumptions about the specialist terminology (or jargon) used, and having a lack of necessary distance. This may result in not necessarily asking the 'naïve' but probing questions that a stranger to a social services organisation might employ. As discussed in Chapter 6, I travelled from 'emic' (insider) to 'etic' (outsider) in the perception of locality team members, as circumstances within Parkside

changed. This was not a comfortable position to be in, but it did prompt useful reflection on the assumptions both others and I had made about my role, which could also be applicable to any research undertaken by apparent 'insiders' within social services organisations in the future.

### **Contribution to Knowledge**

The thesis has presented a case study of local authority provision of domiciliary care with older people, applying a realist evaluation framework to the interlocking components. This has taken a whole system approach, acting within a wider policy and political context with the key triad of care manager, provider and service user at its core. The case study of Parkside's confirms research on what service users value in home care services, and reasons why they exit services. It also engages with the literature on the exercise of street-level bureaucracy, and the professional discretion wielded by social work practitioners and their practice-based middle managers. However, the research also challenges assumptions made about the intrinsic value of the personal relationships between home carers and their clients.

The thesis contributes methodologically and addresses a gap in realist evaluations of interventions in social work and social care by applying a realist epistemology to an area of practice interest, forging an alliance between empirical welfare service evaluation and interpretation of underlying generative mechanisms. Existing studies on community care with older people tend to focus on one particular group or aspect of structure and practices (discussed in Chapter 2). This thesis is distinctive in its realist evaluation applied to a case study, providing original data on the workings of one local authority in the course of the 'commonplace complexity' (Evans & Hardy, 2010:2)

of practice, and from the perspectives of multiple agents. By focussing on routine practice rather than special projects, this thesis addresses a gap in studies of the everyday realities of social workers, as noted by Ash (2013).

Stake's (2008) view of case study research is that of cumulative empirical insight into how a particular system operates. On the other hand, realist evaluation claims an explanatory focus (Pawson & Manzano-Santaella, 2012), not only addressing issues of how a system under scrutiny operates, but why. This thesis brings together the realist analysis and case study method into an open, complex system (Emmel, 2013). The research design has been mixed-method, employing both qualitative and quantitative methods. These have complemented each other, for example in the quantification of standardised measures of self-reported needs that combined with in-depth interview responses, and the content analysis of case files triangulating care manager interview data. In the latter example, the case file recording in Parkside reinforced the findings of Parry-Jones and Soulsby (2001) on the difficulties care managers may have in distinguishing between needs-led and service-led assessments and records, and Olaison (2010) in highlighting the functional focus on physical and health determinants for the provision of services. These insights may not have been so apparent from interview data alone. Such cross-verification and contrasting from multiple sources has thus contributed to building up a layered view of the different factors at play in Parkside's operationalisation of domiciliary care and other services.

Maxwell (2012) argues that realism applied to qualitative research re-legitimises ontological questions about the phenomena being studied; meaning and culture are 'real', rather than abstractions. In other words, in relation to the interviews conducted with older people, care

managers and provider managers, their standpoints, experiences and choices are essential to causal explanations. The insights generated from this thesis may therefore be extrapolated to current and changing paradigms of care in the context of personalisation and cash for care systems; how care may be provided and co-produced both within and outside the home, how these new kinds of provision may be assessed for, delivered and received. Beyond the practice area of care with older people, the thesis also generalises to ways in which front line practitioners in general may adapt their practices in the face of uncertainty and resource management. Quality issues in externally provided 'traditional' models of domiciliary care remain contemporary. Even within personalisation, such care markets will continue to form a significant component of the repertoire of care and meet a demand in current practice.

In its long view of policy and practice in social care with older people this thesis looks both to the past and to the future in terms of policy and practice. It therefore contextualises current debates on user-directed support, the marketisation and fragmentation of welfare, and the role of social work in a period of austerity as eligibility criteria rise and managerial resource panels prioritise the highest dependency levels.

### **Indicators for future research**

A significant aspect of practice that remains unexamined in the thesis is a study of the micro interactions between the home care staff and their clients. Richards (1994) carried out an early ethnographic study of the assessment interface between care managers and older people, by direct observation of the interactions. Other ethnographic researchers have adopted the worker role to conduct participant observations. At the time of fieldwork, there was a body of work on

the anthropology of social welfare organisations (Wright, 1994; Lewis & Glennester, 1996; Russell & Edgar, 1998), and the social exchanges that take place within smaller scale interactions between service users and providers (Warren, 1998), although this ethnographic approach later petered out in the area of social care. As it stands, the Parkside case study only indirectly approaches the situation of the paid home carers themselves, filtered through the lens of their older users of services, their employers, or, more remotely still, the commissioners of their service. The very issues raised as complaints by older people about time constraints for this group of staff militated against interviewing them directly. However, these under-observed home care interactions would be a prime topic for further research, for example in more ethnographically oriented studies of directly-provided home care services.

As indicated in the previous section, the current policy climate of personalisation in England and citizenship in Wales opens up a new field for further research about the negotiations that take place in the operation of Personal Assistants (PAs). Further research in this rapidly developing area of practice is important, as the employment of Personal Assistants remains an arguably under-regulated field. There would need to be careful consideration of ethical aspects of such research with older people and the staff or PAs concerned, but further studies could produce insights into working practices in individualised relationships that may occur away from the gaze of more public scrutiny. Such examination of micro-interactions is just one piece of the jigsaw, however, as has been demonstrated in this thesis. Whole-system studies are also required to evaluate and make sense of the layered nature of complex systems. Clearly, I also favour further evaluations within the realist framework in order to do this. There is a developing acceptance that realist approaches have a place in social work (Houston, 2010). There remains plentiful scope for expanding



this approach into the empirical examination of the diverse scope of social work. In turn, such studies can help to elucidate and develop the theory of realistic evaluation as applied to health and social care. This is a growing area of interest, but still a relatively recent one in social work and social care, in which debates about terminology and design, and what may conform to different interpretations of realist evaluation persist. For example, Marchal *et al.*'s (2012) review of realist studies in health contexts reveals a range of interpretations in the application of realism. Pawson & Manzano-Santaella (2012) apply a 'realist diagnosis' to published studies, finding many of them wanting. There is a danger that these debates can assume an almost theological aspect. A counterbalance may be forthcoming, however, as Greenhalgh *et al.* (2015) are developing at the time of writing protocols for guidance and reporting of realist evaluations.

As personalisation becomes embedded in social work and social care practice through recent legislation in England and Wales, care management has reached the end of its operational existence. Personalisation and cash for care systems promise (at their best) flexibility and variety of care provision that were seen to be lacking at times in the care-managed services in Parkside. A return to an emphasis on social worker knowledge of community networks, rather than reliance on care markets, echoes the recommendations of the Barclay Report (Barclay, 1982); a fact that has not gone unnoticed by contributors to the Centre for Welfare Reform (Rhodes & Broad, 2011), an organisation at the heart of the contemporary philosophy of personalisation. What the future may hold for professional social workers and how their roles may be transformed should provide opportunities for further research and evaluation of how the personalisation agenda translates into the complex world of routine services. This may then be compared with preceding histories of how

front-line staff and their managers implement policies in their practice, in order to inform the facilitation of flexible person-focussed care with the range of people who may seek support.

## **Conclusion**

This thesis has provided a case study of a complex system for the provision of domiciliary care, with the interactions between the three key groups of older people, care managers and provider agencies analysed within a realist framework. The research net was cast wide to encompass these different perspectives, covering organisational issues, theories of ageing and welfare, and the changing face of social work policy and practice. Other work in this area has tended to concentrate on one aspect of care management; this research brings together key components of an interlocking system centred on the older person, where different agents respond to sometimes concordant, sometimes competing interests and pressures. The thesis began in the aftermath of one major upheaval in the delivery of social care through care management, and is finalised in the wake of another, in the form of personalisation. The operation of the mixed economy of care, the diversity of responses from older people themselves, and the exercise of professional discretion by social workers (in whatever role they may fulfil in future models of social services provision) are likely to persist in their importance in both facilitating and frustrating the pursuit of good quality care.

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## **Appendix 1: Initial Information Sheet for Interviews with Older People**

### **What is the purpose of this survey?**

I am asking people like yourself who use Parkside Social Services' Community Care about their views on the services they are getting. The aim is to look at how these services are working for older people and their carers.

### **How have I been chosen?**

I am approaching people who have recently contacted Social Services staff to arrange services like home care, etc.

### **Who is carrying out the research?**

My name is Michele Raithby. I am an independent researcher based at Royal Holloway College, part of the University of London. I do not work for Parkside Social Services.

### **How will my views help?**

Your views on the services that Parkside provides will be very valuable in showing how Community Care is working locally. With this information, Parkside will be better able to make their services suit the needs of people.

### **What kind of questions will I be asked?**

If you agree to be interviewed, I would like to talk to you to get a better understanding of your current living circumstances, and what help you may be getting from Parkside or other sources.

### **Will the interview be confidential?**

Yes. The interview is completely confidential. No member of social services or health services will have access to your answers. Your name will not appear on any written documents.

**Where and when will the interview take place?**

The interview can take place at a time and place that suits you, including in your own home.

## Appendix 2: Participant Consent Form

**Title of Research:** Community Care Survey

### **Contact Details of Researcher:**

Michele Raithby, Royal Holloway College (Parkside office telephone number)

**Please initial  
box**

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

3. I agree to take part in the above study.

---

Name of Participant

---

Date

Signature

## **Appendix 3 : Older Person Interview**

### **CONTENTS**

- **Section 1: Interview information**
- **Section 2: Interview introduction**
- **Section 3: Screening**
- **Section 4: Demographic Information**
- **Section 5: Health & Well-Being**
- **Section 6: Assessment**
- **Section 7: Charges**
- **Section 8: Services**
- **Section 9: Aids and Adaptations**
- **Section 10: Help from Main Carer**
- **Section 11: Other Needs**
- **Section 12: Permission to Contact Carer/Proxy**
- **Section 13: Interviewer's Comments**

**THIS INFORMATION IS CONFIDENTIAL**

## USER INTERVIEW

### SECTION 1: INTERVIEW INFORMATION

(Including information from records and staff)

1. Case Number

2. Date of interview.

3. Gender.	Male	1
	Female	2

4. Date of birth  
Current age

5. Is a carer named? (From records)

5a Carer's name (if applicable)

5b Carer's address (if applicable)

6. Location of interview:	Older person's home	1
	Carer's home	2
	Residential home	3
	Nursing Home	4
	Hospital: North	5
	South	6
	Other hospital	7
	Other (specify)	8

7. Time of interview: Start; Finish.

8. Present at interview:

9. Older person currently resident at:	Home	1
--	------	---

Hospital	2
Residential Home	3
Nursing Home	4
Carer's Home	5
Other	6

10. Current address:

11. Home address if different:

12. If not at home, date of admission/ entry.

13. If not at home, are these arrangements temporary?	Yes	1
	No	2
	N/A	3

14. Name and address of GP

15. Services received (from records);

Service	Details (times, frequency, days)	
	Yes	No
a Home Care (Parkside)	1	2
b Home Care (Independent)	1	2
c Putting to Bed	1	2
d Sitting	1	2
e MoW	1	2
f Day Care	1	2
g Relief	1	2
h Handyperson	1	2
i Bathing	1	2
j Nursing	1	2
k Other (specify)	1	2

16. Is there an assigned worker?	Yes	1
	No	2

Is case open?	Yes	1
	No	2

Is case held on duty?	Yes	1
	No	2

17. Name of care manager/ assigned worker/assessor

18. Locality/team.	West	1
	South	2
	North	3
	Hospital North	4
	Hospital South	5
	Hospital West	6
	Other	7

19. Date of first referral.

20. Date of assessment.

21. Level of assessment.

22. ECIS number

23. ECIS Assessment Grid level/score

24. Date of last visit by social worker/care manager

25. Other relevant information

(significant impairments/ ability to sign name/ communication difficulties/  
approach to carer first/ translator or interpreter required)

26. If translator required, note arrangements to be made.



## **SECTION 2. INTERVIEW INTRODUCTION**

Thank you for agreeing to this interview.

I am here today to find out about the services and help people like yourself may get from Parkside Social Services, and your views about those services.

I am located at the University of London (Royal Holloway College) **Show ID.**

I do not work for Parkside, and being interviewed does not affect the services you receive. Any information you give is confidential.

(Check received information sheet.) **Show information sheet.**

Do you have any questions so far?

I ask the same questions to everyone, so some may not apply to you. The interview takes about one to one and a half hours. Please ask any questions.

If you do not want to answer a particular question, you do not have to.

I will take notes as we speak. I would also like to tape record the interview, to jog my memory. You can have the tape recorder switched off at any time.

### **Agree to interview?**

Would you mind signing this form to say you agree. (check with staff/ carer that can write name). If you agree, but cannot sign, I will note verbal consent.

I am going to begin with some basic questions about yourself. I will then go on to ask about your contact with Social Services.....

### **SECTION 3: SCREENING**

Some people have difficulty in answering some questions so I'd like to begin by asking a few simple questions which have been designed to ensure that I don't put too much strain on you.

I would just like to check some basic information.

(MENTAL STATUS QUESTIONNAIRE)

1. What is your address/name of this place?
2. What is today's date? (error of 3 days either side of correct date allowed)
3. What month is it?
4. What year is it?
5. What age are you?
6. What is your year of birth?
7. What is your month of birth?
8. What is the Prime Minister's name?
9. What is the name of the previous Prime Minister?

#### **SECTION 4: DEMOGRAPHIC INFORMATION**

I would now like to ask you for a few more details about yourself, so that I know about the backgrounds of the different people I interview.

Could you tell me if you are married, single, etc?

Married/cohabiting	1
Single	2
Widow/er	3
Separated/divorced	4

Do you have any children? (If so, how many?)

None	1
------	---

(enter number)

Do you live here with anyone else? (If so, who?)

(NB. Live with means common housekeeping; share at least one meal a day/ share common living room)

Alone	1
Spouse/partner	2
Son	3
Daughter	4
Sibling	5
Grandchild	6
Other relative	7
Other non-relative	8

How many(if code 2-8)?

Which group would you say you belonged to? (How would you describe yourself?)

White	1
Black-Caribbean	2
Black-African	3
Black-other (describe)	4
Indian	5
Pakistani	6

Bangladeshi	7
Chinese	8
Other(describe)	9

(If appropriate) What is your first language?

When did you last do any paid work? Year

What was the job called?

Were you a	Manager	1
	Supervisor	2
	Employee	3
	Self-employed	4
	Other	5

Did you work full time (more than 30 hours a week) or part-time?

Full-time	1
Part-time	2

(If has or had a partner)

When did s/he last do any paid work? Year

What was the job called?

Was s/he a	Manager	1
	Supervisor	2
	Employee	3
	Self-employed	4
	Other	5

Did s/he work full time (more than 30 hours a week) or part-time?

Full-time	1
Part-time	2

## Home & its Amenities

I would now like to ask you some questions about where you live and the facilities you have. (Don't ask if have seen some of the amenities)

(If living with someone else); How long have you and X lived in the same household?

Years

Months

How long have you lived here?

Years

months

(Note type of accommodation and check type if necessary)

Would you describe where you live as a	Whole house	1
	Self contained flat	2
	Room in house	3
	Other	4

Is it sheltered housing?	Yes	1
	No	2

Do you rent or own your home?	Owner occupied	1
	Privately rented	2
	Council	3
	Housing Association	4
	Living in other's home	5
	Other	6

Have you had any alterations to the house to help you?	Yes	1
	No	2

If so, what?

Who arranged/paid for this?

Have you applied for alterations but been turned down/ still waiting?	Yes	1
--	-----	---

	Waiting	2
	Refused	3
	No	4
Are there any alterations you would like done?	Yes	1
	No	2
If yes, how would this help?		
Do you like living here?	Yes	1
	No	2
	Mixed	3
Are there any difficulties about your housing?	Yes	1
	No	2
	Mixed	3
Have you wanted to move to different housing?	Yes	1
	No	2
	Mixed	3

## **SECTION 5: HEALTH & WELL-BEING**

I am now going to ask you a few questions about your physical health and how you are feeling in yourself. The next few questions are about your physical health. You can fill in the form yourself if you would like.

### **Lambeth Disability Schedule**

Please answer each question by ticking either the 'yes' or 'no' box.

### **Because of illness, accident or anything related to your health, do you have...**

YES NO

1. Difficulty walking without help?
2. Difficulty getting outside the house without help?
3. Difficulty crossing the road without help?
4. Difficulty travelling on a bus or train without help?
5. Difficulty getting in or out of bed or a chair without help?
6. Difficulty dressing or undressing without help?
7. Difficulty kneeling or bending without help?
8. Difficulty going up or down stairs without help?
9. Difficulty having a bath or all over wash without help?
10. Difficulty holding or gripping (e.g. a comb or pen) without help?
11. Difficulty getting to and using the toilet without help?
12. Difficulty eating or drinking without help?

### **Because of your health, do you have....**

13. Difficulty seeing newspaper print even with glasses?
14. Difficulty recognising people across the road even with glasses?
15. Difficulty in hearing a conversation even with a hearing aid?
16. Difficulty speaking?

### **Because of your health, do you have....**

17. Difficulty preparing or cooking a hot meal without help?
18. Difficulty doing housework without help?
19. Difficulty visiting family or friends without help?
20. Difficulty doing any of your hobbies or spare time activities?

**Thank you for your  
help.**

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and 1983: 296-304. Reproduced with permission of the BMA Publishing  
Group.]



The next questions are about your health in general.

Would you say your health is better, worse or about right compared to other people your age?

Better	1
About right	2
Worse	3

Do you currently or have you in the past 12 months suffered from any other health problems?

Yes	1
No	2

(If yes) can you tell me about the health problems you have had in the past year?

Have you needed to see your doctor in the past year?  
(How many times?)

Have you needed to go into hospital in the past year?  
(How long for?)

Have you had any serious accidents or injuries in the past 3 months, such as a fall at home or a road accident?

Yes	1
No	2

Is there any area of life that is still particularly difficult?

How long during the day do you feel you can be left without help?

## **SECTION 6: ASSESSMENT**

### **6a: KNOWLEDGE OF SERVICES**

Now we have finished with those questions, I am going to ask you about your knowledge of social services, and about any previous contact.

First, let me check when you last had contact with a social worker/care manager (Date)

How did you hear that social services might be able to help?

Friend	1
Newspaper	2
Leaflet	3
Public meeting	4
Other	5

Had you contacted social services before?	Yes	1
	No	2

What about?

What happened?

Have you been to any public meetings organised by Social Services?

Or seen any leaflets?

Do you belong to any other club or community group?  
(Have you had any information from them?)

What other ways of giving you information would have helped?

## **6b: ASSESSMENT**

I would now like to ask you about the time when (S/W name ) got in contact with you recently because of your (incidents/history). Although I obtained your name from social services records, I will not speak to them about things you say.

We know from X (staff or carer) that social services were contacted in (month). Did **you** or **someone else contact** them? (Prompt; this would have happened a few weeks ago)

user	1
someone else	2

(If user) Who **first suggested** that you should contact social services?

Own idea	1
someone else (specify)	2

Were they doing it with your **knowledge/consent**?

Yes	1
No	2

Can you tell me why social services were contacted?

How did social services get in touch with you first?	Telephone	1
	Letter	2
	Visit	3

How many times have you been contacted since then?

How?

Have you been <b>visited at home</b> ?	Yes	1
	No	2

Did X **let you know** they were coming to see you? **How?**

Yes 1

No 2

How long did you **wait** before being contacted?

Did **anyone else** come with X?

Yes 1

No 2

If yes, who?

What sort of things did s/he ask you about?

Did you **know what they were there for?** Yes 1

No 2

Unclear 3

Was there **anyone else present** at this meeting/visit?

Friend 1

Carer 2

Other 3

Did you want them to be there? Yes 1

No 2

Neutral 3

Did you **know what services** were available? Yes 1

No 2

Unsure 3

(If yes) **How?**

### **Aims**

What did you want social services to do?

Were you **able to say** what was on your mind? Yes 1

No 2

	Mixed	3
Was there anything you did not feel able to say?	Yes	1
	No	2

If yes, why?

Did s/he say they would arrange anything for you?	Yes	1
	No	2

(If yes) What?

(If no) Why not?

Was <b>risk</b> discussed?	Yes	1
	No	2

How long did you **wait** before any services start? (check with records)

Were you receiving anything before?

What?

For how long?

Have you seen X since the assessment?

Was s/w interested in **what you could do** as well as what you could not do?

Yes	1
No	2

How far did it feel as though **you had a say** in the plans being made?

(if translator used or from ethnic minority) Did s/w take into account any special cultural or language needs you have?

Yes	1
No	2

(if no)How would you have liked your needs to have been taken into account?

Did s/w take into account any problems you may have in communicating, such as hearing difficulties, speech difficulties, or difficulties in reading written information?

Yes	1
No	2

(If no), How would you have liked your needs to have been taken into account?

Were there any **specific services** you wanted s/w or social services to provide or to **give you more of?**

What were the reasons you did not get any of these services?

Looking back over the assessment as a whole, were there any **differences of view** between you and s/w over what your difficulties and the sort of help you needed?

Yes	1
no	2

(If yes) What were those difficulties about?

How were these differences sorted out?

Have you <b>refused</b> any services?	Yes	1
	No	2

If yes, why?

Have you been given any services you did not want?	Yes	1
	No	2

Were you referred to <b>any other agency</b>	Yes	1
	No	2

(State agency)

**Information**

Thinking of around the time when social services contacted you because of the problem/s I have just mentioned, were you given any written information by them about what they could help you with and how?

Yes	1
No	2

Were you given a Care Plan (explain)	Yes	1
	No	2

Did you sign anything?	Yes	1
	No	2

Who was it agreed with?

Do you have a copy? Can I see it?

(If started) What **difference** have the services from Parkside made to you so far?

(Is life better/worse/same)

What did you **like**/find useful?

Is there anything you would have liked to have had **done differently**?

Are there any other comments you would like to make?

**SECTION 7: CHARGES**

Were any charges for services discussed with you?	Yes	1
	No	2

If so, how much are you (will you be) charged for the services?

Amount

D/K

Did you know that you might be asked to pay before you were in contact with PARKSIDE?

Yes	1
No	2

How were you told?

In person	1
Letter	2
Telephone	3
Other	4

Were you given any written information about charges and how you might pay?

Yes	1
No	2

What do you think about paying for any services?

(Has it put you off accepting or applying for anything? Would you have acted any differently if the services were free?)

Do you receive any help that has not been organised by Parkside?

(What? How long for? Why?)



## **SECTION 8: SERVICES**

### **Formal helpers**

Now that I know a little about the services you are getting now, I would like to go through them in more detail with you.

Who do you usually receive help at home or elsewhere from? (Prompt)

Home helps from social services	1
Private home helps- paid for by you or your family/friends	2
Helpers from voluntary organisations	3
Volunteer helpers from places of worship	4
Social workers/care managers	5
A technical worker for blind/deaf people	6
OT	7
Someone to sit with you during the day	8
“ “ “ the night	9
A warden (of sheltered housing or ‘street’ scheme)	10
Nurses (not hospital nurses)	11
Meals delivered to your home (either hot or cooked/chilled)	12
Day care centres, resource centres, lunch clubs or drop-in centres	13
Day hospital	14
Laundry service	15
(where applicable) continence service	16
Other (specify)	17

I’ll now ask you a little about each of the services in turn.



Sitting service	7
Other	8

Is this what you wanted to be done?

Yes	1
No-too much	2
No-too little	3
No-tasks unwanted	4

For how long does your worker usually stay each visit, every time they come to see you?

Is this enough time for work to be done properly?

Are the jobs done well?

Do these times suit you?

Yes
No

Is it what you expected?

Yes	1
No	2

**Regularity**

Do you have a regular person? (What is their name?)

Yes	1
No	2

Has anyone else come since the service started?

If someone else comes, is it a relief worker you know?

If there are any changes in arrangement, are you told in advance?  
(How/how much notice/ever not turned up)

Have you been left without help for more than a day?      Yes

No

### **Punctuality**

Have there been times when the worker has been late?  
(How long for?)

### **Relationship with worker**

Is the worker polite? Respectful? Or ever rude? Friendly?

Do you look forward to them coming?

Do they ever do extra tasks?

### **Choice**

Does the worker let you decide what you want?	Yes	1
	No	2
	Sometimes	3

How much choice do you have in what is done?	A lot	1
	Some	2
	A little	3
	None	4

### **Privacy**

Are you given enough privacy for more personal things (e.g. going to the toilet)?

### **Independence**

Do services help you be more independent or less (help you live the way you prefer)?

More	1
About the same	2
Less	3

Does your worker do things you could do for yourself?  
(Do you do things for yourself?)

Is the current level of help more or less compared with 3 months ago?

more-was not helped before	1
more-was helped before	2
same	3
less	4

### **Impact**

What difference has having the service made to your life?

None, life same	1
Some, life better	2
A lot, life much better	3
Some, life worse	4
Some, life mixed	5
A lot, life worse	6
D/K	8
N/A	9

Have the services helped you stay at home ?

Is there anything you like about their visit?	Yes	1
	No	2
	D/K	8
	N/A	9

Is there anything you dislike?

(Have there been any problems)

Yes	1
No	2
D/K	8
N/A	9

What would life be like without the service?

Is there anything you would like done differently?	Yes	1
	No	2

D/K	8
N/A	9

**Contact with the office**

Do you know who to call in an emergency?	Yes	1
	No	2

Have you had to do this? (Example)	Yes	1
	No	2
	D/K	8
	N/A	9

Do you know about how to make a complaint?	Yes	1
	No	2

Have you done so? (Example)	Yes	1
	No	2
	D/K	8
	N/A	9

**Information**

Did anyone discuss the service with you beforehand?	Yes	1
	No	2
	D/K	3

Were you given a booklet or leaflet about the service?	Yes	1
	No	2
	D/K	3

Do the staff leave anything in writing? (Day book, etc)	Yes	1
	No	2
	D/K	8
	N/A	9

**Payment**

Can I check who pays for the service?		
	Joint household	1

User only	2
Carer only	3
Other	4
D/K	5
N/A	6

Do you have anything else you would like to say about the service?





(How/how much notice/ever not turned up)

What do they do when they visit?

(What is a typical day)

Housework	1
Laundry/ironing	2
Preparing meals/snacks	3
Shopping	4
Personal care	5
Social care (chat etc)	6
Sitting service	7
Other	8

Is this what you wanted to be done?	Yes	1
	No-too much	2
	No-too little	3
	No-tasks unwanted	4

Is it what you expected?	Yes	1
	No	2

Did anyone discuss the service with you beforehand?	Yes	1
	No	2
	D/K	3

Were you given a booklet or leaflet about the service?	Yes	1
	No	2
	D/K	3

Does the worker let you decide what you want?	Yes	1
	No	2
	Sometimes	3

How much choice do you have in what is done?	A lot	1
	Some	2

A little	3
None	4

For how long does the x usually stay each visit, that is every time they come to see you?  
 under 5 mins.  
 (code in 15 minute periods)

Is the current level of help more or less compared with 3 months ago?

more-was not helped before	1
more-was helped before	2
same	3
less	4

Do services help you be more independent or less (help you live the way you prefer)?

More	1
About the same	2
Less	3

What difference has having the service made to your life?

None, life same	1
Some, life better	2
A lot, life much better	3
Some, life worse	4
Some, life mixed	5
A lot, life worse	6
D/K	8
N/A	9

Is there anything you like about their visit?

Yes	1
No	2
D/K	8
N/A	9

Is there anything you dislike?	Yes	1
	No	2
	D/K	8
	N/A	9
Is there anything you would like done differently?	Yes	1
	No	2
	D/K	8
	N/A	9
Do you know who to call in an emergency?	Yes	1
	No	2
Have you had to do this? (Example)	Yes	1
	No	2
	D/K	8
	N/A	9
Do you know about how to make a complaint?	Yes	1
	No	2
Have you done so? (Example)	Yes	1
	No	2
	D/K	8
	N/A	9
Do the staff leave anything in writing? (Day book, etc)	Yes	1
	No	2
	D/K	8
	N/A	9
Can I check who pays for the service?	Joint household	1
	User only	2
	Carer only	3

Other	4
D/K	5
N/A	6

Do you have anything else you would like to say about the service?



If there are any changes in arrangement, are you told in advance?  
(How/how much notice/ever not turned up)

Is it what you expected?	Yes	1
	No	2

Did anyone discuss the service with you beforehand?	Yes	1
	No	2
	D/K	3

Were you given a booklet or leaflet about the service?	Yes	1
	No	2
	D/K	3

Is the current level of help more or less compared with 3 months ago?

more-was not helped before	1
more-was helped before	2
same	3
less	4

Do services help you be more independent or less (help you live the way you prefer)?

More	1
About the same	2
Less	3

What difference has having the service made to your life?

None, life same	1
Some, life better	2
A lot, life much better	3
Some, life worse	4
Some, life mixed	5
A lot, life worse	6
D/K	8
N/A	9

What do you think of the meals? (Are they what you wanted? Do you usually eat them?)

positive	1
negative	2
mixed	3
D/K	8

Do you have a choice of meals?  
(How)

Have they been reliable?	Yes	1
	No	2

Have you needed to contact someone if they have not arrived?	Yes	1
	No	2

Who?  
Example.

Can I check who pays for the service?

Joint household	1
User only	2
Carer only	3
Other	4
D/K	5
N/A	6

Do you have anything else you would like to say about the service?

What would life be like without the service?

## **8d DAY CARE**

You have said that you go to (day care centre/s; resource centre/s; lunch clubs; drop in centres; venue).

What is/are the name of each establishment you attend?

What are the days and times you attend during the week ?

	Breakfast	AM	Lunch	PM	Tea	Evening	Bed	Night	N/A
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

What help do you receive? (prompt)

medical/nursing help	1
physio	2
OT	3
washing/bathing/showering	4
foot care	5
meal	6
laundry	7
advice on finances/housing	8
advice on keeping warm/eating well	9
personal advice	10
social activities and leisure	11
companionship	12
other	13

How long have you been attending at the current level?

under 4 weeks	1
4-12 weeks	2



longer than 12 weeks	3
more than a year	4

How do you get to these establishments?

Walk	1
public transport	2
own/private car	3
ambulance/transport from SSD	4
other	5

Has it been reliable?

Yes	1
No	2

Is there anything you like about the day centre?

Is there anything you dislike about the day centre?

Can I check who pays for the service?

Joint household	1
User only	2
Carer only	3
Other	4
D/K	5
N/A	6

Do you have anything else you would like to say about the service

What would life be like without the service?

## **8e RELIEF CARE**

You have said that you have spent some time at (venue)/ received care in the home.

When was the last time?

How many times have you been/ received care?

Do you have any other relief periods planned?

(If in residential) can you tell me the sorts of things you do there?

Is there anything you like?

Is there anything you dislike?

What would life be like without the service?

## **8f OTHER SERVICES**

Is there any other help you would like to tell me about?

What happens when ...comes to see you? (you go to this place)

Who pays for this help?

(prompt for services)

### **Day Hospital;**

Do you attend a day hospital at least once a week?

yes

no

How many days do you attend during the week?

How many days do you attend at the weekend?

How often do you attend a day hospital?

For how long do you normally attend the day hospital?

Do you or your family pay to attend the day hospital?

yes

no

How do you get to the day hospital?

Like/dislike

What would life be like without the service?

### **Laundry**

Do you receive any help with your laundry?

How often do you get help from social services with your laundry?

Do you or your family pay for this service?

yes

no

### **Continence Service**

Do you receive help from a continence service at home/ at a surgery/health centre or elsewhere?

at home

surgery/health centre

elsewhere

(if so) How does the continence service help you?

give advice

provide fresh equipment

provide special underwear

talk through personal problems

other

How often do you get this help?

Is the current level of help more or less compared with 3 months ago?

Do you or family pay for the service?

yes

no

What would life be like without the service?

### **Emergency Help**

Sometimes in an emergency people get help for a short while. Is there any special help you have received in the past few weeks which you are not getting now. This might include help from social services , health services or family or friends.

Yes	1
No	2

(If yes), what help was that?

- help from nurses
- help from physio/OT
- help from social workers
- stay in res or nursing home
- home help
- meals delivered to your home
- main carer/other carer moved in
- respondent moved in with main carer/other carer
- high level of help from main carer/other carer
- other

## **SECTION 9:AIDS AND ADAPTATIONS/EQUIPMENT**

Have you been supplied with any of the following pieces of equipment or adaptations?

(If yes) Who supplied this equipment?

Did anyone come to visit you/give advice?

Is it what you asked for?

How long did you wait for it to be supplied?

How has it helped you?

Are you still waiting for anything?

Have you or your family paid PARKSIDE for any of these items?

Have you bought any yourself?

## **SECTION 10: HELP GIVEN BY MAIN CARER**

I would now like to ask you about help you may be getting from others. First of all can I ask you if there are any family members and friends who help you.

Is there a family member or friend who does a lot for you, seeing you at least once a week?

What is the name of this person?

Can I just check what relationship this carer is to you?

(If not living in same household) How far away do they live?

I now want to ask you about how (x) helps you now

Over the course of a week, what does x do for you? (prompt; personal care, housework, meals, shopping, jobs about house, helping with bills, company, making sure everything OK)

do they do any of the following?

medical & toileting

personal care

housework

meals

shopping

company & leisure

help with administration

other

How often do they do these things (per week)

Does the help you receive from x cause you or them any problem?

yes-causes user problems	1
yes-causes carer problems	2
no	3

(If yes to user problems) In what way?

(If yes to x) In what way does the help you receive from x cause them problems?

**Other helpers**

Are you currently getting any help from any other family members or friends?

Yes	1
No	2

(if yes), how often do you see any of these people?

(if yes) who are/were they?

(Code as above)

Which if any of these people live with you?

What do these people do for you?

For how long in total per week do these people help you with practical things, like washing, bathing, helping you get in/out of bed, getting dressed, running errands, and so on?

For how long have these people been providing this level of help?

(if under 4 weeks) Is the current level of help more or less compared with before this time?

Does the help you receive from these people cause you any problems?

In what way does the help you receive cause you problems?



In what way does the help you receive from these people cause them problems?

## **SECTION 11: OTHER NEEDS**

Thinking of your current situation I would like to ask you some questions about how happy you are about the way things are now, and any additional help you may need

How happy are you with your personal care- I mean keeping as clean and tidy as you would like.

Is there anything you'd like done differently?

Do you need help, or more help with your personal care

In general, how happy are you with your ability to get out of bed?

Would you like help or more help in getting up in the morning?

Do you feel you are eating as well as you should?

yes all/most of the time

only sometimes

hardly ever

Do you need help, or more help to make sure you are eating enough?

How satisfied are you with the cleanliness and tidiness of where you live?

Do you need help or more help to keep your home/room clean and tidy?

How satisfied are you with the way your money is managed, things like paying bills and making sure you have enough money to live on?

Do you need help or more help with managing your money?

How happy are you with your safety indoors, e.g. if you fell, are you satisfied that you would be found soon enough?

Do you need help or more help to make you feel safe should an accident happen?

How happy are you with your chances to meet people and socialise?

Do you need help or more help to enable you to meet more people?

How happy are you with the chance you have to talk to people about personal or confidential things?

Overall, how happy are you with your ability to live at home in the way that you want to?

How far does all the help you are getting make it easier for you to live and stay at home in the way that you want?

yes to a great extent

yes to a degree

no difference

no

not at all

Is there anything you would like to add?

## **SECTION 12: PERMISSION TO CONTACT CARER/PROXY**

(If have name of carer);

I would also like to talk to your main carer. Perhaps this has been mentioned already. If it's OK with you, can I go ahead and meet them?

(Record consent/lack of consent)	Yes	1
	No	2

(If no main carer)

Is there anyone else who knows you well, perhaps a friend or a neighbour that I can talk to about the help you are getting?

Yes	1
No	2

(If no) Is there anybody at all that I can talk to about your situation, perhaps someone who comes and helps you?

Yes	1
No	2

What is the name of the person you suggest I should go and talk to about your situation and the services you receive?

We have finished the interview. Thank you for your time and co-operation

If it's OK with you, I shall be coming back to see you in about 6 months time to ask you how you have been getting on. I look forward to seeing you then.

### **SECTION 13: INTERVIEWER'S COMMENTS**

What was respondent's apparent attitude to interview?  
(uninterested; distracted; co-operative; confused; distressed etc.)

Was a translator used/needed?

Were there any disabilities that impeded the interview?

Were there any other circumstances that affected the interview?

Any comments on interview schedule.

Any other comments.

## Appendix 4: Vignettes of Older People Interviewed

### 1: Mrs Peploe.

Mrs. Peploe is an 88-year old white woman, born in England and identifying as Jewish. She has been widowed for a number of years. Her husband was a tailor, supervising staff, and she did not work outside the home herself. She has 2 sons aged 64 and 67 who live nearby. She describes them both as 'very caring', and between them they ring her 3 or 4 times a day.

She has lived in a third floor flat owned by one of her sons for the past 30 years. She loves living there, and her sons do not want her to move away. She had had her family around for a meal the previous day.

Fifteen months ago, a stroke affected her left side: she now uses a wheelchair and is unable to go outside unaided. Her first contact with the SSD had been via the hospital after her stroke.

### 2: Mrs Burley.

Mrs. Burley is a 75-year old white woman, born in England. She was divorced over 30 years ago, now lives alone and has 2 sons whom she rarely sees. She used to work as a full-time administrative secretary for a Church organisation in the local area. She has lived in her present Housing Association flat for 4 years, but would like a move to a bigger property. The flat was crowded with boxes and papers, for which she would like the help of a 'secretary' in organising. She is registered with partial sight. Her first contact with the SSD was over 15 years ago after a fall, but her most recent contact was over an assessment for a transfer to a different, council-run Day Centre. The voluntary Day Centre that she used to attend had an uncertain future due to local cuts, and a Centre for people with higher physical needs was thought more appropriate by the assessors from the new Day Centre.

### **3: Mrs. Grant.**

Mrs. Grant is an 86-year old white woman, born in England who identifies as Jewish. In her working life, she was a furs saleswoman full time in a non-supervisory role, describing herself as a 'dogsbody'. She was divorced 50 years ago. By Mrs. Grant's account, she has one daughter she described as 'estranged', who doesn't live nearby. However, the case file claimed that her daughter supervised Mrs. Grant's bath once a week. Mrs Grant is unable to bath herself, but asked for the council-supplied bath assist to be taken away as she did not like its battery operation. She had had a Home Care service for "many, many years" to help with cleaning and laundry. She lives in a council ground floor flat. During the interview, she opened the sash window and learnt out to ask a passing man to get her some milk, and whether he could recommend a window cleaner. It emerged that this man was a complete stranger. In the interview, she described how she often stopped passers-by to ask them to get a newspaper for her. She had refused an offer of a sheltered flat on the fifth floor in a block a few miles away, on the grounds that she did not want to be stranded so high up if the lift failed (and, it could be speculated, where she would be unable to obtain the passer-by service). Her most recent contact with the SSD had been a full needs assessment. She had been offered another Day Centre placement organised by the local Jewish Care voluntary organisation. However, she had declined the offer.

#### **4: Mrs. Herman.**

Mrs. Herman is an 84-year old white, Jewish female, born in Hungary. Her first language was German (she had German-speaking nannies as a child), but she speaks English fluently. She had left Hungary in the 1930s. Mrs. Herman was married for 66 years, now widowed. Her husband worked as a director of an international company. They had travelled extensively around the world as part of her husband's work before settling in England about 25 years ago. Mrs. Herman worked as his secretary in an unpaid capacity ("I did not need the money"), and also undertook unpaid voluntary work, for the Red Cross and for local Jewish organisations. They had no children. She had moved from a larger house when widowed, and was the main lease-holder for the current house. Mrs Herman had a stroke 7 years previously, and was now dependent on a wheelchair, but mentally alert. She had lived with a live-in housekeeper, Hortense, for the past 20 years, who since the stroke undertook the major caring role for Mrs. Herman. The financial aspect of this arrangement was not clear, and Hortense (described as "shy" by Mrs. Herman) did not participate in the interview of her own choice. Hortense had been involved in a road traffic accident 3 months ago, and had been hospitalised. Although now back in the house, her mobility was impaired, and the local SSD was arranging an assessment of Hortense's own needs separately. As Mrs. Herman required assistance with all her activities of daily living, the SSD had arranged a live-in carer from an agency while Hortense was in hospital and recuperating. There had been a shocking incident when Mrs. Herman had wanted to change the carer as they were not getting on, but the carer became angry, threatened Mrs. Herman with scissors and imprisoned her in the house, cutting off the phone and not allowing anyone one for two days. This episode had only ended the previous day, and a niece of Mrs. Herman had organised a carer from another agency that day. The SSD were arranging another replacement live in carer immediately.



**5: Mr. Sergy.**

Mr. Sergy is a 75-year old white, French male. He has lived in a privately owned flat for 45 years, since he emigrated to England. He now has British nationality. He used to work for a brewery in exporting, based in Paris and Zurich. He had been awarded the Legion d'Honneur, which was on display in his sitting room, and was a Freeman of Paris. He spent much of his free time writing a book. His wife died 4 years ago. He had 2 daughters, one living abroad. His first contact with the SSD had been a referral for assessment on discharge by hospital ward staff 6 months previously, after admission for heart failure and a triple bypass operation. He is also on the waiting list for a hip operation. He had received home care on discharge for shopping, but refused the service a month later over a dispute over wanting a white European to do the cleaning. Following another assessment, he was now receiving home care for shopping, cleaning and laundry twice a week. He had also had a bath step delivered, and had a further OT assessment the previous month for rails to be fitted to the shower.

**Mrs. Yates & Carer 1 Mrs Collins.**

Mrs. Yates is a 89-year old white woman, born locally. She worked full time for a brewer. Her husband was a drayman, killed in the second world war. She lives alone in a council flat, and has lived in the same Peabody estate for 50 years. Her only daughter, Mrs. Collins was present and was interviewed, as the main carer. Mrs. Collins lives locally and visits twice a day -once a day on Day Centre days. Mrs. Yates has a significant degree of cognitive impairment due to dementia, and was unable to communicate or participate in the interview. On the SSD file there were not details of a care plan or details of assessment. There was a SSID rating of medium -high dependency, but no score given. Mrs Yates had been receiving home care for personal care tasks (getting up, putting to bed, washing and toilet) twice a day for the past year. Her attendance at the local council-provided Day Centre had been increased from 1 to 3 days in the past month, following an assessment in response to Mrs. Collins' request for residential care for her mother, which was not forthcoming as yet.

## **7: Miss McTaggart.**

Mrs. McTaggart is an 84-year old white woman who lives alone in a warden-controlled council estate flat. Mrs. McTaggart had not married, and had no children. She had moved to the current flat for the benefit of the warden service 15-18 months ago, as she was becoming more mentally infirm with dementia. She had been visited by her 2 nephews 5 months ago, but had not recognised them at that stage. She had been admitted to hospital a month ago with a chest infection, but although the infection had been treated, her dementia was deteriorating. She also had a history of depression, and was visited by a Community Psychiatric Nurse. Mrs. McTaggart had been receiving a home help service for 15 years. The current level of service was home care for personal care 3 times a day for 7 days a week, and meals on wheels. One day a week at a day centre had been discontinued for 5 months as Mrs. McTaggart's mental state had worsened. At the time of interview, Mrs. McTaggart's condition had deteriorated to the stage where she was not able to participate in an interview. She nodded off to sleep immediately after the start of the visit. Her home care worker Marion acted as a proxy by arrangement in order to give some details about the services received. Marion had known Mrs. McTaggart before the move to the current flat, and felt that the move had resulted in Mrs. McTaggart going out and talking to people less. An escort was provided to take Mrs. McTaggart to a local café twice a week. This conversation was not taped. In the case file, there were no details of Mrs. McTaggart's life before dementia. Mrs. McTaggart went into residential care for a 6-week trial the day after my visit.

**8: Mr Andrew Stewart & 9: Mrs. Verity Stewart.**

Mr. Stewart is an 82-year old white man born in Canada. He met and married his wife Verity (79 years old) 20 years ago. Mr. Stewart was a Canadian soldier, then a cook, then worked as a security guard until he had a stroke 12 years ago. Mrs. Stewart is Welsh, and uses a wheelchair following a stroke. Both have been diagnosed with Alzheimer's disease, with Mr. Stewart being more cognitively impaired than his wife (not reflected in the MSQ). Mrs. Stewart takes on the role of carer for her husband in terms of cooking and cleaning, and Mr Stewart assists his wife with her wheelchair. They live in a council flat. They have 2 daughters -one in living about 15 miles away, but whom they had not seen for 6 years. Their younger daughter lives in South-West England, and phones once a fortnight. This daughter had requested an assessment by the SSD as she was concerned at her parent's ability to manage without further domiciliary care. Mrs. Stewart had seen this as interference. They had been assessed in the previous 2 months as being independent in most activities of daily living. They receive a cleaning, shopping and laundry service 7 days a week, and a District Nurse visits both every morning. Friends and neighbours visit to see if other help needed twice a week. They also receive meals on wheels every day. The SSD hold a joint file, with a rating of medium dependency for both.

**10: Mrs Lowe: Carer, Mrs Fitter.**

Mrs Lowe is a 91-year old white woman who lives alone in a council estate flat. She has lived in a ground floor flat on ground floor for the past 5 years, having moved from the first floor 32 years ago. She used to work as a housekeeper in a private residence locally. She is a widow, and has a daughter, Mrs Fitter, who lives 30 miles away, but who was visiting on the day of my visit and participated in the interview. Mrs Lowe has arthritis, walks with the aid of a Zimmer frame inside the flat and does not go outside except with a wheelchair. She has been diagnosed as having mild cognitive impairment. Mrs Lowe has received home care for personal care for the past 18 months, and meals on wheels. Three months ago, Mrs Fitter requested an assessment for residential care. The Care manager assessed Mrs Lowe in the category of medium dependency and eligible for residential care, which was refused by Mrs Lowe, although she felt more amenable to relief care, and has agreed to go to a Day Centre, which is pending.

**11: Mr Wilder.**

Mr Wilder is an 89-year old Jewish man, who used to work as a master tailor. He is registered blind. His eyesight had been deteriorating over the past few years, but he had lost all his sight 3 months ago. He was referred to the SSD from the Eye Hospital, and assessed in the high need category. He lives alone in a 6<sup>th</sup> floor council flat, and has lived in the same area for 70 years. He was divorced many years ago. He has one daughter, but reported that he did not know where she lived. Mr Wilder's flat was cramped and in a state of confusion, with boxes of his belongings piled up, and he had difficulty orienting himself in the flat. He had also made allegations of theft against different home care staff, which had been investigated by Parkside, but not substantiated. He had a NHS rehabilitation worker to help him with orientation, a link alarm and a bath board supplied by the SSD.

**12: Mrs Connelly.**

Mrs Connelly is a 75-year old Irish woman. She is a widow, with one son who lives in the South-East of England with his own son. Her son visits weekly to help her with shopping. Mrs Connelly used to work full time in a shop. She has lived alone in a council ground floor flat for 17 years. Mrs Connelly had received home care for shopping and cleaning for 2 months. However, she reported that she did not know who had contacted the SSD, and whoever had done had done it without her consent. She had reported no health problems in the past year, but there was a strong odour of urine in the kitchen where the interview took place. She did not wish for the interview to be taped, as she had worries about anonymity.

### **13: Mr Smith: Carer, Mrs Smith.**

Mr Smith is a 75-year old white man, married to Mrs Smith (56 years old). They live in a ground floor Housing Association flat. Mr Smith used to work as a caretaker with an airline company. Mrs Smith works 5 days a week as a catering supervisor in a local hospital. She is originally from the Philippines, and now acts as Mr Smith's main carer, since Mr Smith had a stroke 2 years ago, resulting in hemiplegia, chronic pain and fits. Mr Smith now uses a wheelchair, and has also been affected cognitively. The couple had moved from a 2<sup>nd</sup> floor flat to the present one, but were still awaiting the completion of a wheelchair ramp. Mr Smith attended a pain clinic, and had to give up physiotherapy as it caused him too much distress. Mr Smith used to receive home care 3 times a day since discharge from hospital to assist with all aspects of personal care. On discharge, nursing home care had been discussed with Mrs Smith, but they both wanted Mr Smith to be cared for at home. The home care arrangements had broken down dramatically one month ago. Mrs Smith was very critical of the lack of consistency in care staff. A new carer had come to the house. She was unfamiliar with Mr Smith's needs and preferences, and had caused him pain when attempting to assist in a transfer from the wheelchair. Mr Smith had lashed out physically at the carer, and the service had been withdrawn on the grounds of his violence. Mrs Smith claimed that she had not been consulted about the withdrawal, which had also upset Mr Smith. The couple had been without any service for a fortnight. Mrs Smith now got Mr Smith out of bed in the morning, and prepared snacks and drinks for him to last during the day while she is at work. A place in a voluntary sector day centre for 3 days a week had begun in the last week, about to be increased to 5 days the following week. As Mrs Smith's job continued into the evening, a sitting service had also been introduced for 4 hours in the evening, and Mrs Smith now received an additional evening sitting service from a local carer organisation once a week. No services are received on Mrs Smith's days off at the weekend. Mr Smith needs 2 people to transfer him in and out of bed, and Mrs Smith felt he needed 24 hour care.

**14: Mr Garfield: Carer, Miss Rose.**

Mr Garfield is a 75-year old African-Caribbean man from Dominica. He is a widower, with no children, and has lived alone in a council estate flat for the past 10 years. He worked as a bus conductor for 10 years, then as a railway ticket collector. He is blind in one eye, and has poor mobility. He has been assessed as having mild confusion, and depression. (Despite the diagnosis of cognitive impairment, Mr Garfield scored full marks on the MSQ, which may cast some doubts on the sensitivity of the measure). He was referred to the SSD by Age Concern after he went to them for financial advice, as there were problems with payment of bills. Miss Rose was introduced as his niece, and although not living with Mr Garfield, as providing substantial care on a daily basis. However, the SSD had some doubts over the whether she was Mr Garfield's niece, and whether he was being subjected to a degree of financial exploitation. Mr Garfield received home care for shopping and cleaning twice a week. Miss Rose arrived towards the end of the interview, and contributed.

**15: Mrs Pigeon: Carer, Miss Carlton.**

Mrs Pigeon is a 91-year old white woman. She is a widow, with one son. Her granddaughter, Miss Carlton, lives with her grandmother in a split level Housing Association maisonette where Mrs Pigeon had lived for 28 years. Mrs Pigeon used to work as a cleaner for a Church organisation, and Miss Carlton does not work outside the home. She acts as the main carer for Mrs Pigeon. Mrs Pigeon has had a number of falls in the past year, resulting separately in a broken arm and a broken wrist. Miss Carlton contacted the SSD for help with aids and adaptations. Following assessment, Mrs Pigeon has received an assisted bath and stair rails. A move to a level access flat across the road is pending. No other home care services are received. Further referral has been made for a District Nurse.

**16: Mrs Said: Carer, Mrs Sadat.**

Mrs Said is a 74-year old Egyptian woman, whose home language is Arabic. She has 4 daughters and 6 grandchildren. Mrs Said had a stroke a year ago. She now uses a wheelchair, and has severely impaired mobility, communication and cognition. Her daughter, Mrs Sadat (52), her son-in-law and her grandson live with her in a 5<sup>th</sup> floor former council flat they now own, and Mrs Sadat acts as her main carer. Mrs Said was assessed as having high dependency needs following the stroke. She receives home care 3 days a week for personal care, and attends a voluntary sector day centre for one day, and a day hospital for another day. A further assessment had been requested by the District Nurse for Mrs Sadat, as she needed increased support for caring for her mother. The SSD communicate with the family via one of the grandchildren, without using an interpreter. An interpreter was not available for the interview. Mrs Said was unable to communicate throughout.

**17: Mrs Joan Cornwell: Carer, Miss Julie Cornwell.**

Joan Cornwell is an 84-year old white woman. She is a widow, and has a son and a daughter. Julie, her daughter (55), lives with her mother in a council flat. Mrs Cornwell did not work outside the home, and Julie does not have paid employment, but acts as full-time carer to her mother, who has Alzheimer's disease, arthritis, a colostomy. Mrs Cornwell has had a number of falls in the past year resulting in hospital admissions. Julie requested an assessment for relief care 2 months ago, as she was feeling increasingly under strain. The conflict between mother and daughter was evident in the interview. Mrs Cornwell was assessed as moderate to high dependency. Julie Cornwell receives sitting services from a local carers organisation once a week during the day, and one evening. A carer's dementia support service has just started. Mrs Cornwell attends a day hospital once a week and a voluntary sector day centre 3 times a week.

**18: Mrs Earl.**

Mrs Earl is a 92-year old white Jewish woman. She is a widow, with one son. She lives alone in a flat belonging to her son, and has lived in the same place for about 60 years. She had worked a servant part-time for 30 years in central London. She has restricted sight, very poor mobility, and is assessed as high dependency with assistance needed in most activities of daily living. Mrs Earl's mood fluctuated through the interview, which was brought to an end early.

**19: Mrs Markova.**

Mrs Markova is a 81year old white woman, originally from Poland. She was married twice, widowed with 2 daughters. She has lived alone in a Housing Association flat for the past 18 years. She worked as a manageress of a large hotel in London, often working 7 days a week. She had referred herself to the SSD for an assessment for an alarm, which she received. She was mobile and independent. She was awaiting the handyperson service for some minor repairs in the flat. No record of assessment or dependency rating was on file.

**20: Mr Adams: Carer, Mrs Adams.**

Mr Adams is a 78-year old white Irish man. He lives with his wife (63) in a flat they bought 2 years ago. They have a son who visits once a week and a daughter who lives on the South coast. Mr Adams used to work for the United Nations, and Mrs Adams still works as a consultant psychiatrist. Mr Adams has dementia and his cognitive state and mobility are deteriorating. He attends a specialist council-provided day centre 5 days a week. Following a further request for assessment for relief care, this is to be increased to 7 days a week soon. Home care is provided 2 days a week to help with bathing and shaving. Mrs Adams receives some sitting service help from a local carer organisation. Rails and other adaptations have been fitted, and relief care is pending.

**21: Mrs Shea.**

Mrs Shea is a 78-year old Irish woman. She is a widow with one daughter. She lives alone in a council flat where she has lived for 18 years. She used to wok as a part-time cleaner. She has arthritis and asthma. Following a hospital admission, Mrs Shea was referred from hospital for help with cleaning. She receives one hour home care a week for domestic tasks.



**22: Mrs Bugno.**

Mrs Bugno is an 83-year old Anglo-Italian woman, born in England with Italian parents. She is a widow, with one daughter living in the south of England. Her husband worked as a hotel, and Mrs Bugno did not work outside the home. She has lived in the same owner-occupied flat for the past 37 years. Her daughter requested an assessment for domestic help following a hospital admission for cancer of the colon. She now receives an hour a week for help with cleaning, but is independent on other activities of daily living.

**23: Miss Jura.**

Miss Jura is a white woman who would not give her age. She is not married and has no children. She worked a civil servant, then as a part-time office worker for a church organisation. She has lived in a Housing Association flat for 26 years. She has glaucoma, and also injured her eye in a fall and went to a convalescent nursing home following discharge from hospital. Her GP suggested an assessment for help with cleaning. She received home care for domestic tasks one day a week, but found the service too unpredictable, and terminated the service. She now receives no services.

**24: Mr Marsh.**

Mr Marsh is a 75-year old white man. He has been a widower for 3 years, and lives alone in a council flat, where he has lived for 23 years. He used to work as a manager of an off-licence. He does not see his 2 children. He was admitted to hospital a month ago for a heart condition. On discharge, he was assessed for home care assistance with domestic tasks. He received home care for cleaning and shopping once a week. However, when he found that he would have to pay for the service, Mr Marsh terminated the service, and asked a neighbour to help him with cleaning.

Two other older people were scheduled for interview originally, but entered hospital or residential care before interviews could take place. Their informal carers were interviewed in the absence of their relatives, as proxies and about their own experience as carers. Both of these interviewees raised concerns over quality of services for their relatives, and conflicts of interest as carers. Debbie Hastings (North locality) is the, 21-year old granddaughter and main carer for the past six years for Fred Hastings, aged 78. They live together in a council house, having been rehoused four months earlier from a flat where Ms Hastings had to sleep on the

couch. Mr Hastings was in hospital in a specialist ward, having broken his hip and knee after a fall on the stairs in the house. Mr Hastings was diagnosed with Alzheimer's disease the previous year, and has a longer-standing mental illness, leading to paranoia and aggression. He is also Deaf, and uses BSL. He used to attend a Deaf club once a week, but since his cognitive state declined he stopped attending. Attempts to obtain respite care stalled, as there was no one able to communicate in BSL in the locality office. Ms Hastings claimed carer's allowance, but she found out about it by herself, not through Parkside. Mr Hastings did not like having anyone in the house, and could display aggression. Mr Hastings had attended a Parkside Day Centre, but staff had not been able to manage his behaviour or Sign. Ms Hastings was also unhappy with charges for respite care. She had not received a carer's assessment.

Ms Lipman (West locality) is the daughter of Mrs Lipman (aged 91), who had recently moved to residential care after being in hospital for 10 weeks. Mrs Lipman had fallen at home and broken her hip. Ms Lipman claimed that there had been a number of falls, which had not been reported by the home carer. Her mother had not wanted to make the move, but Ms Lipman was happy with it. Ms Lipman was angry about turnover of home care staff, their lack of training, and occasional dishonesty. Her mother then had 24-hour care from an independent agency, for which she was overcharged. Ms Lipman had not received a carer's assessment.

## **Appendix 5: Provider Interview Topic Guide**

### **1. Interview Details**

- 1.1 Interview number
- 1.2 Date of interview:
- 1.3 Agency name:
- 1.4 Person Interviewed:
- 1.5 Job Title:
- 1.6 Place of interview:
- 1.7 Present at interview:

### **2. Provider Details**

First of all, I'd like some background /history information about the agency.

- 2.1 How long has the agency been in operation?
- 2.2 Are there other branches?
- 2.3 How many staff do you employ? (At this branch)
- 2.4 What are the main areas of care you are involved in?
- 2.5 Do you do any work with other boroughs?

### **3. Staff information;**

- 3.1 How many managers are there?
- 3.2 What is the ratio of managers to front line staff?
- 3.3 What hours are staff required to work?
- 3.4 How many hours does the manager have to work?
- 3.5 What is the average length of staff stay? (Turnover; how many staff starting/leaving in last year)

### **4. Contact with Parkside**

- 4.1 For how long have you been contracting with Parkside?
- 4.2 Do you cover a particular geographical area?
- 4.3 What tasks do you undertake?
- 4.4 Is this spot or block contracts? (Has it always been like that? Which works better for you?)

- 4.5 How many clients do you serve?
- 4.6 What is the profile of your clients?
- 4.7 How many care hours does this amount to?
- 4.8 How long does the contract run for?
- 4.9 Is there a specification for length of visits?
- 4.10 What are the range of hours covered by your agency?
- 4.11 Do you provide any emergency or short-term care?
- 4.12 Are there particular staff within Parkside that are your main contacts?  
(E.g. Contracts Managers, locality managers, care managers, Head of
- 4.13 When tendering for the initial contract, what information did Parkside ask of you? (Was this different to other purchasers?)
- 4.14 What are your views on the contracting /tendering process?5
- 4.15 How do you regard Parkside as a purchaser, compared to other local authorities you deal with?
- 4.17 Are there any areas you would like to see improved, from your point of view?
- 4.18 How is the contract reviewed centrally?
- 4.19 Are you happy with promptness of payments, and the future of the contract?
- 4.20 Do you feel there is there a level playing field?

## **5. Training;**

- 5.1 What qualifications/experience do you ask of staff?
- 5.2 What induction is carried out with new staff?
- 5.3 What training do you do in-house, e.g. NVQ?
- 5.4 Any there any other sources of training? What would you like?
- 5.5 Is there any joint training with Parkside?
- 5.6 What supervision of staff happens, whether on-site or at the office?
- 5.7 How are absences dealt with?
- 5.8 Are there relief staff, or staff available for emergencies?
- 5.9 Is there any training on equal opportunities, dealing with people from other cultures, encountering racism, etc.? (E.g. working with white clients)

## **6. Care Management;**

- 6.1 What information does the agency receive from care managers after their assessment about the client? E.g. are you shown the aims of the care plan?
- 6.2 Is this information adequate, or do agency staff have to do their own assessment?
- 6.3 How do you deal with users with complex needs, e.g. where 2 workers needed in lifting?
- 6.4 Do you have any input into care planning; joint meetings etc.?
- 6.5 What is the general exchange of information like between the SSD and the agency?
- 6.6 Does the agency generally provide the whole package or part of it?
- 6.7 Who is usually the main point of contact for queries; CM, client, carer.
- 6.8 Do you provide written information for users? If so, what?
- 6.9 What information do you give the client and/or carer.  
(How do they know what service to expect?)
- 6.10 Are you asked to attend any other regular meetings with Care Manager and/or client/carer?
- 6.11 How difficult or easy for you is it to attend meetings?
- 6.12 What feedback do you get from Parkside staff?
- 6.13 What feedback do you get from users and/or carers?
- 6.14 Who should clients/carers contact in an emergency.
- 6.15 What is your view of the agency's monitoring role: Is it done in practice; what does it mean; who does it; how; how often.
- 6.16 How are outcomes, rather than process, measured (How do you know if your service is making an impact or is working?)

## **7. Quality Assurance;**

- 7.1 Are you part of any voluntary registration scheme, or the London-wide accreditation scheme?
- 7.2 What Quality Assurance systems are in place?
- 7.3 Do you have Quality standards in writing?
- 7.4 What are your views on punctuality of care staff?
- 7.5 What are your views on turn-over of staff?
- 7.6 What is your complaints procedure?

(How well is this used? Who makes them? How are they dealt with? Are the complaints/outcomes recorded?)

7.7 How are problems with racism, equal opportunities etc. dealt with?

7.8 How do you see your service developing in the next 3-5 years?

7.9 What have been the main advantages for agencies like yourselves in the increased use of the independent sector in community care?

7.10 What have been the disadvantages?

Do you have any other comments?

## **Appendix 6: Assessment & Care Management Teams Group**

### **Interview Topic Guide**

#### **Assessment**

How far are the currently-used assessment tools and methods helpful in measuring all aspects of users' needs, including cognitive impairment, mood and functional needs?

What are your views on the usefulness of the SSID dependency grid?

Can you tell me about care plans?

Are they written? Who contributes? What is their purpose? Who gets a copy?  
What are they about (service inputs or outcomes?)

How far is there a role for providers in assessment at lower levels?

What about unmet need?

How is the boundary into residential care decided?

What are your views on the charging policy?

How far are there restrictions and ceilings on costs?

#### **Monitoring and review**

What are your views on the effectiveness of monitoring the delivery of the care package?

Who's role is it? Who does it in practice? Who should do it? For example, care manager/ provider/ contract compliance/ IQA & complaints/ someone else independent/ user or carer?

## **Outcomes**

How do you measure success of the care plan aims?

How do you know if package working well?

What would have happened if service was not available?

What are your views on the desirability and feasibility of outcome measures (e.g. baseline measures, performance indicators.) Are there any advantages and/or fears about this approach?

## **Carers**

What has been the impact on your work of the Carers' Recognition Act in assessing carers' needs and providing resources?

Balancing user and care giver interests; how are conflicts resolved? Who is the user?

## **Inter-agency working**

How effective are communications with other agencies and departments, such as the Contracts section, health services and independent providers?

How successful have joint planning arrangements between SSDs and health been in recent years in clarifying agency roles to the benefit of older service users?

## **Other issues**

Which areas of your service do you think work particularly well?

Are there any areas where you would like to see improvements or different arrangements?

How far have there been effects of resource -cutting on service and morale?

Do you have any other issues you would like to raise?