OLIVE ✓
MERYL ✓
JIM ✓
IVIS ✓
TONY ✓
AUDREY ✓
DAVE ✓

Karen Gaskill would be most interested in this as it's her sphere of work. We trained Lady Seear's niece!

Paper for House of Lords Seminar, January 16th 1987,

organised by Institute of Domiciliary Care Organisers

in conjunction with Lady Seear.

DOMICILIARY CARE SERVICES: SOME ISSUES AND PROBLEMS.

FEBRUARY 1987

OLIVE STEVENSON.

QUESTIONS ARISING FROM THE PAPER.

If there is to be a 'mixed economy' in the provision of the "home Helps" component in domiciliary care -

i) what factors should be taken into account in deciding upon the balance between sectors?

ii) what is the role of social services departments in 'strategic planning' of such mixed provision?

In what ways would domiciliary care organisers like to extend the range and type of "home help" services? Resources apart, what are the difficulties in so doing?

What are the main obstacles to achieving effective collaboration, at 'grass-roots level', between health and social services in providing domiciliary support? Is integration at local level, as Audit Commission suggests, desirable and feasible?

What patterns of service delivery in social service departments seem likely to provide most efficient and effective domiciliary care services to vulnerable people at home?

likely to provide most efficient and effective domiciliary care services

The focus of this paper is on one aspect of domiciliary care provision, which is traditionally known as the Home Help Service. Domiciliary care services cover a much wider field, such as meals on wheels, and day care. Such considerations take us into the whole complex system of arrangements, formal and informal, statutory and voluntary, which we describe as community care. In a brief paper, it seemed preferable to concentrate upon that key element in community care support, the Home Help Service.

The work undertaken by those called Home Helps has changed considerably in the past decade. They have increasingly undertaken tasks and assumed roles to do with personal care; household cleaning, tho' still central to the role in most cases, is mixed in with other activities, such as help with dressing, shopping, emptying of commodes, pension collection and so on. Thus they have become the foundation of many community care arrangements, without which no other service input would be effective. It is desperately important that this element of provision should be adequately resourced, efficiently well organised and sensitively delivered. The lives of hundreds of thousands of old frail and vulnerable people, who live alone, is critically affected, even determined, by this single element of service. For many more, including carers of the dependent, the service has a potential as yet not realised.

There are 3 major policy issues which I wish to address.

First - 'the mixed economy of welfare'

Secondly - the workings of the home help service at present

Thirdly - the structure and organisation of the statutory services within which domiciliary care is located.

"The mixed economy of welfare".

We cannot and should not take for granted that what is needed is 'more of the same' without consideration of the alternatives that might be available and of the balance we should ideally wish to see between different sectors of welfare, statutory, voluntary, private and informal in this kind of provision. It is not my intention today, in this place least of all, to debate the political aspects of this, though they will inevitably play a significant part in the directions that are taken. What I can do is to point to certain evidence, largely derived from research, which should inform policy.

There is general agreement and understanding that informal care, whether from neighbours or relatives, is extensive and by far the most significant element in community care. Nor is there any evidence that statutory support in post war years has undermined it. Indeed, over 80% of elderly people receive no help of any kind from social service departments. (Audit Commission 1985).

There are, however, a number of factors which should make us cautious in our assumptions about the extent and kind of informal care which is now, and will be, available.

- Increases in numbers of very old people, both in absolute terms and in relation to adults in middle years, means that informal care is put under increasing strain.
- Large numbers of very old people do not have close relatives available to support them. For example, Abrams (1980) found that 45% of his sample had no living children - a finding paralleled by Sinclair (1985) in a London study.
- In that connexion, it should be borne in mind that there are wide variations across the country in the amount of informal help which is

(1985) in a London study.

available, turning as it does in part upon the degree of stability in a neighbourhood. In particular, we have cause to be worried about the effects on old people left behind when families move in search of work. In certain areas of the North, this is especially marked.

- The effects of divorce and remarriage on informal care have yet to be appraised. They will bear not only upon children but also upon other dependent and vulnerable people.

- Research (Abrams 1979: Sinclair 1985) has confirmed what many knew from experience, that there are important qualifications and limits on the kind of care that neighbours are willing to provide or old people to accept from them.

All these matters, and many more besides, make it clear that we must not look to informal carers to provide more than the very substantial input they already make and that, for a range of interlocking reasons, we have to plan for a 10 or 20 years period when a greater number of dependent people, especially the very old, will depend more on formally arranged care than heretofore. That raises the question of the interweaving of formal and informal care. Such interweaving has two very important implications for the statutory domiciliary services. It suggests the need for greater 'preventive' involvement to support informal carers. And it emphasises the need for organisational structures which facilitate coordination and cooperation between the different elements of care. These are both points to which I shall return.

So: if a plan for the future envisages greater sharing and interweaving of care why should the statutory sector assume a role of increasing prominence? Why not the private or voluntary sector?

The role of the private sector in providing domestic care is, of

interweaving of care why should the statutory sector assume a role of

course, long established. Innumerable arrangements exist between householders and individuals to provide a range of services. Many are long established, work well and are a source of mutual satisfaction. Such transactions do not preclude warmth and concern. They have, however, always been subject to market fluctuations, such as the availability of other employment, and are geographically very variable according to the income and class characteristics of a neighbourhood. Few seriously challenge their place in the overall scheme and their value to those who can afford to buy them, although, looking at them from the angle of womens employment, it is clear that these individualised arrangements may place the employee in a vulnerable and relatively powerless position so far as payment and job security are concerned.

Recently, there has been growing interest in the growing sector of private domiciliary care provided by registered employment agencies. We have little evidence about it, apart from a recent study by Midwinter (1986). He estimates (and it is very speculative) that there may be between 200 and 300 such agencies in England and Wales which offer care to older people and he suggests that the agencies may employ up to 4000 staff. It is a very small element in domiciliary provision in comparison with existing statutory provision. But it cannot be ignored for it raises some fundamental questions about future direction.

Midwinter notes with approval the flexibility of the services offered under this general head of domiciliary care, which he suggests 'tend to fall outside the normal range of statutory provision' (P.12).

"... gardening, house maintenance during long absences; holiday-sitting or travelling companions; outside window

'tend to fall outside the normal range of statutory provision' (P.12).

cleaning; help with house moves; small repairs inside and out; decorating; plumbing, electrical work; carpet and upholstery cleaning; pet and plant care, including dog-walking and looking after pets and plants during holidays; dressmaking; driving; home catering, anything from 'simple funeral teas' to dinner parties in one case; typing and message-minding; financial advice."

There can be no doubt that such flexibility is attractive and that, on occasion, efforts to achieve greater flexibility within the statutory sector have been hampered by restrictive practices. Yet, equally, it would be unhelpful not to acknowledge that resistance to change may be high when job insecurity is high. Public service employees have had reason to be anxious. However, this issue of flexibility goes well beyond particular aspects of domiciliary care service and public service employees. It is commonly alleged that bureaucracies such as social service departments are not flexible in their response to social need, that people, i.e. clients, get allocated available categorised services rather than receiving help which is based on a creative assessment of their particular need. These important matters cannot be fully explored here.

The point here at issue, however, is that we should not simply admit defeat and say that statutory provision is <u>inherently and inevitably</u> less flexible than that of the private (or for that matter) voluntary sectors. That they <u>may</u> be so is unarguable. That they have to be so, I would dispute. We should also bear in mind that flexibility in the private market is guided and controlled by its profitability. That is appropriate when it results in the customer getting what he or she

to be so, I would dispute. We should also bear in mind that flexibility

wants or needs. But we cannot assume the necessary equation between social need and market forces in the forms of care we are discussing. Tensions and difficulties, for example, are likely to arise when the client is 'problematic' in general behaviour or in relation to the care worker. Bluntly, it is unlikely that an employment agency would be motivated to go on serving such clients, if other more amenable people are needing help and able to pay. The more dependent the client the more vulnerable they are to failures of service on the agency's part. Midwinter, for example, points to the problem of impermanence - private agencies going out of business. At its worst, there are also possibilities of exploitation which, whilst they exist in the public sector, are there more open to control and to systems of accountability.

In considering the balance between sectors, we should also consider the reputation and standing of the present statutory domiciliary care services so far as consumers are concerned. This is a matter on which we have quite a substantial body of research and indicates, quite simply, an overwhelming vote of confidence. Over and over again, we read of comments from consumers which indicate a high level of satisfaction. (Goldberg & Connelly 198 : Sinclair et al 1986: Levin et al 1985). This is not to deny that there are issues and problems about the service which urgently need resolution. But the high level of confidence which the service commands would surely suggest building upon its sure foundation rather than developing or encouraging new structures which would, by the nature of the service, be even more difficult to control and regulate for the protection of consumers than private residential care.

A brief word about the voluntary sector that is, formal voluntary organisations, as distinct from informal care. In general, of course, it

protection of consumers than private residential care.

is of great importance in any discussion of "the mixed economy of welfare". In relation to essential domestic support, it has not traditionally assumed a major role. Whilst there is no reason in principle why such service should not be contracted out to voluntary organisations, they are not the obvious candidates, and there is one powerful argument against such an arrangement. It would hive off organisationally, one critical element in the domiciliary care packages which, carefully planned and managed, are the core of good community care. Frankly, it would seem perverse in the light of continuing emphasis on better coordination of service delivery.

So far, then, I have addressed the question of the 'mixed economy of welfare', in this case, of that element of domiciliary service provision we have called 'Home Helps'. Surely one must conclude that the development of this statutory service should be regarded as of high priority, if community care policies are to succeed in ensuring that vulnerable, dependent people have a life worth living in the community. This is not to denigrate the contribution made by other sectors but it is to suggest that it would be misguided to hope for more from the informal sector or to ask for much more from the private or voluntary sector before we have made strenuous efforts to modify those aspects of present statutory provision which may limit or reduce its effectiveness.

The workings of the service.

Major areas of concern are highlighted by the question - who gets how much of the service where?

Who gets the service? It is not surprising that old people living alone get the highest priority, given the traditions of the service and the fact

how much of the service where?

a number of such old people are 'high risk', socially and physically. Yet distribution of resources that way leaves us with a yawning gap in provision for younger carers, usually women caring for parents. To support such carers has increasingly been emphasised as a vital component of community care policy. As the Equal Opportunities Commission (1980: 1982a: 1982b) has graphically shown, the position of many middle aged and young elderly carers is distressingly isolated and bodes ill for their futures as old people. Moreover, even a small increase in the number of carers who are unable or unwilling to continue would place statutory services under severe strain. That is, unless such inability or unwillingness results in an increased take up of private residential care. But that only shifts part of public expenditure to the social security budget. In any case much of the evidence suggests that many carers want to carry on, if only the burden could be shared. Both humanitarian and financial considerations suggest that increased domiciliary support of this group would be highly desirable.

Although it seems clear that increased expenditure will be necessary, it is also important to consider the implications of the Audit Commission's (1985) finding that local authorities varied in the extent to which they used their home help budget in the care of those classified as 'high dependency', as compared with low dependency. The Commission comments:

"In many authorities, substantial community expenditure is devoted to those apparently able to care for themselves with the little help from the public sector. Authorities with relatively high levels of community expenditure on the less dependent should clarify their purpose in providing those services. If the preventative value of such care is a

major factor, the authority should satisfy itself that community expenditure is preventing or allaying a sufficient number of people from needing more intensive services in the longer term". (P.35).

Whilst it is good to see the Commission acknowleging the potential preventative function, they seem to gloss over the difficulies of evaluating effectiveness in the way they suggest. It will not be easy; nor will it be easy to disengage from the local political factors at work in allocations to "low dependency" clients. The Home Help Service is quite a jewel in local political crowns and attempts to concentrate it all on a small group of the very vulnerable will undoubtedly meet with resistance.

This distinction between high and low dependency clients involves the second parts of the question, who gets <u>how much</u> of the time and <u>where</u>. Clearly there are important policy decisions as to how thinly to spread the service. The evidence suggests that wide variations exist within as well as between local authorities and it is hard to avoid the conclusion that the idiosyncrasies of organisers may be at work! Indeed, it would be strange if it were not so, given how little systematic guidance and support they have been given. Yet resource variations between authorities are also considerable; in the areas which they studied, expenditure on community services (of which home helps is by far the largest component) ranged from under £10 p.a. per 1000 elderly persons to £130). The latest Audit Commission report (1986) shows that spending by local authorities varies by a factor of 5:1 on elderly people: 6:1 on mentally handicapped: and even more widely on the mentally ill. Such variations cannot be explained solely by social and demographic

differences and must reflect differences ascribed to the value of such support and willingness to devote resources to it. The differences are so extreme that it becomes important for elderly people to investigate the provision in an area to which they intend to move!

So far, much of my comment has centred upon elderly people and their carers for it is there that most resources are presently needed. However, it is important to acknowledge the significance of such service for other individuals and families, especially the mentally and physically disabled: to relieve strain on carers in these groups and to provide the daily support needed for the physically disabled to live independent lives in the community are clearly critical areas although their budgetary significance is not so great. There is another group whose needs have as yet been scarcely touched by the domiciliary services. I refer to those families with young children where family stress has produced a situation in which the children are at risk. Whatever we choose to call the helper, home help or family aide, the potential for creative support from such workers at times of stress is enormous and it is a thousand pities it is so little available. The role of an older women experienced in housekeeping and child rearing could literally make the difference between life and death and the unity or destruction of the family. That is a facet of community care about which we hear too little.

The third policy area concerns the <u>structure and organisation of services within which domiciliary care is located and homehelp services delivered.</u>

There are three aspects which we need to consider:

- The patterns of service delivery which SSDs are developing.
- The feasibility of locally managed and organised services.
- Relationships with the health service.

These three aspects are interlinked and vitally important for effective community care.

<u>Patterns of Service Delivery</u>.

Since 1970, SSDs have been struggling and experimenting with different patterns and 'mixes' of field work team. Some of the debate has centred upon the merits and demerits of specialisation whether of individual workers or of teams. These are complex matters, some of which go beyond the scope of this paper. The group of staff who organise home care services are much affected by such trends and hold strong views about them, yet their position has received relatively little consideration until recently and has been the subject of less discussion. In some SSDs, organisers form a separate element within the departments, with their own structure and a cohesive group, located at H.Q., from which services have been organised. In others, (and increasingly), organisers have been located within fieldwork teams, alongside social workers, with close day to day links with members of the team. There are many variations on this theme; where specialist teams exist, organisers are usually situated in teams which serve mainly or exclusively elderly people; here and there, and controversially, the roles of social workers and organiser have been merged, a pattern which has some parallel with the position in Northern

teams which serve mainly or exclusively elderly people; here and there,

Ireland where the Home Help Scheme has been delivered by social work assistants.

To those outside SSDs, these organisational variations may not be of compelling interest. Indeed, organisational issues as such rarely seem exciting and there is a tendency to dismiss them as matters of detail, without realising how profound an effect they have on the quality of service offered and the job satisfaction of the workers. I have spent a good many post Seebohm years studying these patterns. What has become apparent is that, as with all design, design of service delivery is a compromise, in which one seeks to find a balance between various desirable elements. Where local authority SSDs are concerned, certain elements are continuously in tension and potential conflict. For example, if a local authority is to ensure consistency of policy, as in the criteria for allocation of home helps, a degree of centralised control is necessary and this will be reflected in the structures of authority and accountability which it develops. Yet, equally, SSDs are increasingly concerned with the importance of effective cooperation at field level so that the needs of clients are not fragmented between service providers and the strengths and problems of specific geographical areas are better understood. That concern tends to result in greater devolution and delegation to local levels of operation and less centralised control. Nor can employers afford to ignore the effect of structures on the morale of workers - in this case organisers - in particular the sources of support which they have in highly stressful work. Since the core provision of domiciliary care - the Home Help Service - is central and critical to effective community care, far more attention should be focussed than heretofore on the most effective ways of deploying the managers of that service.

the most effective ways of deploying the managers of that service.

One of the most interesting trends in the past few years has been the growing number of innovatory schemes for the provision of intensive care to high risk, vulnerable people, especially to the very old. An Age Concern Survey in 1984 noted 40 such initiatives but the list was even then far from comprehensive and the number will undoubtedly have increased. I referred at the beginning of my paper to the question of flexibility in the statutory sector. The Age Concern survey shows that most of these innovatory schemes are under the aegis of SSDs, usually joint financed with Health, some in conjunction with the voluntary sector. The most important aspects of these schemes lies precisely in their greater flexibility, both in what is done for the person in need and the times of day (7 days a week including evenings), in which care is provided. Reading local reports, as I have done, is a moving experience, demonstrating the committment of the workers, the affection, and respect accorded to them by the client. Inevitably, there is a debate about the costs of such intensive domiciliary care and the point at which it may equal or (very occasionally, exceed) residential care. But, leaving aside the very important issue of the form of support the client prefers, the debate about cost is sometimes conducted as if there were, in general, a real choice for the future between home and residential care. In fact, we have no possibility of providing residential care for a much increased proportion of elderly people - the accommodation is simply not there. Intensive schemes, therefore, must be here to stay. It is regrettable that, although these are often separately evaluated by local or health authorities, they have not, so far as I know, been the subject of a more systematic and general national evaluation.

authorities, they have not, so far as I know, been the subject of a more

Local management and organisation of social services, and their relation to the Health Service.

In recent years, contemptous and denigrating attitudes have been displayed towards researchers in the social sciences. So it's galling to read recommendations from the recent Audit Commission report on community care which either owe more to such research than is acknowledged or have reached similar conclusions by a different route! I refer in particular to their emphasis on local neighbourhood, 'locality planning' which has been the subject of much background research by researchers such as the late Philip Abrams, Roger Hadley at Lancaster University and Sinclair's team at The National Institute for Social Work. The Audit Commission recommend that such local developments should include integration of health and social services, greater delegation both within NHS and PSS and services to a small enough local area "with a recognisable identity". They conclude that:

> "The present statutory frameworks constitutes a barrier to the necessary change. The focus is on service, not clients".

In 1984, when undertaking some work for a London Borough on services for elderly people, I came to a similar conclusion; that effective planning would only be possible if a structure was devised in which health and social services in a given locality worked as one. A first step would be to study that locality from the point of view of its strengths and weaknesses, in this case in providing for frail elderly people. The Audit Commission have gone further in recommending budgetary devolution which is a likely consequence of such a focus.

Yet no one underestimates the practical barriers to be overcome,

people. The Audit Commission have gone further in recommending budgetary

even if there is good will. To take but one example, it is not always an easy matter to agree on areas with "recognisable identity", as commissions of inquiry into local government boundaries have found to their cost! However, if we move down that road, domiciliary care organisers will inevitably find themselves more and more working in structures in which their roles and tasks are performed in a multi disciplinary context and in which their peer group support is not necessarily derived from those of their own discipline. This sharpens the urgency of the need to clarify their position, status, remuneration and training, which has been the subject too long of an ambivalent and confused debate.

I have undertaken work with one County Council who 'collapsed' the roles of social workers and home help organisers in home care teams. This was made possible by the creation of the post of Key Home Help - women in the locality who take responsibility for management of small groups of home helps and thus relieve organisers of one time consuming element of administration. One of the positive aspects of this local initiative, from which we should all take heart, is the wealth of talent the scheme discovered in the women who 'emerged' to take on these roles. Perhaps we should reflect on and acknowledge more often, the high level of skill and administrative competence shown by women whose experience has been solely in the domestic domain.

One aspect of community care which makes closer links , and perhaps integration, between personal social services and National Health Service essential, is at the very centre of domiciliary care provision. It concerns physical care of the frail. There is an area of overlap between auxiliary nursing and "home help" care. The Cumberledge report (1986), with its emphasis on better local integration of nursing services, offers

concerns physical care of the frail. There is an area of overlap between

an opportunity for progress, although I smiled wryly as I read their recommendation for coterminosity with social service areas! (Where have we heard that before?)

A final word about people - organisers, home helps and clients.

Up to now, organisers and home helps have been overwhelmingly female. There is no reason why this should remain so. Indeed, some have expressed the opinion that, if salaries and wages were improved, men would move in to corner the market! So far as organisers are concerned, it is certainly not obviously 'womens work' as conventionally defined. With home helps it is rather different. As Roy Parker has suggested, there are a range of activities which comprise physical 'tending', a part of social care which is conventionally associated with womens' roles. We have already seen these conventions breeched - men in nursing being the obvious example and Care Assistants in residential care. Some SSD's are employing men in tending roles in the intensive domiciliary care schemes to which I referred earlier. In many ways, this is highly desirable, especially if it helps to break down unhelpful gender stereotypes and encourages men to play a greater part in informal as well as formal care. If, as a result, it pushes the financial rewards up, so much the better! Recognition of these activities as more skilled than the purely manual in terms of grades and status is coming at last. Even while government, local and central, must worry about cost, it has to be said, unequivocally, that human beings who care for other human beings in this way, who require qualities of reliability, sensitivity, good humour and courtesy - sometimes in face of great difficulty -, and who are required to take some direct responsibility for vulnerable people at risk, must be accorded the respect which in our society is associated with levels of

courtesy - sometimes in face of great difficulty -, and who are required

remuneration, Of course, resource constraints mean that we can only move slowly. But move we must. Nor is this only about remuneration. It is about training, which acknowledges that some of the people who are helped are not easy to relate to and others may raise in the helpers high levels of anxiety about risk. In short, the training must have a human relations component, in particular a component which takes account of the fact that a substantial number (1 in 4/5) of the over 80s will have a significant level of mental impairment. The DHSS study in 1984 reported that some training for home helps was available in the authorities surveyed and that some included a human relation element. However, it is disappointing that in the latest Audit Commission Report, strong emphasis is laid on the importance of quality of staff and of training for community care but reference is mainly made to nurses and occupational therapists, omitting the key groups with whom we are here concerned.

Today, hundreds of organisers and thousands of home helps have been struggling to provide critical life and death services to hundreds of thousands of people. But when the snow melts and the sun comes out, the need for this form of service is still critical. As we enter 1987, we are in grave danger, as the Select Committee (1985) and Audit Commission (1986) have told us, of failing millions of people for whom the rhetoric of community care does not accord with the reality. We are in danger too of failing to support adequately the public servants who give unstintingly in this field of service.

What is to be done? The issue must not become a party political football in which the object of the game is to score by pointing out the deficiencies of the opposing team. That way, local government blames central government for inadequate resources and central government blames

football in which the object of the game is to score by pointing out the

local government for inefficient use of resources. There is truth in both allegations and the clients of this service should not become the political football. They are citizens who need support to care for themselves and each other in the community. Our society will be judged by the quality of that support.

Olive Stevenson

January 1987.

Audit Commission. Managing Social Services for the Elderly more effectively. HMSO 1985.

Abrams M. Beyond 3 score and ten (pts I & II) 1978/1980. Age Concern England.

Sinclair I et al. Networks Project: a study of informal care, services and social work. Nat.Institute for Social Work. 1984.

Bulmer M. Neighbours: the work of P.Abrams. Cambridge University Press. 1985.

Midwinter E. Caring for Cash. Centre for Policy on Aging. 1986.

Goldberg E.M. & Connolly N. Evaluation of Social Care for the Elderly. Heinemann, 1982.

Levin E. et al: Supporters of Confused Elderly People at Home. National Institute of Social Work. 1983.

Equal Opportunities Commission:

a) The Experience of Caring for Elderly and Handicapped Dependents. 1980

b) Caring for the Elderly and Handicapped. 1982 (a)

c) Who Cares for the Carers? 1982. (b)

Audit Commission. Making a reality of Community Care. HMSO 1986.

Cloke C. Intensive Home Helps and Home Care Services: a directory. Age Concern. 1984.

Hadley R. Going Local. NCVO. 1980.

(Cumberledge Report). Neighbourhood Nursing - a focus for care. HMSO 1986.

HMSO 1986.