THE UNIVERSITY of York

Social Work Research and Development Unit

The Management and Effectiveness of the Home Care Service

Ian Sinclair
Ian Gibbs
Leslie Hicks

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Contents

1 Introduction to the Study

Introduction

This report is about measuring the performance of different home care services and explaining variations in them. It considers measures at the level of the agency, sub-units within the agency (e.g. teams) and the individual member of staff (in order to avoid any possible confusion with 'informal carers' we use the term 'staff', or 'home care staff', when referring to carers employed by the statutory and independent providers). At each level the aims are the same: to determine the criteria against which performance can be measured, to develop appropriate measures and then to explain, if possible, why some units or individuals seem to do 'better' than others.

The study forms part of the OSCA (*Outcomes of Social Care for Adults*) initiative. This was funded by the Department of Health as part of its drive to introduce better measures of outcome into the field of personal services for adults. In introducing the report we consider the reasons for undertaking the study, the way we carried it out, and the way it has been written up. To anticipate the latter section we have tried to tackle these matters as concisely as possible. In this way we anticipate the approach taken in the rest of the report.

Reasons for undertaking the study

The reasons for undertaking the study can be seen by asking four questions:

- Why measure variations in outcomes and performance?
- What is the case for studying performance rather than outcome?
- Why seek to explain variations in performance?
- Why undertake these and related tasks in connection with Home Care services?

We consider these questions in order.

Why measure variations in performance and outcomes?

The interest in measuring performance in services has varied origins.

In part it reflects the recent growth of the independent sector in personal social services. The 'consumers' of these services are vulnerable. Often they do not purchase the services themselves. Even if they are purchasers, they may have little choice. So the market may not ensure high quality services. Without performance measurement, contracts are likely to be awarded on the basis of price rather than quality or on the basis of claims to quality rather than achievement.

The potential advantages of performance and outcome measurement are clearly perceived by those awarding the contracts to the independent sector. Those who are measured naturally desire a level playing field, feeling understandably that if they are to be measured so too should their public sector peers. Recently they have begun to get their wish. Public services long assessed for the probity of their activities are increasingly assessed in terms of quality and outcomes achieved.

Current policy on public services is marked by an emphasis on a variety of indicators. There are targets and measures for hospital waiting lists, prison escapes, air pollution, school examination results, the turnover of children in foster care, and a great host of services besides. New terms have entered the public arena - 'benchmarking', 'beacon authorities', 'best value', 'naming and shaming' - superseding or complementing older ones such as 'value for money'. Joint and other inspections concentrate the minds of public sector managers. Administrative heads occasionally roll as a result of such inspections. There is an uneasy awareness of task forces, hit squads, and private sector managers lurking in the wings.

Whatever may be thought of the approach to achieving the end of assessing public services the argument for doing so is strong. There is no inherent moral superiority in salaries funded through taxation rather than profit or charitable donation. If there are large variations in the quality and effectiveness of public services these surely need to be identified and action taken to bring all to the level of the best. If this attempt is to be made it is surely important that the measures used should be as valid and reliable as possible.

Why measure performance rather than outcome?

Against this background many of the studies in the OSCA initiative rightly concentrate on measures of outcome for individuals. How far do the services received by these individuals improve morale or well-being, lessen the likelihood of admission to residential care and so on?

This study complements the others by concentrating on the performance of a service rather than the outcomes for its individual users. The concepts of outcome and performance are linked. Performances that tend to produce poor outcomes are unlikely to be judged good. However the concepts are not identical and it is worth distinguishing between them.

The New Shorter Oxford English Dictionary (1993) provides various definitions of 'performance'. These include 'the doing of any action or work, the quality of this, especially as observable under particular conditions ... the capabilities of a machine .... the carrying out or fulfilment of a command, duty, purpose, promise etc'. These definitions suggest that a service's performance has to be judged in the context of what it is meant to do (its duty, purpose etc). However, they also suggest a concentration on the quality of actions rather than the outcome achieved. This concentration on fitness for purpose, rather than the achievement of purpose, marks a crucial distinction between assessment of effectiveness and assessment of performance.

First, good performance does not invariably lead to a good outcome. A lawyer can perform well and lose the case. In the case of services the link between performance and outcome often depends on context - a G.P. service may perform well in identifying cancers early but outcomes may be poor because of waiting lists or the quality of the local surgeons.

Second, measures of performance tend to concentrate on the immediate rather than the long-term. In the longer term we may be concerned to prevent the need for old people to enter care or to enhance their mental health or that of their carers. Immediately the concern is to ensure that their houses are clean, they have an adequate diet, they do not spend all day in bed and so on. These immediate concerns tend to be called 'intermediate outcomes' and judged as of less concern. They provide, however, the concepts of need and related criteria against which elderly people and their carers judge a service.

These characteristics of performance provide three main reasons for studying it.

- *Accountability* - managers are accountable for services not for the outcomes achieved by individuals served by them. Contracts tend to be let on the same basis.

- *Measurability* - it is easier to determine whether a service is delivered on time, courteously, flexibly and so on than it is to determine its longer term effects.

- *Immediacy* - such measures can be made cross-sectionally at a particular point in time, whereas measures of outcome typically involve following-up individuals over time.

Performance measurement therefore holds out the promise of providing feedback to managers which is immediate, reliable and closely related to their responsibilities and field of influence.

These advantages do not negate the need to look at outcomes. Research on outcomes needs to inform concepts of performance, changing ideas of what constitutes good practice and appropriate standards. Such research, however, is likely to change performance measures rather than do away with them.

Why seek to explain variations in performance?

Feedback on performance is useful. Even without research a manager provided with comparative data on the performance of her or his service will have a better sense of the room there may be for improvement. Managers of services which are apparently performing poorly are likely to form hypotheses on why this is so and act accordingly.

Research on reasons for variations in performance is likely to help in:

- giving managers a better sense of the 'levers' which are important. (How far, for example, is the key to good performance to be found in the training of staff or in the clarity of procedures - or do both need to go hand in hand?)

- restraining, qualifying, or endorsing enthusiasm for centrally imposed requirements. (Frequently requirements for, say, proportion of trained staff, or frequency and nature of meetings or inspections are imposed at a relatively high level. They certainly raise costs and restrict freedom of action. It is therefore important to determine whether they have positive impact on performance.)

In these ways research on variations in performance is an essential adjunct to the growing importance of management in public services. In suggesting effective actions it is an aid to management. In identifying actions which may not be effective, it checks overweening ambition.

Why is this relevant in the home care service?

The first and most obvious reason for studying home care services lies in their size and financial importance. In 1997/8 local authorities in Great Britain spent around 1.5 billion pounds on Home Care. The bulk of this went on elderly people for whom expenditure was 1.2 billion in 1996/7 (CIPFA, 1998,1999). In terms of volume of clients served at any one time, the service is larger than any other one provided for elderly people by social services'

departments with around 8% of those over 65 receiving local authority home care. About 7% private home help in addition or separately (OPCS, 1996).

A second reason for studying the service lies in the fact that it has been changing. The home help service began in atmosphere of postwar austerity. Reasonably fit elderly people were unable to cope with the queues for British restaurants or manage their mangles. Meals on wheels and simple home help service had been pioneered in the war. They were required to meet such basic needs and on a large scale. Many of these needs - for example, for shopping, laundry, pension collection and domestic cleaning - were not acute. Provided a house was cleaned once or twice a week, it did not matter too much when this cleaning was done. Except for those whose coal fires required daily lighting the resulting service was based on a pattern of once or twice weekly visits and was greatly appreciated (See references in Sinclair et al., 1990).

The pattern of low level domestic help delivered to large numbers of elderly people persisted into the 1980s. Five main factors have required this pattern to change. First, the growth in the number of very elderly people has put all services for them under strain. Second, financial pressures on the health services and the closure of geriatric wards has decanted some of the pressure on them onto social services. Third, social services responding both to considerations of cost and evidence of what elderly people wanted, have operated policies of community care, seeking to keep as many elderly people as possible in the community. Fourth, a policy of community care serving the very frail elderly people required, as described below, a very different style of service from the traditional one or two visits a week delivered by the home care service. Fifth, the growth of the independent sector, a potential rival or complement to local authority services, challenged the position of the latter as virtual monopoly providers. The initial concentration of this growth in private homes led to serious criticism (e.g. the audit commission, 1986) that this was giving undue priority rather than community care and attempts to redress the balance.

These changes meant that many very frail elderly people were being maintained in the community. Many of them required services seven days a week and at a variety of times of day. These requirements included personal care (for example, bathing and toileting) which had not been seen as part of the remit of the original home help service. These new needs could only be met by a massive increase in resources or by a withdrawal of service from some individuals and a concentration on others. Authorities have managed these pressures in different ways, have come to varying accommodations with Health Authorities over what constitutes the boundary between social and medical care - for example, between a ‘social’ or ‘medical’ bath - and have made varying use of the independent sector as a resource for those able to pay for domestic work or of care for clients paid for by the authority. However,

the Social Services Inspectorate in particular promoted the idea that good practice required a concentration of resources on the very frail (1987). There is no doubt that the service changed greatly as a result.

A second consequence of the changes was an increased requirement for co-ordination. Residential care for all its limitations provides for all basic needs over 24 hours. In the community the needs of people of equivalent frailty had to be met by different peripatetic services and sometimes by a combination of informal care, public care and care from the independent sector. The need to co-ordinate these efforts was acute and led to the growth of 'care' or 'case' management. Originally conceived and evaluated as a method of providing 'tailored packages' of care this approach was also seen as an essential part in financing care. Care managers are increasingly purchasers of care - individuals within the local authority who aim to get the best deal for their clients at the lowest cost, who keep control on costs and who inject an element of competition into the provision of care (Challis, 1999, Lewis and Glennerster, 1997).

These changes mean that conclusions reached on the basis of research on home helps prior to 1989 are no longer necessarily valid. Useful research before this date was carried out on the criteria against which clients evaluated services. Generally they valued home carers for their social qualities - warmth, cheerfulness and willingness to be obliging and for their task performance (thoroughness, timekeeping, putting things back in the right place and so on) (Sinclair et al., 1990). Some studies also suggested that management was in some respects unhelpful and quite commonly disregarded. So researchers criticised rules that home helps could not change curtains - a regulation that might leave elderly people teetering on chairs while home helps dusted round their ankles. They also suggested that although the time allocated for visits was based on a list of tasks to be undertaken what the home help actually did was negotiated between client and home help.

More recent research includes important work by Henman and her colleagues (1998) and by Qureshi and hers (1998). These suggest that the criteria used by clients to evaluate services prior to 1989 are still relevant. Neither study, however, aimed to examine the effects of different ways of providing services on whether the criteria were met. A survey of the CARE DATA and ASSIA databases using the key words 'Home Care' failed to identify any British research study of the Home Care service that tackled this problem.

What were the aims of the study?

Against this background, the research we have carried out was intended to provide:

- a description of the role that home care now plays and its part within the wider scheme of care management

- consumer research on the criteria against which the stakeholders - particularly clients - evaluate the service
- evaluative research on what is required if the service is
  - to perform its appropriate role and
  - to meet the criteria set by its clients, staff and managers.

What methods did we use?

The study was carried out in four northern authorities. They included two county authorities (which contained rural areas, former pit villages, and some sizeable towns), a large urban unitary authority, and a large city including both inner city and more affluent areas. In each of the four authorities we also approached agencies in the independent sector including all those who agreed to take part with the exception of one authority where the numbers were too great. (We included eight of the 12 who volunteered.)

Details of the sampling and response rates are given in appendix 1. In broad outline, however, the study comprised three main sub-studies.

Initial exploratory phase - We interviewed singly or in groups twenty five managers in the four authorities and independent sector. (Numbers are approximate since some of those in joint interviews said very little). We also carried out three focus groups - with local authority staff, local authority organisers and organisers in the independent sector. The aim of interviews and focus groups was to understand the issues in home care as the respondents saw them, what they felt home carers were and should be doing, and what factors affected their performance.

Qualitative interviews - We undertook guided interviews with 17 organisers, 33 home care staff and 55 'clients' (the term used in this report as preferred by the service). In the case of the organisers the focus was on the general issues explored in the focus groups. In the case of clients and workers the focus was mainly on the carer's work with a particular client. The aim was to understand what she did, how well it was done as judged by worker and client, and what factors seem to influence performance. In

30 cases it was possible to link ratings of the worker made by the organiser with ratings of the worker made by interviewer (on the basis of the interviews) and ratings of the worker made by the client. The purpose was to see whether there was consistency between these three sources of evaluation, and hence whether there was grounds for saying that some workers consistently performed better than others. (Organisers were rating workers general performance and the other ratings focussed on performance in a particular case - if the organisers were right in their judgements there should be some correspondence between the latter ratings which were made 'blind' and their own)

Quantitative Surveys - We carried out three large scale postal surveys with organisers (n=103), carers (n=1389) and clients (n=885). With the exception of one authority we sent questionnaires to all organisers in the local authority sector and to organisers in the participating agencies in the independent sector. One authority asked us to send postal questionnaires to all its staff. With this exception we sampled both clients and staff in order to avoid an unmanageably large number of replies. Questionnaires to organisers and carers were designed to find out something of their characteristics and explore their assessments of their organisation. Questionnaire's to clients were brief and designed to get a measure of performance of the service from their point of view. The data have been used descriptively but also to explore variations between service units in client evaluations. Two questions have been central. First, how far are there variations between services? Second, do variations between units in the clients' experience link to variations between units in the way carers and organisers describe the organisation. In this way the quantitative surveys complement the more qualitative data, exploring the same questions but in a different way.

This design reflects a number of changes which were made with the agreement of the department. These changes involved:

The number of authorities. We increased the number from 3 to 4 to allow for more diversity in ways of providing home care and in social conditions.

The number of focus groups in the initial exploratory work. We found them very time consuming to set up, and the collection of a representative focus group of elderly clients almost impossible. We therefore reduced the number and substituted interviews.

The number of guided interviews. These were intended to focus on matched sets of organisers (24), home care staff (48) and clients (96). Each organiser was to have two

home care staff in the sample and each carer two clients who were over the age of 65, living on their own, and sufficiently lucid to take part in an interview of the kind proposed. This plan proved impractical. (See chapter 4 for more detail on what we did)

The inclusion of the postal surveys. The organisational diversity within and between authorities was such that a sample size of 96 would give very little chance of estimating the effect of any differences and the authorities themselves were keen to receive feedback from the research. We undertook the surveys to meet these considerations and compensate for changes of plan in the guided interviews

Our conclusions are based on a combination of our data. Each data set provides a description, albeit from varying viewpoints, of the role of home care staff. Each yields information on the criteria against which different stakeholders evaluate home care. Each yields insights into the organisational and other conditions likely to promote 'good home care'. The ways in which we use the data will be apparent from the chapters which follow. We believe that they allow us to achieve the aims of the study - albeit in a somewhat different fashion from that originally intended.

The study has a number of limitations. The authorities do not constitute a large enough sample to be nationally representative and the independent agencies may not be representative of those in their authorities. The response rates to the postal questionnaires varied from the good to the poor, depending on the agency and the client group involved. For both reasons the study should only be cautiously used as a description of the current state of home care at a national level.

We are, however, confident that we have identified issues that are of national relevance. This confidence stems from the study's strengths. Analytically we have been able to identify issues that seem to stem from the nature of the home care tasks (e.g. from the need to serve a large number of frail clients at similar times of the day). Different individuals (managers, organisers, carers, clients) in different departments seemed to highlight the same issues albeit from varying perspectives. Our statistical analysis broadly confirms the conclusions of the qualitative analysis, providing a welcome degree of 'methodological triangulation'. Clearly individuals in other departments will have to judge how far our conclusions apply to their situation. We believe they will find that many of them do.

Structure of report

At the beginning of the study we were asked by the Department to aim for a 50 page report. This is unusually short. It makes it difficult to provide sufficient information for referees to evaluate the research. It means that much interesting descriptive information has to be excluded. However, it has the advantage of forcing the authors to concentrate on the main messages. It also results in a product which has some chance of being read.

Our strategy for achieving a short report has been as follows.

- We have placed statistical tables, details of sampling and instruments used in Appendices 1 and 2.

- We have included details of method to the degree that these seem required to understand what was done. These make for indigestible reading but can easily be skipped.
- We have tried to write in plain, intelligible English, giving the main messages from any figures without numbers, and relying on the reader's ability to turn to the appendices when the figures matter.

The report builds from the qualitative description of the organisation (Chapter 2) and practice (Chapter 3) to the quantitative analysis (Chapter 4). The final conclusions are based on Chapters 2 to 4 taken together.

As can be seen we have not achieved the 50 page report at which we aimed. A reduction in print size and in the space between lines might have achieved apparent brevity at some cost in eye strain. We believe, however, that the report allows intelligent skipping. Those who are interested in method should be able to see the kind of evidence on which we based our conclusions. Those who are only interested in the conclusions can turn to chapter 5.

2 Organisational Issues

Introduction

The work of the home care staff is organisationally constrained. It is also largely unsupervised. As an organiser from the independent sector put it '*You actually go to knock on the door at nine o'clock at night alone. You're expected to work on your own in someone else's house following policies and procedures three inches thick.*' One objective of the study was to find out how much, in such situations, performance was down to the individual member of staff. Another was to discover to what extent and in what respects performance was organisationally determined whether by policies and procedures or other factors. This chapter is primarily concerned with identifying possible organisational constraints.

The central theme of the chapter is implicit in the quotation at its beginning. In knocking on the door at nine o'clock the member of staff lays herself open to a complex and uncertain situation. The cat may not have been fed, a daughter may been diagnosed with cancer, a granddaughter may have become engaged, the fridge may have begun to defrost ... the range and variety of joys, problems and issues is as large as can be imagined. At the same time the member of staff comes to fulfil a care plan within a limited time and subject to policies, rules and regulations. Cats, operations and fridges are unlikely to figure in the plan. A key question is how far home care is or should be holistic - potentially concerned with the full range of these issues. A second question is about the degree and direction of the organisation's influence on the response of home care staff.

Method

The data on which the chapter is based come from interviews with managers in the exploratory phase and the guided interviews with organisers. For the former we relied on notes taken after the meetings, but the latter were tape recorded and transcribed. We used both sources of data to generate our analytic themes.

As explained in the introduction we have tried to use our data in ways which generalise beyond our data. Descriptive data are unlikely to be nationally representative. Even in relation to the authorities concerned such data have a limited shelf-life. For these reasons we have tried to use our data analytically. Thus we have sought to use our descriptive qualitative data to

illuminate fundamental issues in home care. Insofar as we succeed in identifying such issues the analysis is likely to remain relevant even in superficially different situations.

A core issue was certainly that of change. In two authorities the changes had led to a large number of redundancies or early retirements. In the other two authorities existing or proposed changes had led to considerable dissatisfaction among organisers and/or senior home care staff. Basically managers in all four local authorities were seeking to turn a home help service into a home care one. Their methods of doing this varied. In each case, however, they sought to:

- define the task of home care
- clarify the principles according to which it should be provided
- put in place the infrastructure and budgetary controls to provide it
- define the role of organisers and home care staff within this context
- identify, and if possible manage, the role of the independent sector
- define the process of referral, assessment and review
- locate the service within the context of its community and other services
- enhance quality through training, support and quality assurance.

Responses to these issues may vary over time. The issues themselves, however, are likely to recur wherever home care is carried out. We therefore structure the chapter in terms of these eight themes. Many of the issues discussed were similar in the independent and local authority sectors. Where this is so we deal with the independent sector under the relevant theme. Issues specific to the independent sector or to its relationship with the local authority one is dealt with under that heading.

The tasks of home care

The tasks of home care are defined by its purpose, and within that, by a variety of influences - tradition, the skills and qualities of home care staff, the characteristics, home environments and attitudes of those receiving the service, the influence of their relatives, the willingness of other services to undertake certain tasks, the money available and so on.

Home care staff are paid as manual workers. So in all authorities home care, like the former home help, was officially defined in terms of its practical tasks. The value of the 'social care' provided by staff was recognised. It was, however, something they were expected to fit in as they worked. They did not go to elderly people to lift their depression. They went to bath them, get them out of bed, or perform some other practical task. If in the course of this activity they lifted their depression so much the better. And from time to time it was possible to take elderly people to the shops, or even out in a car. Such exceptional events were used as examples of the spirit and potential of the service. No one, however, pretended that they were anything other than uncommon.

Less exceptional, and undoubtedly as important, was the role of the service in monitoring the condition of elderly people and linking them to appropriate services. Organisers and staff commonly undertook this task. Again, however, it was seen as a byproduct rather than aim of their activities. In bathing or dealing with catheters they noticed the beginning of bed sores or that urine had blood in it or was cloudy. So they linked the old person to a medical service. They did not, however, go to monitor the old person's condition or act as such a link.

Despite these limitations the tasks of home care were highly varied. An organiser in the independent sector gave a long but still incomplete list:

> *Home carers do whatever it is that's necessary to enable somebody to continue to live in their own home - so that could be anything from pension collection, shopping, writing letters, paying bills, cleaning the fire out, hoovering, cleaning - some agencies do gardening and decorating, we don't - making the beds, changing the beds, all of which comes under the domestic umbrella. ... then you move into personal care, which can be getting up, putting to bed, bathing, washing hair, dressing, undressing, moving into things like emptying catheters and providing assistance, prompting medication. If all you need to enable you to stay in your own home is someone helping you with your medication then that's what should happen.*

This list of tasks is common to both sectors. For the local authority sector, however, it represents a considerable change from the work undertaken by the home help service. The latter is now seen as having concentrated on domestic care - cleaning, shopping, pensions and laundry. All but one of the four authorities in the study now aimed not to provide such a service on its own. One authority did provide a free domestic care service along the model of the old home help one. It was, however, increasingly under pressure to provide personal care. An issue for the authority was whether the service was not so paired down as to be of little value.

The workload of the new home care staff was seen as more varied and more pressured than that of the former home helps. A senior home carer in one authority described the difference.

> *When I first started work in the department in 1986 you would have a member of staff works four hours a day - say 9 till 1 and the expectation was that he or she would have two clients in those four hours. Whereas now things have moved on so much that the expectations are that he or she would have six or seven clients that they go to in that four hours. Because going back to when I first started in the department they would do cleaning, just cleaning, for those two clients. They would spend two hours with one client, have fifteen minutes travelling time and spend the rest of the morning cleaning for somebody else. ... A typical morning could be that they have three personal care calls of half an hour each, travelling time between, and they could, maybe go and assist someone to the toilet, do somebody's shopping and then do two lunch calls.*

A home care organiser with equally long experience described the process in another authority. Part of it she put down to a reduction in resources combined with an increase in the number of very frail clients:

> *I have been in the Home Care services in the city - well it will be 17 years next month and when I came into the service I had 54 staff and about 350 clients. I now have 37 staff and just under 200 clients - about 180 something like that. What happened was that the first five to seven years of my service here we still provided preventative services. We used to provide people who were beginning to struggle with domestic tasks in their own home, perhaps even only once a fortnight... and what it came down to was what I call getting up and getting down jobs. ... They could function, they were capable of their own domestic care, and they were capable of their own meals but they couldn't clean windows any more, they couldn't clean the fridge, they couldn't get behind the furniture, do the corners and things, it's very depressing living in that sort of way. And so we used to provide, possibly only once a fortnight, to do those tasks but not to do the things they could do and that was proper preventative work.*

In the organiser's mind this change of role had less to do with an increase in the number of very old people than with the pressures on the health service:

> *And then the shift came when the district nursing service seemed to stop doing as many of what people thought of as nursing tasks. We were involved with*

> *dealing with people with their catheters - admittedly not the indwelling part of it, that is done by the nurse or doctor, but the general daily looking after the piping, changing the bags, emptying them and all that sort of thing that an elderly person could not manage for themselves because there is a loss of agility in their own hands and things like that or for various reasons - maybe they were suffering from dementia. So we started filling this void that the nursing service were leaving behind. We used to have an auxiliary nursing service that provided for people. That doesn't exist any more and it's very, very fragmented in the rest of the city. People don't want to live without having a bath. They don't want to have dab washes for the rest of their lives. So we fill that void.*

These changes involved changed relationships with other services and were accompanied by cuts:

> *That also involved me in referring people on for aids and adaptations in their bathroom ... The funding available for Home Care services started shrinking ... So you start to think these sorts of people are very dependent on us. They won't be fed, they won't be clean if we don't continue our services. Whereas these* [other] *people always provided for their windows and corners being done ... So we had to cease to take on these sorts of cases.*

These changes did not mean that the previous service ceased over night:

> *People who have been assessed for a service continue to receive it unless they have improved and we could take the service out because they were able to manage independently again. Because there is a sort of law, or whatever you want to call it, if somebody is assessed for a service you can't withdraw it if their need for that service hasn't gone away ... but if any new cases only wanted corners or windows doing, we say I am afraid that is not a service we provide any more and we can give you a list of people who will take that sort of work on.*

This practice was seen as in certain respects unfair:

> *But that disadvantaged some people because some people had got the finance to pay for this list of people ... But if they fell into the category that they wouldn't have paid for the home help service because they had income support and hadn't got the finance to pay for windows and corners being done and they*

> *couldn't get attendance allowance because you can't have that for windows and corners, it's only these people over here that need bathing and feeding that can have attendance allowance, which will increase their income. So they are the ones that can actually afford to have windows and corners done as well.*

This situation produced in the organiser's view an anomaly:

> *But rather than have packages that were fragmented we continued to do everything. If we went and washed, dressed, breakfasted, made the beds, got to the commode, went back and did lunch, then we also generally did housework as well. But you go out there and people say 'oh, you don't do cleaning any more do you?', you say 'well, we don't just do cleaning, it's part of a package'. So the job has changed a lot in 17 years.*

We give these quotations at length because they introduce what follows. All organisational change is unsettling. Those just described may be particularly so. In their wake there had been large scale redundancies and early retirements. One authority estimated that it had recently lost half its home care staff.

For this reason and others the changes were not uncontested. Staff remained who were used to supply domestic care only and were said to be anxious about the new approach. There were arguments in favour of preventative work. Elected members in one authority hung on to the idea of a home help service. For the very frail domestic care was an essential part of their 'package'. It was also provided out of principle as in authority one, through reluctance to withdraw service in others, or perhaps through need (as in a coal-mining area where many elderly people were dependent on coal fires). All authorities continued to provide some domestic care. One authority (not the most prone to provide domestic help) still provided a third of its 'in-house' home care hours in amounts of no more than two hours a week.

So the changes raise issues of principle. Indeed they raise all the issues around which we structure this chapter. Who, for example, should get care because they can pay, who because they need it, who because they want it? How can such an intensive service be financed and supported? And because there is room for legitimate difference of opinion on these issues, it may be more difficult for management to make their view prevail throughout the organisation.

The principles governing provision

The quotations illustrate the variety of influences that play on the provision of home care. Politics and pragmatism are important. Withdrawal of a service may generate resentment and, if carried out on a wide scale, political difficulty. It is therefore done reluctantly. If a personal carer ('informal carer') is in someone's house, it is natural that he or she should also do the odd bits of domestic work. Such tasks are needed to keep the old person out of care and in reasonable comfort. It makes sense to include them in a package rather than expect such care to be delivered by someone else.

In addition, home care may be provided because someone is thought to need it, because he or she wants it, or because he or she can pay for it. It may also be provided or continued out of a relationship between the carer and the person cared for. The relationships between need, want, payment and relationship are complex. All may be involved in determining the package a person gets. Our interviews suggest that the relative importance accorded to each varies with sector, predilections of the assessor, and the persuasiveness and power of the potential client.

Care in the public sector was supposed to be provided on the basis of need. This meant that it should be relevant to the purpose of enabling the person to stay at home, and, ideally, to rehabilitating them. Assessments and referrals were criticised by organisers on the basis that need had not been taken into account:

> *It's for the social worker to assess what the client needs to return home. That's the problem that they sometimes find it difficult to deal with. Because their culture is what they feel the person needs is what that person wants.*

Requests for 'pop-in' visits were particularly criticised on this basis:

> *It could be in the context of 'well I think this person needs four calls a day'. 'Yes but to do what? 'Just to see that they are OK.'.. 'Well the intention is that we don't do pop in calls. It has got to be a sort of specific task.' 'Oh well, it could be to make her a drink or something like that." It is like they are making it up'. Well OK they might need an evening call. But for what purpose would that be? Are you having difficulty in getting undressed. Or are you having difficulty in getting into bed? That kind of thing.*

Three slightly different conceptions of need seemed to be invoked. First, services should not be provided in such a way that people ceased to be able to function. So they should only do those things that people could not do for themselves. As far as possible they should help people to regain function. Second, services should not be provided if another service could

meet the need better or more cheaply. Alarm schemes were seen by organisers as a more practical response to the possibility of falls than 'pop-ins'. Third, services should be justified in terms of the severity of the person's condition. Night calls to elderly people who were capable of getting themselves a hot drink and undressed were not seen as justified.

From the point of view of social services 'wants' were considered relevant in two respects. First, they were involved in *whether* a service was provided. For example, if an elderly person was seen as determined to remain in their own home this was a reason for providing a service. By contrast elderly people were seen as sometimes ready to agree to a package when in hospital only to reject it as interfering when they got out. This was seen as their right. Second, there was concern that *how* a service was provided should as far as possible fit with the individual's preferences. In both respects, however, there was scope for negotiation. For example, an organiser might say to an elderly person that if they wanted to remain at home the two would have to work together. Organisers also might try to find a way of negotiating a package that met their service requirements but was not exactly what the client wanted.

> *I usually ring them and say 'I can't give you half past eight, this is the time I can give you' and nine times out of ten that's fine. You get the odd one who is very 'well I want that time and that's the time I will get'.*

Organisers in the public sector criticised those in the independent one as predominantly concerned with want rather than need. In their view the independent sector was motivated by profit and would continue to provide a service if the client wanted it.

Matters were naturally seen rather differently in the independent sector. To a varying extent the organisers we interviewed in the independent sector were involved with private clients. For these want was indeed the predominant principle. If their client or her or his relatives wanted one of the services they would generally try to provide it. This did not mean that the organisation was unconcerned with standards. All those we interviewed seemed to have a sincere wish to provide high quality service. They wished to make sure they could provide the service requested to an adequate standard. They might discuss with the local authority the quantity of service to be provided, even on occasion and for the sake of good relationships say they could provide it in less time, but they were not predisposed to ask whether the service was needed. The nearest approach to this was provided by a company manager, who emphasised the importance of 'wants' in asking clients whether they wanted the package the local authority had ordered. The question, however, was whether the client was unwilling to accept the service not whether he or she did not need it.

The question of whether clients should pay was also more of an issue for the public sector. In the independent sector it was taken for granted that someone - relative, client or local authority - would pay. Without payment service was not provided. Organisers in the independent sector did advocate that unmet need should be met but not that over-provision to needy clients should be reduced. Some organisers in the public sector were similarly concerned that the need for payment meant that need was not met. However, others welcomed payment as a means of deterring less needy clients. They instanced clients who were up and breakfasted at morning calls, who 'hoovered', who went out with relatives, and even drove cars or visited golf courses. They felt that such clients should not be given a service and pointed to the efficacy of payment in deterring them. In one authority clients discharged from hospital with an intensive free service apparently often stopped all service when payment was requested after two weeks. Clients who had accepted a service apparently often stopped it when given a financial assessment. Other organisers were more concerned about anomalies arising from certain methods of charging - for example, the effect of flat rate charges on clients receiving a very low level of service. The unease over payments was reflected in one authority which made no charge up to a certain level of service and then, at least in some areas and circumstances, invited one.

A final principle determining level of service was that of relationship. Staff might give a larger or better service for some clients, working if necessary in their own time, because they were concerned about their welfare. This principle was resisted by organisers in both sectors, albeit for varying reasons. It was seen as putting staff at risk: they would not be insured, they might be bitten by dogs, cause damage to cookers or infect their families with deadly bacteria through washing taken home to their machines. The workers might be exploited: the odd piece of shopping might become a major shopping list. The worker might become unduly distressed when the client was ungrateful or died. The client might become unduly attached and thus agitated if another worker visited. Other workers might be blamed because they did not offer the same kind of service. Chances would be missed to meet needs on a more reliable footing. Favouritism rather than equity would determine who got what.

So explicitly or implicitly principles clashed. For the independent sector matters were relatively straightforward. The sector was concerned with the possibility that its workers would offer services on their own behalf. However, in general a service would be given if the client wanted it, the organisation could provide it and someone was prepared to pay, perhaps after representations from the agency. The local authority had the more complicated task of assessing need when different definitions of need existed within its ranks. It also had to balance the awkward relationship between need, client (or indeed relative) wishes, and payment. Like the independent sector it faced the bureaucratic problem that its workers became committed to their clients. Argue as it might that clients were '*entitled to a service not*

a particular worker' it relied on workers in a caring profession, exposed to clients whose wants and less urgent needs were not given a high service priority. So there was a potential for conflict between workers and organisation.

Budget and infrastructure

For home care to be provided a number of conditions have to be in place. There has to be adequate finance and some financial control. There have to be the staff, adequate in numbers to meet need and deployed where and when needs occur. It is desirable that there should be criteria and standards against which needs are met. These requirements are harder to meet than they were in the case of the home help service. Moreover they clash.

At the beginning of the study all local authorities in the study were having difficulty in meeting the costs of home care. (Companies in the independent sector also complained of tight margins but this problem is considered later.) Subsequent changes in the conditions of service in both sectors is likely to have increased this financial pressure. In general the local authorities managed the problem through a combination of *block controls* concerned with blocks of expenditure (e.g. budgets, allowable hours of overtime) and *individual controls* concerned with expenditure on individuals (e.g. timed care plans or ceilings of allowable expenditure). Both methods had considerable repercussions on practice.

Block controls partly took the form of budgets allocated to aspects of activity - overtime, weekend work, money to be spent on the independent sector. They also included targets for hours, for numbers of hours to be given to clients in different dependency bands, for staffing at various levels, and for proportion of time to be spent face to face with clients or in support activities. In response to financial crises authorities could (and did) respond by using their block controls - so overtime was held to a particular level, a block was put on recruitment, programmes of redundancy and early retirement were introduced. At the start of the study one or more of these measures had been recently applied in all the four authorities.

Individual controls were primarily applied through a routinised form of care planning. Care plans within and outside the local authority were timed in terms of quarters of an hour. Activities within these times were also classified in routine terms - for example, a 'med call' to prompt medication (15 minutes), a breakfast call (30 minutes), call involving washing machine cycle (45 minutes), breakfast call to severely dependent client requiring hoist etc (60 minutes). These routine bands provided a language for negotiating both individual and volume contracts with the independent sector and a means of explaining expenditure. As seen in an earlier quotation they also required a rational relationship between time, activity, and the purpose of

that activity. Finally, they provided a control on the expenditure on individual cases. Changes might have to be agreed with a panel, and there might be a formal or informal ceiling on the amount of expenditure that could be authorised.

These various controls impacted on practice through waiting lists, reduction in the time given to support activities such as supervision, staff vacancies, and a somewhat routinised, and potentially rushed, style of practice. One organiser in the independent (voluntary) sector was resisting pressure to accept half hourly visits, arguing that anything less was rushed, unduly circumscribed and not respectful of a client's dignity. Generally standards were written to allow some leeway in the timing of visits and thus some flexibility in their timing. Nevertheless, a small number of organisers argued that the emphasis on standard tasks and timing was excessive, allowing too little for differences between clients, variations in their state from day to day, and differences in their houses and available equipment.

Budgetary and resource controls were in part a response to the greater demands generated by the shift from home help. One aim was to squeeze out low priority clients. However, the switch to high priority personal care clients brought logistical problems. Personal care is dominated by the clock. It is urgent. A client cannot wait too long between being taken to the toilet. A large number of people require such care at particular times of day - around 8 a.m., for example. The routine does not fit the standard working day - there is a lull mid-morning and one person can only fit in one or two clients around 8 a.m. The rushed times and the tightness of resources leaves little room for the unexpected. The frailty of many clients implies a greater likelihood of crises - accidents at night, falls, unusual stiffness and hence unforeseen variability in work load. Yet when all cases are urgent, fluctuations in workload cannot be managed by leaving some unserved.

These problems could be compounded by special factors. Geography was important. Organisers in the independent sector complained of widely spaced 'spot purchases'. Staff who were not generally paid for their travel time required cars and had to race from one client to the next. Complicated arrangements had to be made when a client required two workers who had to be brought on foot, by bicycle or in cars, together at the same house at the same time. Organisers in rural areas pointed particularly to these geographical difficulties.

These logistical problems were compounded by staffing problems which they in turn exacerbated. Staff were widely seen as difficult to acquire and - at least in some parts of the independent sector - hard to keep. Staff freezes in the public sector were compounded by what were seen in one authority as slow and bureaucratic appointment procedures. Once inducted staff required training in moving and handling before being allowed to work. The sectors were seen as in competition with each other for staff and also with the supermarkets.

In the independent sector - and increasingly in the public one - there were staff who were only paid in relation to the hours they did. They did not relish the prospect of one hour's work at eight o'clock in the morning. In the independent sector some worked for more than one company or belonged to 'banks' of staff serving residential homes or hospitals.

For their part, organisers in the public and independent sectors felt a dual responsibility to both staff and clients. The heavy packages of care received by some clients implied that a death could mean a sudden decrease in workload. This could have major financial implications for staff concerned with the client. Conversely the sickness of a member of staff could imply a sudden large increase in workload for others. Outbreaks of 'flu and the demands of sick children and school holidays threatened operational efficiency.

In order to manage this situation, organisers relied heavily on the goodwill of staff to work outside contracted hours to cover for absent colleagues. Diplomacy was required. Organisers were conscious that without staff the service could not be supplied. Unions were also naturally concerned at any suggestions of 'bullying' staff. Organisers were correspondingly wary of confronting staff with deficiencies of practice.

Some also tried to share loss of earnings equally among staff by redistributing the hours that remained. In the local authority sector organisers loaned or borrowed staff to cope with shortages. Unions were naturally keen to protect their members' positions - requiring, for example, in one authority that staff could only be loaned to a neighbouring district with the result that staff under-employment in one district could only be matched with lack of staff in another through a complicated process of 'shunting'. In general local authorities which felt under threat from the independent sector tried to take on all the work they could.

The problems of fluctuating demand, financial stringency and staff shortage were compounded by the need to maintain standards. In relation to the independent sector these were partly defined in terms of logistics and procedures - how staff were recruited, arrangements for training, staffing and quality assurance, qualifications of manager and so on. In both sectors - although arguably less in the independent one - there was an emphasis on health and safety. Staff had to be trained in moving and handling. Homes had to checked and made safe workplaces for staff. So the electrics must not be dangerous. The stairs must be safe. The bed should not be of a height that makes moving dangerous. There had to be a hoist if it is required. Certain jobs required two workers. And in both sectors there was a concern with patterns of service delivery - reliability, flexibility (being able to respond to client wishes as to time of visit), continuity and number of staff visiting one household.

Such criteria were hard to meet in conditions such as those described. Reliability is hard to supply in conditions of rush and fluctuating demand. The dependency of clients increased the numbers visiting their house. For example, a client receiving a moderately heavy package of service might require 14 visits in the week - seven to get them up in the morning and seven to help them get to bed. At the minimum this client could expect to have two regular helpers - one perhaps the key one and the other backing the first up at weekends or in the evenings. In addition it is likely that the client would have contact with a care co-ordinator and at least one other carer to cover holidays. In practice this minimum number of helpers was often exceeded. We did not collect figures on the actual numbers involved but 10 did not appear to be an uncommon figure and these not necessarily all from the same agency.

This situation reduced the power of the organisers and the organisation. The minds of the former were turned to logistics, to the problems of keeping the show on the road. They were conscious of requiring staff to do a difficult, dirty job for low pay. They were also dependent on staff to respond with flexibility and goodwill. As we will see our evidence suggests that the show was kept on the road. This reflects great credit on those concerned. However, it probably does not reflect a straightforward, top-down imposition of good practice. In seeking to understand why the system worked we need to look at the motives and behaviour of those in the front line. To say this, however, is to jump ahead of the evidence presented so far.

Roles

On a daily basis the key roles in managing this situation are those of organiser and home carer. Both roles have changed since the days of the home help service, becoming on the face of it more stressful, and more skilful.

Potentially the role of organisers is highly diverse. They may be involved with strategic issues (business planning, reorganisation, policy creation), budgetary and financial control, issues of scheduling, holidays and rotas, staff management, training and support, staff recruitment and selection, assessment of clients and management of workload, various routine processes such as billing, circulation of authority policy, monitoring of equipment, maintenance of records, completion of questionnaires from universities. This plethora of tasks has to be undertaken in atmosphere of pressure and sometimes threat. Doctors see no reason why staff should not give a client a morphine pill. Relatives ring to complain. Staff ring in sick. Their cars have broken down. Clients or relatives ring. Work schedules are interrupted.

In one authority all these tasks appeared to be carried in the main by one person - the organiser with, in this case, somewhat variable clerical support. In other authorities and in the

independent sector the roles were parcelled out. Day to day scheduling and support might be done by senior home care staff or care co-ordinators who might also do assessments and monitoring visits. Routine clerical work and office management would be done by a clerical officer or office manager. Overall management would be undertaken by the organiser, who might also, for example, be responsible for training staff and for managing overall workload. Both our qualitative and quantitative data suggested that organisers in the independent sector had a rather more 'hands-on' role, sometimes going out themselves to fill a vacant slot in their work schedule.

According to our quantitative data staff in the authority where the organisers carried out the most diverse role were on average least satisfied with the organisers or their organisation. This suggests that satisfactory home care does require attention to the support of organisers. Unsurprisingly the organisers concurred with this view. The need for good clerical support was a theme throughout the interviews. Supportive senior home care staff were also valued where available. Whereas the absence of computers was lamented in one authority, organisers in two other authorities complained of the computer systems they had. Other organisers suggested a need for mobile phones so that staff could be contacted when out in the field. One system which was appreciated by the organiser was found in the independent sector. Staff entering a client's home telephoned the office. The call was not answered but was logged by a computer. Failure to ring the office within half an hour of the expected time of arrival resulted in a warning flashing on the screen. The organiser was then able to interrogate the system as to which of a number of staff eligible to attend the call was available to do so.

Even more important in the public sector was the need for roles that fitted the new tasks of home care. This implied at the minimum:

- changes in hours worked - the pattern of full or half day working inherited from the days of home help was unsuitable for demands of home care with its need for late evening work

- contracts which could require flexibility - senior managers were uneasy with a system which depended so heavily on the goodwill of the staff

- changes in required tasks - in two authorities there was a distinction between staff who did and did not carry out more skilled personal care tasks and the aim was to ensure greater flexibility by requiring all to be able to perform the more skilled role.

Insofar as these contracts were not in place the authorities relied perforce on the independent sector as the only source of workers able to work at the hours required. They could do this

either by putting out the whole package or encouraging a mixed one. We deal below with the relationship between the independent and public sector.

Independent and public sectors

The independent agencies involved in our study were far from a random sample of such agencies as a whole. The range of agencies of which we were aware included those run by large national charities such as Age Concern, some run by large companies which related to more than one authority, some which were essentially franchising operations - taking over or franchising smaller operations and putting in a management package, and some which were small, run as it were from front rooms and surviving through the labours of the owner. Some of these agencies were off-shoots of other operations - one included a nursing arm, another grew from an organisation providing residential care. Others were growing rapidly or were in danger of going out of business or being taken over.

Faced with this diversity, local authorities looked warily and with some ideological unease to the independent sector. Organisers regarded the sector as a threat. Elected members were uneasy about introducing the profit motive into public care. Nevertheless, there was the incentive of community care grants, 85 per cent of which had to be used in the independent sector. Moreover, there were practical needs to meet. So managers looked to the independent sector:

- to reduce costs
- to provide flexible services at unsocial hours
- to provide some specialist services.

In seeking these advantages they wished to avoid too much uncertainty - they did not desire the collapse of a company on which they relied - to assure themselves that the services they bought were of adequate quality, and to keep their own care services occupied. The goal of acquiring low cost, flexible services was dubiously compatible with that of managing and assuring the market and was pursued in different ways by different authorities.

The goal of maintaining their own services was pursued in three authorities by the simple means of making themselves the preferred provider. This meant that those identifying a need for a service turned first to the local authority. Only if the authority was unable to provide would they turn elsewhere. Quite often it was possible for the authority to provide by day but not at night or at weekends. Mixed packages were therefore provided (and generally disliked

on all sides as leading to problems of communication and unclear responsibility). In other cases the local authority 'spot purchased' packages from the independent sector. Block purchases of a number of hours from the independent sector occurred but were uncommon.

The other authority had put in place a 'purchaser-provider split'. This meant that its care managers or social workers were able to spot purchase packages from the local authority and the independent sector as was thought fit. The market was however firmly managed. Fifty per cent of the hours were bought through block purchases. The price was set - the local authority announced the price at which it was prepared to buy. There was an elite 'club' of providers - considerably fewer than the 55 approved providers in the county as a whole - and these formed a bench marking club which met monthly and agreed standards. These arrangements did not suggest raw competition on price and quality. However, they seemed to be intended to avoid the risk of catastrophic failure in commercial or service terms.

For their part the organisers in the independent sector that we interviewed seemed intent on establishing themselves. They did not regard themselves or their organisations as typical of the independent sector. Sometimes they contrasted themselves with their competitors. Generally they prided themselves on their quality, the efficiency of their systems and the professionalism of their approach. They were content initially to take the contracts offered, even if they complained that local authorities were 'dumping' difficult cases. They sought to build good relationships with care managers, and to establish their interest in providing a quality service over the longer term. Some of them sought to meet the gaps which the local authorities did not cover - providing private clients with domestic services, 'sitting-in' services, and breaks for hard-pressed relatives. They put in place arrangements for training staff to NVQ Level 2 and for paying an enhanced rate to those who passed it.

The greatest difficulty facing the independent sector probably related to their staff. Spot purchases in scattered locations did not provide secure employment. The volume of work was unpredictable and the price was put at a level which in the agencies' view made it impossible to pay mileage. In this way the problems of uncertain demand, lack of finance and anti-social hours were passed by the local authorities to the independent agencies who in turn passed them to their staff. In relation to our research concerns the net effect was the same as in the public sector. The operation worked through the goodwill of the staff. The power of the agency to influence practice was correspondingly reduced.

Referral, assessment and review

The infrastructure we have described had to be accessed by a system of assessment, referral and review. In the independent agencies clients and their families could approach the agency directly. Our concern, however, was with care purchased or directly provided by local authorities. Here the system was considerably more complicated.

In one authority most referrals came directly to the organiser who assessed and provided a service if she though it appropriate. In that authority 'heavy cases' (about 15% of those served) had care managers who organised a 'package' seeking services first from their own organisation and then buying in as appropriate.

In the other three authorities all referrals were expected to come through social workers (in hospitals, the equivalent of former intake teams, or specialist long-term teams) or through care managers. In two of these authorities referrers had to go first to their own providers. In the other they could go to either sector. In all authorities budgetary control was vested in these referrers who put together the packages. Changes to the package had to be agreed with them but there were systems of review. Generally cases were reviewed six weeks after referral and thereafter at intervals of six months.

These systems were in some cases relatively new and they were subject to severe criticism.

The first criticism related to *needless duplication.* At least two, and commonly three, assessments were required. There was a needs assessment to determine eligibility and define the package. There was a financial assessment to determine what, if anything, the elderly person should pay. There was then a service assessment to make sure that the home was a safe workplace, ensure that the package was one the service could provide, and determine who would be an appropriate worker. This duplication was then carried over into monitoring. Different individuals might monitor the service from the point of view of the service and care management. Reviews involved people from both sides. It was alleged by some that in former times, all these activities had been carried out by one person, the home care organiser, at considerably less cost.

The second criticism related to *delay*. A consequence of the need for three people to assess was that either the system moved at the pace of the slowest or the service was put in before the organiser could assess exactly what was needed. As a result 'rapid response' teams intended to enable hospital discharge or respond to crises seemed to bypass some of the assessors. For example, in one authority the assessment was done by the organiser or senior home carer. In another the initial service was provided free, bypassing the need for a financial assessment.

A third criticism related to the potential *inaccuracy and waste of time.* It was stated that elderly people would agree to assessments until the financial assessment was made at which point they would withdraw consent so that the work done up to that point was wasted. It was also believed (although not by all) that assessments made in hospital or under the influence of forceful advocacy from relative or client often resulted in a misreading of the situation. A more accurate assessment might be possible when the organiser visited to assess from a service point of view - and for this reason she (usually) seemed to go over much of the same ground. A more accurate assessment still was possible when the home carer started to do the work. By that time, however, the package was fixed, at least until a review.

A fourth criticism related to the *number of people involved*. It was possible for the elderly person to be visited by six or more assessors - to agree the package, for the financial assessment, to arrange the service from the point of view of local authority, to do so for an independent agency, to arrange a further service (e.g. a meals service), to involve the community nurses. Amid this plethora of visitors it might, it was said, be hard for an elderly person with failing memory to make clear distinctions between them or realise who was responsible for what.

A fifth criticism related to *incentives.* This criticism was made in one authority which changed its system in the course of the study. In the old system the organisers took referrals and did the assessments. Somehow or other, so they said, they always managed to fit new referrals in. In the new system the pressure of referrals was on social workers and care managers. The organisers were not in a position to make an assessment, negotiate with the new client and juggle and fine tune the service to others so that a new referral could be taken on. Instead it was in their interests to keep their service fully occupied with current cases. It was in the interests of the assessors to accept referrals to placate referrers. The outcome - whether for this reason or others - was a waiting list which had never existed before.

A sixth criticism related to *inflexibility.* Old people fluctuated from day to day. If they had a fall or they or a caring relative fell ill, more care might be needed rapidly. What then occurred seemed to vary with custom and practice, the relationships between the people involved, the current state of the budget and no doubt much else beside. In some places it was possible for the organiser to vary individual packages up to a certain amount, in others they could do so in an emergency but would need to seek approval within a certain time, in others they would need to ring and approval was almost always granted, in others there was much more difficulty. One organiser stated that where service was urgently needed home care staff would provide it. However, the staff were not always paid for the hours they then put in.

A final and related criticism was that *assessment should be continuous and negotiated rather than punctuated and 'hands-off'*. Organisers continually emphasised the need for communication with their staff. In this way they could be aware of the feasibility of packages, changes in the client's condition including improvements in their capacity to manage. Arrangements for one off assessments followed by reviews at six weekly or six monthly intervals did not allow for this process. In particular they did not allow for the need for negotiation when services were to be lowered. In these circumstances organisers liked to present the change positively. It was good that the old person could now manage. She need not worry about a lack of service if the client deteriorated again - the situation could be reassessed. Such renegotiations required trust and ideally a relationship with some authority to make the changes proposed. The more 'hands -off' the assessment the less the chance that this would take place.

In the face of these criticisms it was hard to see what virtues the new system of referral and care management had. Theoretically it should have had three. First, it should have enabled competition and lower prices. Second, it should have encouraged assessment and practice based on client need rather than service provision. Third, it should have led to a higher degree of co-ordination.

The contribution to competition was not great. The system of preferred suppliers meant that in three authorities the public sector was not effectively in competition with the independent one. The existence of the independent sector put pressure on the public one. However, the care management system did not add greatly to it. Arguably competition existed between companies. However, it was diluted by geographical distribution and the formal or informal arrangements with preferred or trusted suppliers. In the one authority where there was, in a sense, an 'even playing field' between local authority and independent sector, block contracts and budgets still ensured an agreed division of work. In such circumstances it is hard to see that assessments by care managers required to put an agreed amount of work out to the independent sector would have had much effect on competition.

The potential (as opposed to the actual) contribution of the system to quality of assessment was considerable. The logic of care management is that it enables a rounded assessment of a person's needs which leads to a co-ordinated package of care. In the Kent Community Care project and its successors budget holders were encouraged to buy flexible patterns of service to meet those needs - for example, by paying a neighbour to help a person to bed at night. In this way service could be sensitively related to a person's wishes and situation. Something of the social work ethos was brought to the former cafeteria approach to service provision. By contrast the fear was that home care organisers assessed in the light of the service they had available.

Unfortunately this danger had not apparently disappeared with the introduction of care management. It was hard to imagine that the needs of old people fell so neatly into half hourly or hourly packages with which they were provided. We came across no examples of care managers working with neighbours or relatives to tailor packages. (Interestingly this was not the case with individuals given money by social services to manage their own care - two promptly lured away their carers who were staff from an independent provider, paying them higher wages and reducing their own costs simultaneously.)

So the argument for a more rounded approach to need assessment remains. It is questionable whether the current approach to care management meets these requirements. We return to this problem in our concluding chapter. For the moment we need only note that the quality of assessment again depends crucially on the home care staff. Without feedback from them it is in danger of being inflexible and ill-adapted to the requirements of the situation.

Integration with the community and other services

The need for integration between the Home Care service and others is considerable. Whereas the potential benefits are great, actual practice in this regard seemed patchy.

On the health side the main contacts were with hospitals, G.Ps, and community nurses. Home care staff could benefit these services by a rapid response to hospital discharges, by reducing need for visits by community nurses (for example, to prompt medication), by alerting the community services to changes in the clients condition, by taking parts of the former role of community nurses, and by facilitating the work of the nurses or ambulances (for example, by having the old person ready for a certain procedure or to go to hospital). For their part, the home care service was dependent on the medical services for expert back-up, for training in certain specialised procedures, and for equipment (for example, incontinence pads or a hospital bed to ease problems of moving).

These mutual needs provided scope for considerable co-operation. As will be seen later in the quantitative data, the extent to which this was achieved varied. Relationships with hospitals reflected the degree of warning received by the service and the quality of the information. Relationships with doctors were sometimes seen as reflecting a lack of respect on their part - a tendency to treat the service as a prescription pill. Relationships with the community nursing service but also seemed to reflect the agendas and personalities of the teams involved.

We gathered much less information about social work and occupational therapy, who were the main contacts in social services. The delivery of aids was commonly criticised as late. So it

might take two years to provide a shower. Social workers featured as referrers - sometimes seen as sympathetic and sometimes, as illustrated earlier, criticised for a lack of a hard headed approach. In contrast to community nurses there were few spontaneous references to the ongoing activities of social workers. They were not, for example, referred to as playing a key role in negotiations with relatives or in setting up new packages. Some care managers were, of course, trained as social workers and the important relationships with them have been discussed in the previous section.

The final set of key relationships concerned the surrounding community. In all authorities the relatives were seen as important. Evaluations tended to be polarised. Some relatives were seen as wonderful. Others were criticised. So they were only too glad to shrug off their responsibilities, to keep the old person at home in unreasonable circumstances to avoid the sale of the house, to appear at long intervals and assuage their consciences by criticising home care. There were few references to work with relatives to achieve given ends. However, relatives were seen as a useful means of reducing responsibility. A telephone call to a relative could leave the organiser feeling easier in their mind.

Neighbours featured more occasionally but in one authority quite considerably. The home care staff in this authority worked in quite small patches. They were known to the community and subject to pressure from them. Home care staff were only seen when out and about, and exchanged necessary information with each other in the street. In such circumstances they might be seen as gossiping and lazy. By contrast the staff were also a known resource. In the week prior to one interview a member of the home care staff had apparently saved an elderly woman's life (not her client's) when appealed to by her son and by dint of unblocking her airways and putting her in the recovery position. In other authorities neighbours featured less prominently and mainly as a source of a key to gain entry to the client's house.

An important point about these relationships is that they are again conducted at a low level. The authority features in them but mainly as a means of providing a context or framework. It is easier to conduct relationships when resources are adequate and the person has autonomy to respond. Equally, however, authority regulations provided tools for bargaining. There were, for example, numerous and varying rules on medication. Generally home care staff were allowed to prompt medication, to unscrew the tops of bottles and to place them near the elderly person. Pouring was generally forbidden, as was anything more interventionist. However, there were variations. In one authority one grade of home care staff was involved in giving medication. In others medication could be given if supported by a medication book and a 'nomad pack'. Or it might be possible to give medication if given specific back up on what it was, the procedure etc. The existence of such regulations allowed the organisers and staff

to protect their positions, while on occasion bending the rules when it seemed sensible and safe to do so.

Ensuring high quality

All authorities were concerned to ensure high quality home care. The methods they used involved the training of staff, supervision, quality visits by organisers or senior home care staff, consumer surveys and inspections. Considerable reliance was also placed on complaints and in local authorities there was monitoring of sickness rates on an individual basis. These methods could be required or imposed on agencies in the independent sector as a condition of their approval.

As will be seen in the section on quantitative data, training was generally appreciated. In two authorities there were targets for the number of staff to be trained to NVQ Level 2. In another there was a system of personal development whereby an individual's needs for training were identified and efforts made to provide it. Training was seen as raising difficulties. Staff who were being trained were not available to cover. Sometimes training was cancelled or delayed. However, the only direct criticism made of it was that it was sometimes conducted in rather idealised circumstances - for example hoists were demonstrated in old people's homes rather than in domestic circumstances where they were rather more difficult to operate. More generally training was seen as constructive, needed and helpful.

The extent of individual supervision varied widely. Generally it seemed to be more of an aspiration than a reality. In one agency in the independent sector it took place once every eight weeks and according to a schedule which covered client needs, procedures and other matters. In one local authority it was said never to take place at all, and in another it was virtually restricted to unusual work on child care cases. In all authorities organisers tried to make themselves available to staff so that problems could be discussed at the latter's discretion and as they came.

The main mechanisms for quality control at an individual level were complaints. Apparently these were always taken seriously, although not always considered serious. Sometimes they were explained as reflecting clashes of personality, sometimes as reactions to the withdrawal of a valued carer from the home care team, sometimes as a feature of an awkward client, and occasionally as resulting from bad practice. In addition organisers made, when they could, quality control visits. These were not always given high priority and sometimes skipped. Concerns about malpractice mainly related to staff not turning up. In such circumstances

organisers or seniors might make unannounced visits, or ring the clients home to see if the member of staff was there, or even drive out and wait in a lay-by to see what happened.

Less extreme bad practice and less extreme measures - for example, observing practice within the home - were rarely mentioned in the context of quality control. Organisers made their views known on particular issues. For example, they stressed the need for confidentiality. One organiser appeared to have repeatedly stressed the need not to take the client's washing home. She was, however, resigned to the idea that this was a practice that still continued. So quality control at an individual level concentrated on rare instances when things went badly wrong rather than on raising general standards. Goodwill after all was crucial. Accurate knowledge of what was happening was limited. Home care staff did not take kindly to aspersions on their practice. Unless things went badly wrong it might be wiser to let them go.

At a more general level, there were in all but one authority consumer surveys. Generally (but with one exception) these seemed to demonstrate very high levels of satisfaction. As will be seen later our own efforts in this direction produced a similar result. This conclusion remained despite our efforts to shake it with more detailed qualitative interviews. Nevertheless, the questions remain. Was this a consequence of the organisational framework within which the practice took place? Or was it a demonstration of the ingenuity and goodwill of workers in the front line?

In conclusion

The shift to home care has faced local authorities with major problems. In responding to these demands they have relied in part on the independent sector to provide a more flexible and cheaper service. They have also developed their own services - introducing care management, changing the roles of their staff, renegotiating the boundaries with the health service, and introducing a variety of quality and budgetary controls. The resulting system works in two ways. The bureaucratic arrangements seem designed to ensure that some service, avoiding that of dreadful quality, is provided in circumstances which are logistically very difficult. High quality depends on the initiative, goodwill and commitment of frontline staff.

This conclusion is in line with the evidence presented in this chapter but hardly proved by it. In the next two chapters we will return to the same questions again.

3 Staff and Clients: The Qualitative Data

Introduction

We turn next to the home care staff and their relationship with their clients. One source of data is provided by the guided interviews with both. Another comes from the qualitative comments in the questionnaires where we had left a section for clients (or their relatives) to tell us anything they thought important. We analysed these latter data using a specialist package, *winMax* (Kuckartz, 1998).

The chapter covers much the same ground as in the last. What are the roles and tasks of home care? Against what criteria can they be judged? How does the organisation strive to meet these criteria? What part do home care staff play in achieving success?

Given the similarity of the questions some of the answers repeat those already given. They reflect, however, a different source of evidence, and provide a check on our conclusions. For this reason, and because of our own shortage of time, we have allowed repetition, however, inelegant to remain.

An example

We begin with an example. It is not a typical example as the member of staff provided no personal care and the clients required none. Moreover, the member of staff described her calls as 'pop-ins' - a kind of work which the local management no longer sanctions. Nevertheless, the case, which was selected haphazardly - just happening to be the top of a pile - illustrates a number of key features of Home Care which can then discuss in more detail below.

Margaret Patterson (the worker in this case) is aged 34 and has been in Home Care for two and a half years. She works a thirty hour week for the local authority seeing 11 different clients, six of them on a regular basis, at a rate of £5.12 an hour with enhancements for work after 8pm (*1⅓) or on Saturdays (*1½) and Sundays/Bank holidays (*1½). Her usual hours are 9am to 10am and then 3.15pm to 10pm. Her clients are split between two villages and although she is not allowed to count travelling time as hours, she gets an extra 34p for each hour worked.

Margaret described her work with two clients: Mrs McLaren (whom she has had since she began as a home carer), and Mr Pollock, with whom she has been working for eight months. Service to both clients began when they broke their legs following falls. She describes her tasks with Mrs McLaren as follows:

> *I just put the coal on. She has a big Park Ray fire and the girl goes in in the morning and takes the ashes out as she has a huge ash pan and it can be quite dangerous for anyone unsteady. She's left all day so I go in every evening for about a quarter of an hour and put the coal in or top it up at night and I lock up the coal house and shut the fire doors, otherwise it will just blaze away...*

These tasks are routine and done at a regular time, although there is slight variation in the time depending on other clients, and some odd jobs may also be fitted in, but not too many:

> *We just knock and she knows who it is because it is the same time of day and she says 'just come in'.* [If things come up that you think need doing, do you do them?] *It depends you have got to be very careful - yes, I do bring her post and mail round and I post her letters and things like that ... Sometimes she has just had her tea, she does not like you even to wash up. She is a very independent lady.*

Despite the brevity of the encounters they have taken place over some time and the two get on '*very well'.*

> *Her son has had a by-pass. She was a bit weepy last night, yes you do give them emotional support, you do make time for that. Because we are allowed half an hour either way, so you can make time for things like that .. We get on very well and you have to understand that although Morag has been in in the morning, you are the only other person she has seen all day and you are part of her life line to the outside world.*

Such brief calls over a long period also give some opportunity to note and act on changes:

> *... If I noticed anything wrong I would report to the office right away. Last year she had something wrong with her hip and knee so they increased the service to lunches and teas because the girl in the morning reported that she could not get out of bed ...*

Such changes require good communication and a knowledge of whom to contact:

> *I would report to the manager because your supervisor is out at work ...we have to keep each other informed.... but a lot of it is confidential ... well like when Mr Pollock was taken to hospital they contacted me to save me calling we are all quite local. ...*

Margaret also has knowledge of good contacts with the informal network connected with Mrs McLaren. Indeed Mr Pollock is Mrs McLaren's brother. Her role has involved her in contact with them in a good neighbourly way:

> *She does have a family but they come from Scotland ....They are on the phone every day a couple of times a day.* [I have met them]. *I took them to the train station last time they came ... She has friends from ... that will take her up a couple of times a year so she gets away ... Two nights a week she goes to bingo. Mr Pollock is her brother, his son pops up to see him and then takes her and a couple of her friends to bingo just up here. He comes back and picks them up and brings them back here. That's as far as she can walk to the car.*

Overall Margaret is pleased with the work she does with this client. Certainly she does not find it difficult.

> *It's easy, it's one of my easiest jobs.....Mrs McLaren knows what she is doing. With someone who is confused you would have to watch them a lot more.*

This picture of Margaret's work is essentially confirmed by her clients, although they provide further detail. According to Mrs McLaren:

> *She makes up the fire and makes my bed. She is very thorough and I have no grumbles at all ... If I was wanting anything I would just have to ask her and she'd do it ... She knows all my relatives and friends. She meets all the family when they stay ... she calls the doctor* [if I need it] *... She leaves things to hand. It's important to have her every day. It's a little bit of company because you sit and talk - have a little bit of a chat. I am happy about the service. You know you are keeping your home tidy and clean.*

Mr Pollock, who received a very similar kind of service, was even more forthcoming with his 'encomiums' - a gratifying confirmation until it became apparent late in the interview that he had chosen to describe not Margaret but another home carer who was also looking after him.

They're good really. They only live 80 yards away ... do anything for you ... Janet could come to me any time she wants. People round here think we're man and wife the way we are. No trouble with her. I say 'you're the boss'. She tells me what I need ... things for cleaning and I give her the money ... We have a cup of tea and a chat ... who's going out with who ... I can ask her to get a prescription ... I canna speak too well on her ... she's grade 1.

In relation to the argument we wish to develop, this example, chosen haphazardly and in some ways atypical, illustrates some fundamental aspects of home care. These relate to its *basic characteristics, the personal qualities* it needs and its *organisational requirements.*

The *characteristics of home care* we wish to highlight are among other things that it usually involves:

- *holistic care* - Margaret undertakes practical tasks but is also important for Mrs McLaren's emotional well-being, for making her feel part of the social world and for keeping an eye on her medical state

- *a routine adapted to the client's* - clients vary in whether they get up early or late, have someone to do their 'big weekly shop' and so on and so the care they receive needs to be adapted to their routines and networks. For example, Mr Pollock's big weekly shop was done by his son rather than by the carers

- *flexibility* - in the short run a willingness to do small jobs that come up at the time of a visit and in the longer run an ability to run down or increase the amount of service (both had been done for Mrs McLaren) a feature which relies on the communication between the workers and their central office

- *time and thoroughness* - the typical visit is clearly short - 15 minutes - but Margaret does not seem unduly rushed - she attends to detail - closing the fire doors, locking the coal house and if necessary she has half an hour leeway

- *sensitivity* - Margaret is good-hearted (she runs the family to the station). She is also sensitive. She realises Mrs McLaren likes to be in charge, admires her strength and independence but stays with her when she is weepy, chats to her about matters of local interest and is aware of the different challenges posed by someone who was confused.

Over and above her personal qualities Margaret also benefits from a system that is locally based, allows her to build up a picture of her client over time (she has been with her for over

two years), and gives her some autonomy in how she responds (she has her half hour either way) as well as the possibility of asking for further resources if she needs it. In contrast to someone making a 'one-off' visit she can do her work quickly and without putting Mrs McLaren to the trouble of explaining where the coal is or that the fire doors need to be shut.

In many ways Margaret bridges the worlds of formal and informal care. She often responds as a good neighbour (which, as it happens, she is). However, she is also aware of the need for confidentiality and of her need on occasion to contact her manager. She is aware of what Mrs McLaren can and cannot do, of the particular challenges posed by her housing, of her need for independence, of the details of her support network and of her routine. She acquires this information almost as a good neighbour might. Potentially, however, it puts her in a position to provide the information required for sensitive formal assessments which adapt to the shifts in the client's physical and emotional state and in the support they receive.

How far does our other material support this analysis of the characteristics, organisational requirements and potential of home care?

The roles of home care staff

The roles of home care staff are shaped partly by the needs of their individual clients and partly by the characteristics of their service. The former are of their nature 'holistic' and reflect in part the routines of the client's day. These routines are of varying kinds. Some are conventional - clients need to get up, get washed, get dressed, have breakfast, have lunch and perhaps a nap in the afternoon and then have tea or supper and go to bed. Other routines are medical or personal - clients may need creaming, drops in their eyes, wet bedding or clothing changed, and complicated regimes of pills and medicines at varying times of the day and they need to use the toilet or commode.

These personal requirements are closely linked to the clock. Other needs can be met at less strictly determined times. These include needs for housekeeping, laundry, links with the outside world (the collection of pensions and prescriptions, the payment of bills, the posting of letters), household management (roofs, plumbing, gardening) and, above all, for social company and emotional support.

As we have seen in Chapter 2, the response of the home care service to these needs is quite heavily determined by those which are 'clock driven'. There is a concerted effort to get a large number of clients up, washed, toiletted, creamed if necessary, breakfasted, and into their chairs between 6.30 and 10am. There may then be a slight lull in the proceedings which is

followed by another drive to get clients their lunch between 12 and 2pm. Between 5 and 10pm there is a further drive to get clients their tea, into their bed clothes and into their beds - an operation which may involve two visits (for tea and then for putting to bed) or only one. Less time driven needs - for example, for housework or the collection of TV stamps, may be managed through a regular special visit - as when a client is given an hour for the weekly shop or for cleaning on a given day of the week - or fitted in as the opportunity allows. The net effect of attempting to deliver a standard service to so many clients in so short a time is that the time allowed for many visits is very short:

> *As a general rule not enough time is given for calls e.g. 30 minutes morning call. Help client out of bed. Wash, dress, toilet client, breakfast and wash-up. Prepare food for lunch call (veg). Make bed, tidy up, leave client comfortable. 30 minutes lunch call. Cook dinner, wash up after meal is eaten. Make client comfortable, toilet again, wash again where necessary.*

This standard allowance can clearly take little account of daily variations between clients (e.g. in terms of constipation or accidents), the differences between one client and another, and the differences in their home circumstances:

> *They don't give you enough time to cook meals. They expect everyone to use Micro Meals but a lot of elderly people don't have microwaves.*

As again seen in Chapter 2, this pattern of work is extremely difficult to manage. The needs that have to be met do not fit neatly into an ordinary working day. Most clients want to get up at roughly similar times and the problem of getting round all of them is extremely difficult. The compromises that result do not necessarily please clients, who may find that they are unable to have a lie in on Sunday, or face a choice between going to bed at six o'clock or spending the night up in their chair. Moreover emergencies intervene. Staff go sick, their cars fail to start, clients are found dead or fallen, the plumbing has gone wrong, there is a fall of snow, it proves impossible to open a door. Some way or other the human factor intrudes:

> *No matter how well a day is planned the 'human factor is always going to crop up. You find someone who is fallen, sick, covered in tish* [respondent's euphemism]*, deeply depressed who will need much more time than allotted. ... Rigid times for each client are unworkable.*

Faced with the problem of balancing finite resources against a large and, to some extent, unpredictable demand, the local authorities have, as discussed earlier, responded in a logical fashion. They are attempting to negotiate new contracts with their staff to ensure that peak

times are appropriately covered, to export uncertainty and unsocial hours to the independent sector where staff, as have been seen, work unsocial hours, for comparatively low pay and often for spot contracts, and to provide routinised responses to general needs (e.g. through arranging for the local supermarket to set up a system for shopping). In addition, they have set up a variety of charging regimes which whatever their function in raising revenue, effectively limit the amount of domestic care which clients are able to purchase from the local authority or make it prohibitively expensive to purchase any at all.

These strategies are part of an attempt to manage demand by redefining and limiting what home care staff do and the clients for whom they do it. Thus, even where staff are visiting clients on a reasonably regular basis, there are a variety of mechanisms in place likely to limit their roles. Time is restricted so that there is (in effect though probably not by design) less time for social and emotional interaction. There are rules which vary between authorities but which have similar effects (for example that staff may not accept Christmas cards from their clients).

An important vehicle for implementing this policy is provided by care plans. These specify what the carer is to do (and by implication is not to do) in the client's home.

> *Clients all have different needs on a daily basis. Whatever is needed, if it is not written in the care plan I'm told not to do it.*

In general the plans emphasise personal care. Even where there is space for domestic care it is the first thing to give.

> *When a client needs extra help because of ill-health or deterioration our care manager always asks us to take time from our housework time.*

And care may also be cut because of the needs of other clients.

> *Calls have to be cut short wherever possible ... priority is always given to personal care. Cleaning is either not done or cut short.*

As discussed in Chapter 2, a further consequence of the dominance of the clients' daily routines is that except in the case of a small number of relatively able bodied clients, it is not possible for a single worker to meet all of the client's needs. To do so she would need to work seven days a week and cover at the minimum, breakfast, lunch and bedtime. One worker in the private sector appeared to be doing nearly this for one client. However, a more common pattern was for carers in the local authority sector to cover a client's breakfast (a half hour to hour call depending on the authority and the client's dependency), come back for lunch for half an hour, and - sometimes - provide the same client with an extra hour and a half in the week.

This pattern of work required other workers to cover the evening and the weekend and sometimes specific tasks such as domestic work or shopping. So carers might perform more limited roles exclusively or in addition to their regular work - sleepovers, fire-making calls, putting to bed calls, one off domestic calls. Almost invariably more than one worker was involved in visiting a house. On occasion there were up to ten. Services could also be provided by the local authority and the independent sector or even, occasionally, by two independent providers. As we will note later, this results in a need for teamwork and good communication, and it also restricts the roles of at least some workers.

Yet despite these pressures towards a limited more focussed role for home care staff, those we interviewed seemed to have a holistic view of their job. It may be that some workers who provide brief episodes of task-oriented service, often on a relief basis, do not see their work as involving more than personal and domestic care. Our interview survey of staff did not include such carers. **All** those we interviewed saw it as part of their job to keep an eye on their clients and to respond to their emotional needs if they were able, and in the majority of cases they were providing some domestic and practical help as well as personal care. In some cases, as we document later, this involved a somewhat cavalier attitude to rules and care plans.

> *She likes her breakfast made when I go in and I massage her feet. She gets an hour in the morning and the time goes ... I treat a client such as Mrs D as a person and whatever she needs she has ... taking her into her garden, making her breakfast, whatever she needs if it's within reason. If it's good for her and it's what she wants, that's o.k ... I treat her as a human being, an individual, not what it says on paper. That's how I work.*

The degree to which such a holistic approach was either required or supplied varied. One client had an hour a week domestic help as this was available to him without charge. He met other needs in other ways and, as the interviewer commented, was satisfied with what he got because 'there was little to go wrong'. Other clients had domestic needs met by their families but relied on home care staff for heavy personal care (e.g. two carers to roll client and change bedding and then manoeuvre him on to a hoist). For some clients what was important above all was the standard of domestic work - '*she hasn't got a very good reputation round here, she could walk through leaves ankle deep in your back yard and not do anything'.* Some had their emotional and social needs met by family and friends. For others, however, what was important above all was the relationship with the worker, and so they waited at the window for her to arrive with the kettle ready to go on. Such clients might try to keep the worker talking at the end of the visit or 'manufacture' things for her to do. One worker remarked to her client that time with her passed quickly, only to be met with the reply '*but when you go it will pass*

really slowly'. A small minority expected a high standard of flexible help, controlled by the recipient and enabling her or him to live as near as possible a normal life.

So the roles of home care staff and of home care itself are not the subject of consensus. Some clients want a total response to their needs, others want a response to particular needs only. The local authorities are naturally concerned with supplying a robust, fair service in which all are served to the same standard and staff do priority tasks and do not linger with particular clients simply because they like them. Clients may take a different view of the matter. So too may staff, 70 per cent of whom agreed in the questionnaire that it was sometimes necessary to bend the rules in order to do a good job. In the more qualitative material the issues centred on the restrictions perceived to exist over domestic care, and the time available for emotional support and other more general roles. In what follows we will explore these issues first in relation to the basic job - domestic and personal care - and then in relation to what might be called the added value of home care - what home care staff provide for clients over and above the management of basic tasks.

The basic tasks

It is a necessary, although not sufficient, condition of being a home care client that one is not able to carry out certain key domestic and/or personal tasks. The majority (60%) of home care staff who responded to our survey said there were involved in domestic work to a medium or high degree. (Involvement in such work was highest in the authority from which Margaret came, where many elderly people relied on coal fires). Only a quarter of respondents reported relatively little involvement in personal care and, as discussed earlier, this part of the work was generally seen as having greatly increased.

> *Carers are being asked to do more and more of what I would say is the district nurses' job - applying Tegaderm to clients' bottoms, cleaning and creaming, and putting bandages etc on legs.*

We will examine the criteria against which these basic tasks were judged, the factors which, in the carers' and clients' view made these criteria difficult to fulfil and then the factors which, despite the difficulties, seemed to enable what by any standard seemed to us a remarkably impressive service.

Criteria and difficulties

The criteria against which practical work and personal care were judged were not surprising. They were those which might be expected given the nature of the task and which have, in any case, already been largely identified in the literature. Clients wanted a service which was adequate in amount, value for money, delivered at times which fitted their routine, reliable, thorough and flexible enough to deal with needs that came up. They wanted workers who were obliging, clean, cheerful and matter of fact in dealing with 'accidents' and other potentially embarrassing incidents, gentle and safe in dealing with bathing and personal care, adequately skilled at the tasks they undertook, and careful to leave the house as they found it with equipment and bathroom clean and everything in its proper place. They preferred workers who knew their routines and with whom they did not have to spend time explaining everything afresh.

These criteria were more explicit in the complaints made about the service than in the much more frequent expressions of satisfaction. One respondent, for example, summed up a number of criteria in an unusually explicit critique.

- *not flexible*
- *invasion of privacy by too many workers*
- *hours to suit them not us*
- *my carers were originally home helps and not really cut out for this kind of work*
- *we would like to employ who we want, who <u>wants</u> to do the job, not <u>has to</u> - there's a big difference*

In relation to *the amount of care* the majority of complaints focussed on the withdrawal of the domestic service. Some needed no practical care:

> *I only need some personal care and the food preparation - the rest my daughter does for me like the shopping, washing and cleaning.*

Others made private arrangements with neighbours or others because this was cheaper or otherwise more convenient. Some thought they needed domestic care and were entitled to it as part of the service:

> *I do think I should be able to get my cleaning done.*

Others acknowledged the receipt of domestic care but felt the allowance was insufficient:

My home is a mess because 1 hour cleaning is not long enough, plus I have asthma.

Others pointed out that certain domestic tasks were essential, not luxuries:

I am totally dependent on the careworkers to do my shopping from the local village shop. This causes me distress as the careworkers don't do it willingly and say they haven't the time.

For staff these restrictions on their role could bring a loss of job satisfaction:

I was happy in this job 13 years ago when I started. We only used to do cleaning, shopping, and pensions, laundry and paying bills. But things have changed over the years. Personal care came in our job description and now we've been told all the cleaning, shops and pensions are going over to the private sector. So therefore we will be doing personal care only.

Others complained that these changes showed a lack of understanding of the clients' feelings:

Management seem to think that the domestic side of the job (e.g. housework) is not important and it is the first thing to be cut when cutbacks are necessary. But a lot of old people get distressed if this is not done, and, after all, many of them are housebound and spend their days looking at the jobs that have not been done, knowing they can't do it themselves.

The timing of visits was not a matter raised by many staff. It was, however, of considerable importance to some clients. Many of them were expected to get up at what others might see as unusually early hours and then go to bed at times more commonly associated with early childhood than adult years:

They come at six and you don't go to bed till 10? Well you have to, er, just take it. 'Cause I've often asked if I can have it later ... One of them came at ten past five when we were watching Home and Away, an' I chased her. I said 'there's no way I will get ready for bed at this time'. I says 'come back at six o'clock'.

Clients rarely criticised the domestic care (if any) provided by their regular workers. Reliefs, however, were a different matter. Their arrival could be unexpected and alarming:

> *I opened the door and there was this 6'2" man and he said 'I do sandwiches'. And he didn't say he came from ... And I said 'no thank you' and shut the door.*

Their demeanour and behaviour might not inspire confidence:

> *This child and she was a child came for the weekend. And in the morning the proper one came and she was very, very good. At lunch time this kid, she was a school kid, she came walking in. I said 'who are you? 'Oh, I've come to fill in' ... Well you're not old enough, I thought, 'Good heavens a nice pretty chick like that I don't want her to see me struggling to the loo' ... I thought 'ooh I don't want her doing food. I'll have toast please and an apple. She came in truly. 'Ere's your toast' and (out of her pocket) 'ere's your apple'.* [client asked child to wash apple] *'she said 'you're fussy".*

As implied above, weekends could be a particular problem. There were fewer workers at these times, those working had farther to travel and greater difficulty in keeping to schedules, they also did not know the clients' routines and might even miss calls. Some clients complained they received no help:

> *I am pleased with my regular daily carer. But when she is off I often do not get a replacement and have to ring ... At these times I don't get breakfast until nearly lunchtime and can't take medicines without food.*

Others complained that they did not know the carers:

> *My helps on weekdays are excellent. At weekends I never know who I am going to get.*

The standard of care provided by these unknown workers might also be criticised:

> *After numerous phone calls, I have now got a regular carer who is able to cook. One I had didn't know how to peel a carrot.*

Holidays could also be a source of trouble:

> *If I am on holiday my clients seem to get messed about as well. Either no one turns up say for their lunch and the lady has to ring them up or they are late. The clients seem to get wound up a lot as well.*

> *At major holidays care almost non-existent. My father will receive one visit each morning and be left two rounds of bread and spread in the fridge .... Considering he is totally bed-bound and dependent on help for even his bodily functions this is totally inadequate. How can he need one level of help during the week and 75% less at weekends?*

Routinised meals and shopping services were a further focus for criticism:

> *Most of our clients hate the shopping contracts with the local supermarkets. It was much better when we did it. In a way it is actually abusing the elderly because they are not allowed to make choices of how or where they spend their money. A lot of people like their meat from the local butcher and fish from a wet fish shop. How are they expected to know what they want a week before. I know my clients and if I saw a bargain at a reduced price I would bring it for them. This system has taken a lot of the caring away for our clients which they received from us.*

A client's daughter who happened to be present at one of the interviews made a related point on another routinised service, meals on wheels:

> *When my mum first came out of hospital they said she needed more care and gave her meals on wheels and I would not even give that food to a dog, I'm sorry. My mum had lost a lot of weight and had a very poor appetite and they used to rush in and dump the food in front of her so the only ones she saw were in the morning and evening .. (client) it's much better now, they used to put me to bed at 6.30 pm, it got that early.*

Another focus for criticism was provided by the rules and regulations which made it difficult for staff to respond to the clients' needs:

> *They are only allowed to do what they can reach and are not supposed to move things like cookers which can be infuriating*.

This was sometimes attributed to safety regulations:

> *Health and safety issues means less and less can be done to suit us.*

And sometimes, as mentioned above, to the increasingly 'medicalised' role of the carers:

> *She seems to expect to work for me personally and emphasises she has many other sick people ... A very pleasant person in herself but more inclined to do nursing work ... I do not expect a char lady but sometimes a change of bedclothes or help in hoovering my small abode a great help.*

A key issue was the lack of time for the visits that were made. This restricted the ability of staff to respond to clients' requests or provide other than a basic service because, for example, they were *'restricted to nearby shops which are expensive'.* Tasks that were not essential might have to be left. '*She gets my breakfast ready and washes up - well sometimes they do, other times they don't because I have not finished eating and they have another call to go to'.* Carers were generally perceived as being in a rush and as having to skimp. *'I turn the central heating off by mistake. I wish they would check this. They always seem in a rush.'* And even basic tasks might have to be cut to the minimum. *'I sometimes have as little as 20 minutes to help shower or bathe a severely disabled person. I feel this is impossible and also dangerous.'* And even if the result was not dangerous, it could be seen as leading to a low standard of care. *'You could do with more time when it comes to personal care e.g. bathing or showering a very old person you have to go at their pace not yours'.*

A client made a similar point, emphasising her need to have number of needs met and to a standard which in her view was necessary to an adequate quality of life.

> *Well, I am quite satisfied actually. But as I say when winter comes, I don't really think that to do my feet, which means getting the bowl, getting me ready to sit somewhere, to have them done, to boil the water to leave sufficient supplies for during the night, to make me a meal, to leave the sink clean and the bathroom, just in case of an emergency. I do not think half an hour is adequate for that do you? I suppose you'll say it is. They've already said so. But quite honestly, I've had a fantastic life and I would sooner go to sleep and die in this state than rot away.*

Time was required not only for routine tasks but also to allow flexibility. This was necessary during the visit itself (Margaret, in the example, had half an hour to allow for it). Clients had *'good and bad days'.* On some visits they would be much stiffer and slower than others. They might have accidents or the doctor might need to be called. And there were the unpredictable requirements of daily living. The letter needed to be posted, the client was sick and had not been able to feed her cats, the prescription needed to be collected, the client was weepy and depressed.

Moreover, this day to day uncertainty was accompanied by temporary and more permanent shifts in the client's condition - influenza, the gradual onset of dementia, falls leading to longer term deterioration, the move of neighbours on whom much had depended, admissions to hospital followed by a period of rehabilitation. So there was a need to amend care plans, to arrange temporary additional help, to ensure that houses were adapted. And this need to amend implied also that this could be done with some dispatch - that adaptations did not wait for ever, that authorisation of additional help was not too long delayed.

So complaints about inflexibility related to the lack of time to respond to fluctuating demand on the visit, to slowness in reassessment, and to a refusal to change the 'package' at all. It was commonly said that *'there is no time for the unexpected'.* A worker complained that '*Reassessment is too slow sometimes. Managers used to be able to give extra care in emergency situations. Now it is unofficially relied on that home care workers will bear the brunt of this extra care needed in their own time which they do and this is not right'.* An informal carer complained that *'all the help my mother gets is to give her lunch. I ask for extra help e.g. some shopping and a bit of cleaning but I am refused.'* By contrast *'I find no faults in the care received. If my needs change they change the service to suit my needs.'*

Finally, as emphasised in some of the quotations above, clients wanted willing and obliging workers who knew their routines. Generally they were very reluctant to criticise any of their workers other than reliefs. The odd complaint, however, served both to highlight the criteria against which other workers were judged and to highlight the high standard generally found. That said, a handful of clients out of more than 800 respondents found their care workers...

> *...lazy and inefficient. In the past I have had a careworker who was totally abusing the system, turning up late and going before her time. You feel you can't report it as you may be intimidated ...You just sign the sheet they give you.*

Some did not find them obliging. Hygiene, economy, care of equipment and leaving the place as found seemed to be the points at issue.

> *I have observed extravagance in the use of cleaning agents owing to a lack of care in reading and following instructions.*
>
> *If the microwave is used I would like it washed.*
>
> *Bathrooms and kitchens are left untidy. I think carers need more training in kitchen hygiene.*

The majority of careworkers do not handle your equipment with care or put things away and require your time after they have gone to tidy up after them.

How does the system cope with these difficulties?

The difficulties outlined above are not accidental. They follow from the demands placed on the service and the limited resources available to respond. The withdrawal of domestic care reflects scarcity. The problems over bed-times and getting up times reflect the need to provide a service to so many people at similar times, and the difficulty of organising a response at unsocial hours. Lack of time inevitably leads to rush, difficulty in responding to the unexpected and difficulty in changing the service to meet needs. The routinised responses - frozen meals and shopping services - are natural ways of trying to save time.

Even the occasional complaints about the staff are probably to be expected. In so large a service at least some reliefs will not know the clients' routines and at least some workers are likely to be less good than others. Moreover, the jobs are stressful. Their tasks are frequently dirty and unpleasant involving wet or soiled beds, dirty houses, and, more frequently in the independent sector, work at anti-social hours. Out on their own at night they have to negotiate traffic and rough housing estates on winter evenings. At night in particular they lack back-up and even in the day the organiser is often busy and may have little time for them. Their clients are not necessarily grateful, and may accuse them of theft or even physically assault them. Emotionally they must manage the deaths of clients of whom they are fond, the anxiety of leaving elderly confused and disabled people on their own, the feelings aroused by the complicated relationships between clients and relatives, and the sense on occasion that their own organisation does not do as much for clients as it might.

Given these difficulties both for the staff and for the service how was it that the latter was not a disaster but often very highly praised by its recipients? What features enable both organisation and staff to achieve this feat?

One requirement was clearly *time*. As the quotations given above make clear most of the respondents we interviewed realised that staff had other urgent cases to visit and were understanding if corners had to be cut. If anything they blamed the system or the management rather than the staff. Nevertheless, it was clearly not possible to give an adequate service unless the time was at least just sufficient for the tasks that had to be done. Given such time it was possible to do domestic tasks with the thoroughness and attention to detail the clients appreciated, and also to take time over personal care - giving clients time to soak, ensuring the temperature of the water was exactly right, allowing them to wash the parts they could reach for themselves without '*trespassing on them'*. *'She puts the Comfort in my washing machine and it gets out in the fresh air when possible'. 'She has bought milk for me*

today because yesterday all she could get was semi-skimmed.' 'She puts things in the right place and I have to have things to hand.'

Adequate time was also one prerequisite for *flexibility.* Generally flexibility was attributed to the good-heartedness of the home care worker rather than the responsiveness of the system. The key concept was that of being *'obliging'* and of *'being willing to do anything for you'. 'Nothing is too much trouble she is such a pleasant young woman'* or *'My daughter does my shopping but the carer would do if required and has done when she has been on holiday or ill'* or again*' They will do extra things or other jobs if I ask them'*. As discussed below, carers commonly make time for such eventualities, taking it from other jobs, or working unpaid in their free time. Too little time, however, does not allow even this kind of juggling.

A further desirable feature was *familiarity*. It helped greatly if carers were familiar with their clients and, almost as important, their clients' houses. As noted above, carers at weekends and on holidays were commonly seen as less good and clients complained that '*they're shifting them around all the time'.* Familiarity meant that workers knew the routine, knew where things went, knew that the client was or was not steady on their legs, and so knew whether they needed to be close by when the client was washing, knew how the client liked things done, and did not have to take up the client's time by continually asking where things were or how they worked.

Familiarity enabled a *smooth performance*. The care worker approached the house with the equipment she needed (rubber gloves, tabard etc). If the client required the use of a hoist or other tasks requiring two, two carer workers needed to arrive together. Assuming only one was needed, she let herself in or was let in by the client using an agreed method. She then went through a well-rehearsed routine in which the client too, if she was able, played a part (e.g. by washing while the breakfast was made or switching on the kettle at an agreed point in the proceedings). Typically the carer worked while she talked. *'You don't stop, you don't drink tea, you just keep going.' 'Your hands work as hard as your mouth'. 'She never wastes time.'*

Although the performance of necessity had to be undertaken at speed, it was important to avoid giving the impression of rushing. One of our staff respondents explained that in her opinion this was the key to caring in a way that the clients found satisfactory. Clients who felt the care worker was rushing would not feel well cared for (a conclusion certainly in keeping with the statistical material from our questionnaires). In order to avoid rush, it was necessary to become skilled at coaxing clients who were stiff, slow or simply reluctant to get up. It was also necessary to become skilled at leaving, ensuring everything was to hand, that the place was safe and locked up, and that the client knew when the next call would be. Carers

commonly reported that some clients were lonely and tried to keep them in conversation at the end of the visit. So the carer needed to develop skills in balancing the client's need for a chat against the next client's need to get out of bed, and skills in making her departure (e.g. by making a joke and leaving while the client was still laughing).

Implicitly or explicitly the care workers needed to work as *part of a team*. Teamwork was clearly involved in direct care - in being able to move a heavy client with a colleague in a co-ordinated way, in having a smooth routine together on joint visits and in being punctilious about leaving the lunch prepared so that at the lunch-time visit the next care worker was able to get things under way without delay. Teamwork was necessary in managing time off, holidays, sickness, and unavoidable emergencies. In such circumstances much depended on whether other workers were willing to cover flexibly and without fuss. Teamwork was also necessary in ensuring supplies and preparing the next worker for unexpected difficulties. Thus staff working at night might need to rely on their colleagues to ensure that there was a fresh supply of incontinence pads or cleaning materials and would be grateful for a note that the fridge was broken but that action was being taken to remedy the matter.

More widely the *team* implicitly involved the client's informal carers (relatives, neighbours, friends) and the client herself. These were required for an adequate support system to ensure that the client's practical needs were met. Ideally tasks were distributed not on the basis of role (e.g. it is the task of staff to cream legs) but practicality. So the problem of putting clients to bed at a time convenient for them was sometimes resolved through neighbours or relatives who did this either routinely or on certain nights so that the client could watch their favourite television programme. Similarly housework might be shared between daughters, or the big shop might be done by a relative while the home care worker popped in to the shops to get the odd item. Clients might pay neighbours or others to shop for them - a device which increased their informal network and commonly cost them a great deal less than getting this done through social services. And they could help more directly, for example, by being ready for their bath when the carer called, or by turning on the oven ready to put in the meal.

Teamwork was involved in keeping these support systems in good repair. A client's circumstances changed on a weekly or even daily basis - they fell, they got ill, their daughter fell ill and so on. As a consequence the time needed by clients had to be 'fine tuned'. As seen above, some of this fine tuning was managed by the staff themselves who would take on extra tasks or adapt what they did to circumstances. Sometimes, however, this was not possible. For example, if the daughter who commonly put the client to bed went on holiday, this would involve an extra visit. As we will see in the next section, such adjustments might require assistance from professionals outside the social services. At the minimum, however, it was likely require decisions from within the social services and thus depending on procedures, the organiser and senior home care worker (if any), the care manager (if any), social worker (if

any). So the worker had to be sure that the information could be conveyed easily to these professionals and that appropriate decisions could be quickly made. Equally it was helpful if the worker had a working relationship with the informal network, thus being able to ring a relative or neighbour to check that some minor emergency could be handled.

As just illustrated a key requirement was *good communication*. In part this was simply an aspect of good teamwork. However, it was also a key part of structuring the task. Staff going on visits wanted to know roughly what was expected of them and information on any relevant changes since the last visit. This was particularly important to them if they were reliefs and did not know the client well or even at all. For these purposes the care plan, viewed by some at some times as an unhelpful straightjacket, could prove extremely useful. It provided guidelines on what was needed, and enabled staff to resist unrealistic expectations on the part of the client. Systems for leaving messages in the client's house or at the office where the care worker could pick them up were equally valued.

Paradoxically a directly contrary requirement was *bad communication*. Perhaps this would be better described as *delinquency.* In essence, the system worked as well as it did partly because staff did not behave as they were supposed to and the organisers either did not know or turned a blind eye. This delinquency took various forms. Staff might work for the clients for longer than they were supposed to for no money. In the independent sector this practice could cost the company money. As discussed in Chapter 2, organisers preferred staff to let them know that the client needed more time so that they could negotiate with the local authority to regularise the arrangement. Staff could make a private financial arrangement with the client - a practice which was regarded variably in one authority as a sackable offence or an inevitable consequence of county cutbacks - or they might alter the activities they did within the context of the hours they were allowed. Staff could make time during the day to undertake tasks which were, strictly speaking, forbidden:

> *Jobs that we can do to fill in the time, e.g. cleaning and shopping we are told we cannot do this.*

Probably the most common example of this practice related to taking washing home. Staff said they were not allowed to do this because of the risk of cross-infection. However, not all clients had their own washing machines, so, rightly or wrongly, some staff felt they could assess the risks, and commonly washed the clients' washing in their own machines. Other examples, included fitting in odd tasks during a visit - *you can't leave them without sugar till Saturday* - juggling the length of times of visits (e.g. by putting in an hour and a half shop when only an hour was required and thus enabling the client to get much better value and choice from a supermarket while cutting down on the time of other visits), and putting in eye drops or undertaking other medical procedures when this was strictly against the rules. Health and

safety rules might also be breached, for example, by cleaning the tops of the clients' cupboards on the grounds that this was safer for carer than client and that if the former did not do it the latter would. And moral rules - for example, that carers were not allowed to buy alcohol or cigarettes for a client - might also be flouted. If cigarettes were a client's major pleasure why should they not have them?

This organisational delinquency was variably regarded. Some clients insisted that their workers should not break the rules and cleared changes of plan with the organiser. Others were unaware or indifferent. A sizeable number were aware that the worker was doing something against the rules and regarded this as evidence of how good she or he was. Workers similarly differed. Some felt that it was unfair on their colleagues if they went against the rules, thus creating expectations their colleagues might not be able to meet. Some felt that the care plan was a useful protection for them and the clients needed to learn what the role of the home care worker was. Others adopted the principle that if something was necessary but not on the care plan they would do it and check later. Others breached the rules on occasion (in the survey 70% agreed that it was at least sometimes necessary to do this in order to do a good job) but said that it was necessary to be careful. Some went on the principle that if it was needed and good for the client, that was fine by them. A focus group of workers at the beginning of the project became much preoccupied with the principles that should govern the provision of such informal help.

Inevitably, however, the situation created tension. One client, for example, described an incident which was initially giving her much pleasure. There had been a storm and she was concerned about her garden:

> *I said to Katherine, 'can you take me out to see what has happened in the garden... so she did. Devastation! She said 'alright, I'll get that cleaned up', which she did... I was sitting there thinking 'isn't this lovely', fresh air sitting outside, thrilled to bits, and someone went past and said 'instant dismissal if you're caught gardening' ... So I looked at them and said 'Excuse me her time is finished', which it was ... I said 'this has got to be cleaned because if not it's all over the path here'. I said 'that will go into my house and it will be twice the work and ruin the carpet'....I walked away so frightened.*

For the workers these 'delinquent' acts can create tension and lead to resentment against the department which relies on such delinquency but does not acknowledge it.

Overall, therefore, the successful performance of practical tasks depends on the organisation providing adequate time, enabling the workers to be familiar with the clients they serve, allowing and promoting flexibility, and fostering teamwork and good communication. As

discussed later, these provisions depend to some extent on others (for example, the provision of adequate time depends to some extent on the efficient organisation of rotas so that workers do not have to double back on themselves). However, they also depend crucially on the skill and motivation of the workers. To a degree these qualities can be exercised in the service of both organisation and client. Workers who are skilled at what they do are pleasing to both. To some extent, however, workers can only please the clients by bending the rules. In this respect the organisation can not acknowledge or promote good service. How far does this principle apply to what we have called the 'added value' of home care?

Added value and sensitive caring

The added value of sensitive home caring is something which the organisation can not require and the client cannot expect. It is embedded in the values of the home care service in the sense that home care workers like to see themselves as providing it. However, workers who do not do so could not fairly be disciplined by their managers or criticised by their clients.

In more concrete terms 'added value' involves three main areas:

- undertaking practical tasks in such a way that the clients are not only enabled to manage but their quality of life is enhanced
- monitoring the client's state and situation and ensuring that problems which arise are tackled

- forming a relationship with the client that is not merely friendly and respectful but also enhances the client's emotional and social well-being.

These aspects of the worker's role were not necessarily discrete and, as argued below, depended on many of the same organisational conditions as the efficient delivery of practical tasks. So there is a case for considering them simply as an issue of style - of undertaking practical tasks in a particular way. This is a valid approach insofar as these additional roles grow out of the basic one. It obscures, however, what seemed to us a qualitative difference between basic and 'enhanced' caring that was so marked as to deserve separate treatment.

Enhancing quality of life through practical tasks

Almost all the cases where we interviewed both client and workers seemed to us to show a standard of basic caring that was at the very least satisfactory. This did not mean that the care itself was satisfactory - for there were organisational conditions that meant, for example, that some clients were put to bed much earlier than they would wish. Nevertheless, these criticisms seemed to us problems that related to the system rather than the workers. In addition, some carers went well beyond delivering a service that was merely 'satisfactory':

> *They do my feet again - that's the idea to get the circulation going. Do my food. Every time they come they peel fruit ... In the winter I always have something warm. I've got an easy diet, its fiddly but its easy - fruit, fish, chicken, poached, grilled, only little bits. And fruit, fruit, fruit, vegetables, vegetables, vegetables. I thought I would have a treat and I've been longing for an avocado ... they were so dear. I felt so guilty and I thought, 'damn it all, I don't drink, I don't gamble, I don't go out - only in the ambulance to visit the hospital; for two and a half years that's all I've done except for this carer.*

> *At one point the morning was done by* [local authority] *and the rest of the day by a private sector company. ... There was a worker there called Jean and she did way and above what she needed to do for my mum... she came back in her own time, she was fantastic, the level of care was A1.*

The features that these clients value are almost certainly those valued by most. There are the nice touches: fruit peeled, tea bags put to hand, marmalade with the rind removed, night clothes warmed before the client gets into them, the water exactly the temperature she likes it, the windows closed in summer because of the noise of the local children (or open for the fresh air), the television controller to hand because she wakes in the night and watches that. There is the sense that the worker sometimes stays longer than supposed or takes you out into the garden when this is not part of the care plan. She may even go with you to a show to take care of you along with your family. If she has taken you shopping, you may be pleased that you have been taken for mother and daughter. Such things are marks, if not perhaps of love, at least of a standard of care, greater than the organisation or the client are entitled to require. They were provided by workers who liked to think that they looked after clients in some ways as they would their own mother, who were familiar with the clients' ways (how else would they know what were nice touches) and who were not so rushed that they had to cut their time with everyone to the bone.

Keeping an eye

The practice of keeping an eye on clients was also something that could hardly be required of workers expected to work at home care rates of pay and without qualification. Nevertheless, this was something that home care workers did. They watched for signs that there was little food in the fridge, that the clients who sat all day in their chair were developing pressure sores, that clients' health was deteriorating, that they were having increasing difficulty in getting out of bed, that they had not moved since the morning visit, that they were becoming forgetful, that they were strangely quiet, that their home was becoming more neglected, that they were not taking their medicine, that their home was getting very cold, that they were having increasing difficulty in hearing, that something seemed to have gone wrong with their family.

Skill in this area of work depended partly on knowledge acquired through courses or experience - for example, on knowing the signs of an incipient pressure sore. It depended crucially on familiarity. Workers relied heavily on comparisons with the client's previous states. How else would they know whether the client's difficulty in, say, standing or talking was usual or the symptom of a small stroke in the night? They also relied on skills in working with clients in general and with the given client in particular. So they needed to know how to encourage clients to take their medicines and also which particular ones were likely to forget to do so and who was likely to tell them when they needed the doctor and who would go unusually quiet. Similarly they needed to have a sense of the reasons for which these things might occur - whether, for example, the lack of food in the fridge betokened lack of money, forgetfulness, or increasing depression.

The ability to act on this information depended on skill, confidence and appropriate connections. For example, one worker complained, quite possibly correctly, that the client's bed was too high. As the client had recently had a fall she was very reluctant to get out of bed at night. As a consequence her bed was often wet and sometimes soiled. This took the worker's time, embarrassed the client, and lowered her quality of life. This analysis on the worker's part showed skill and experience. It was not, however, linked to action. The worker did not feel she was in a position to summon an occupational therapist - an action that required confidence, the availability of the occupational therapist and systems which would deliver what was needed in a short space of time. Other workers spoke of the confidence needed to approach doctors, the need for skill in dealing with receptionists, and the unconscionable length of time which seemed to be required for the delivery of aids and adaptations.

In contrast to the worker discussed in the last paragraph, some workers were prepared to act, even in circumstances which might lay them open to complaint. So they might become involved in the payment of bills, in arrangements for fixing a client's roof, in insisting that a client's ears received attention for wax, and in summoning a doctor:

> *I will sort out her bills and things. She asks me to do it. The other day she got this bill for gas ... she must have spoken to them on the phone in June but she doesn't remember. I've got to sort that out.*

Workers could also be involved in rehabilitation - in encouraging a client to walk or take a shower. Of the latter two activities, the former was usually officially encouraged - rehabilitation was seen as an appropriate role for home care. However, the worker who enabled a client to shower was reprimanded when this came to light. The client had suggested to the worker that they might try to achieve this together and the worker had agreed, feeling that it was possible and that she had enough experience to assess this. This, however, breached the procedure which was that the client first had to be formally assessed to ensure that showering was safe:

> *There's a lot of things that we'd like to see more of that we would be allowed to do. But we would like to get them equipment rather than have to wait... in particular bath aids... there's lots of red tape ... in our contact with the client we can see day to day how people have deteriorated or are not well... bath aids can take months .. different departments .. it's like hitting your head against a brick wall... equipment that's the worst.*

No care workers welcomed these delays. However, some workers welcomed the prohibitions in the care plan. In their contacts with the client they had to define their own role and what could and could not be reasonably expected of them. *'If someone handed me a pot of paint I would say sorry I am a bit busy today'.* In such negotiations a care plan could be useful.

> *Clients should be made aware of what we are actually supposed to be doing for them, because some of them think because we are in their home we should do whatever they want and not what is in the care plan.*

More commonly the workers complained of the restrictions imposed by the plan and of the lack of time associated with it.

> *I feel that many of our elderly are cut off from the outside world. I would love to be able to take them for a walk in the local park or to visit a supermarket but time does not allow this.*

> *It is quicker for carers to do things for (and to) people rather than to support them where possible to do things for themselves.*

As in the case of routinised shopping services they complained of the lack of attention to the clients' needs implicit in some of the procedures.

> *They also don't give you time for hospital visits etc. They want clients to use ambulances. These can make a half hour visit last all day... I always take my clients on hospital and doctor visits usually in my own time*.

Arrangements that contrasted with these slow and apparently niggardly bureaucratic processes included emergency alarms than enabled the worker to get instant back-up.

> *They're on 24 hours a day, 365 days a year. Every house we visit has a telephone in with a red button. Press the button and there's somebody at the other end of the line. They respond to any request that we have, it's like back-up for us.*

Others attributed their success in achieving things for their clients to their good working relationships with local community nurses and G.Ps, their own confidence, persistence and knowledge of procedures, and the fact that they had a good organiser who listened to them and was prepared to act on their requests. Social workers might be valued because the clients could talk to them about things which they would wish to keep hidden from their regular home care workers for reasons of self-respect - for example their lack of money. So the conditions for success were again those which prevailed in the case of practical care - time (for rush precludes the conversation which brings things to light), familiarity, teamwork (in a wide sense) and communication, and an absence of rules and procedures which worked contrary to the service's presumed values.

Forming relationships

The relationship with the home care worker had both social and emotional significance. Socially the workers helped connect the client to the outside world. They brought a breath of fresh air, a sense of life, events and involvement in current activities. They talked of the weather, their families, the client's family, the successes of grandchildren in examinations, the news, the client's former work, the people they had in common in former times, bargains in the shop, television soaps, almost anything in fact except their other clients (something about which we specifically probed and which was only apparently breached by one worker who talked about clients with other workers in front of a client). As far as we could tell, this cheerfulness, liveliness, and good humour was much appreciated. So too was the matter-of-fact way in which the workers chatted while dealing with personal care or embarrassing accidents. As for the workers, they quite commonly said that visiting the client was like visiting a friend.

Smashing, we get on famously. I have no complaints whatsoever. We talk about embroidery. We are always laughing, talking about everything, generally what is going on in the world. I was in the forces so I talk about that.

She's happy, she comes in singing, she's very conscientious and she likes her old people. We were singing along to the Spice Girls yesterday.

All the clients we interviewed seemed to have good relationships with their regular home care workers. (With 'reliefs', as we have seen, this was not always so.) This uniformly favourable assessment of regular workers is likely to overstate the true position. We tried to ensure that the clients were selected on the basis of rules set by us. However, we only interviewed where the organiser agreed that this was appropriate and the worker had agreed to be interviewed herself. Furthermore, the client also had to agree to an interview when asked by someone from the home care service. So it would not be surprising if somewhere along this line poor home care workers and dissatisfied clients were weeded out.

That said, no other research study in this field has, as far as we know, found any evidence of widespread dissatisfaction with home care workers. Moreover, there was almost uniformly high praise of regular home care workers in the postal survey as well as the interview study. This is strong evidence for widespread good relationships. It does not mean that all relationships were equally significant. In practice their significance varied considerably. Some clients met their relationship needs through others, and while appreciating their home care workers, made little distinction among them, referring to them on occasion as 'the girls'. Others were strongly attached to particular workers who became their '*rock'.* Given that much of the impetus for these attachments came from the clients, what contribution did the workers themselves seem to make?

An important part of the workers' skill lay in their sensitivity to differing client expectations and needs. This was apparent in their use of names. We asked the workers at the beginning of the interview what name we should use in talking about two clients. Commonly they would use a surname for one client and a first name for the other. Spontaneously they also referred to the different ways you had to respond with different clients. Some needed to be treated as a friend. With others a more distant relationship was appropriate. Some they kissed when they went in the morning. Most they did not. One worker - we'll call her Margaret, as we will refer to her again - was particularly eloquent on the different roles she played.

Discretion and confidentiality is my main purpose. I never discuss anything with others. ... I will tell her about my life and family... I go into another lady who is vegetating, so I sing to her and she can't remember who I am and once I sing,

> *she remembers. Another lady I tell jokes. So I am different with different clients. Some clients need more support. I go to one, James, and he's a lovely young man and I almost talk to him like a mum. I sing to James and make him laugh. The last thing clients want is for me to moan that I am tired. They don't want to hear my problems. They have enough of their own dealing with what they've got. I laugh with my clients.*

The reference to James as a 'lovely young man' is not atypical. Such *respect for clients* can only be good for them. One of the striking features of the interviews with many carers was the obvious respect they had for people whom they saw in situations which others would find humiliating or embarrassing. Their references to clients commonly showed respect. *'She is very strong and independent'. 'She knows a lot and she's very wise'* '*I am abetter person for having known her'*. And this could be so even though the carer had held the client's hand while the latter was in a deep depression or had routinely had to clean fouled beds:

> *There's loads of good carers. It's not just pushing a hoover and talking .... I lost a guy and he was a lovely man. I feel sad - he only ever saw me. He had body works problems so I used to have an awful mess every time I went in but I had to make him feel it was alright. He was a major in Italy in the war so you can imagine coming down to that ...I look at clients and think 'what if I was there'. You have to treat them like a human being.*

Obviously not all clients were seen as equally impressive. Some workers had been hit or accused of stealing things the clients had hidden or lost and had insisted on being removed from such *'ungrateful natures'.* However, even with such clients some workers, including Margaret, tried to see what lay behind the behaviour:

> *There's been the odd client where no matter what you do they find problems... I think 'why are you like that?' I may have a meagre time with that lady but she has to live with herself. She cannot accept her environment.*

But even Margaret had her limits:

> *I once had a lady whom I worked for. She was very particular. An incident happened when the electricity went off and she turned on me for no reason - because I wasn't there when the electricity went off. ... I was very upset. I handled it by saying that my time working with her had come to an end and I phoned the office at the end of my duty.*

This incident may illustrate one of the problems of close involvement with clients. Margaret had being doing more than was required for this client as seemed to be her wont with all. Her upset seemed to reflect in part her degree of involvement. Such emotionality is a problem in bureaucratic organisations. Upsets such as the above create problems, the emotional dependence of clients on workers could render the former liable to exploitation, the partiality of workers for particular clients could lead to unfairness, to their spending more time with one than another, and hence to an uneven standard of service.

Perhaps for these reasons there was quite a widespread perception among carers that the organisation discouraged close relationships:

> *I clean for her when I get round to it... mostly in the afternoon when I have time. This morning I have been to the library for her to change her books. I seem to know what she likes to read. When you've been seeing someone for a long time you get to know what they are like. You get close to them ... they tell you not to but you do.*

> *The staff in the office seem to be turning the job into a production line, instead of a caring service. They don't seem to understand that sometimes we are the only people the client comes into contact with all week.*

This perceived lack of understanding was sometimes resented. It was also seen as contributing to changes which paid scant respect to the relationships which existed:

> *I feel the clients are just a statistic on a piece of paper. I know you're told not to get involved, but maybe if they did the social worker may have a bit more compassion about them.*

Unsurprisingly, lack of time was seen as a barrier to relationships. Conversation was impossible if the practical work was not carried out in the same room as the one in which the client was sitting or lying. Even if the worker was in the same room, conversation was difficult if the client was deaf and could not see the worker's mouth. So a time at the end of the visit to drink tea and chat was appreciated:

> *I have no complaints. She is very thorough. She has a marvellous memory... she's here more than her time. She often has tea and biscuits and we put the world to rights.*

Time for putting the world to rights was short:

Most of the elderly clients that I visit are very lonely and have some depression. Carers don't have the time to give to the clients who need it, time to sit and chat and to give quality time for this as the pressure is to get what is needed to do in the time allocated.

Loneliness and depression are quite common amongst the elderly. A ten minute talk can make a great difference. Time is allocated for physical tasks only.

The generalised discouragement of close relationships was accompanied by rules which strictly interpreted would break the normal understandings on which relationships are based:

I would like to see a closer relationship between client and carer. Unfortunately we cannot give presents and cards etc to clients or receive any back (only a card at Christmas perhaps). We cannot give newspapers, books or any items to clients even if out of date.

I found that my clients are very upset with the strict ruling that the carers are not allowed to accept gifts. I relate this solely to Christmas time when it is an old ladies' delight to give her carer a box of chocolates. ...It gives great upset and offence when such a kindly meant gift has to be refused.

And such an impersonal view of the proper relationship between worker and client may lie behind the lack of respect that organisations were sometimes seen as paying the relationships that did exist:

Well I think when things are changing the clients should be given more notice than 1 or 2 days. They should be given a week or two - not just sprung on them.

It's sad when you think I've been going to one client for 13 years. She's 98 years old. Now she's going to be upset when she finds I will not be going any more and the services will be going to the private sector. She will miss me and I will certainly miss her.

Generally workers did not take this view of their role. They were delinquent in giving gifts as they were in other respects. This was appreciated:

> *A typical example of Jenny is that my mother has trouble opening cans after she broke her wrist. Guess what Jenny bought her for Christmas - an electric can opener. She is very thoughtful.*
>
> *I have her phone number and if I needed she would call back to make sure everything is o.k. especially if I was having a bad day.*

Many relationships were clearly strong. The workers did not hide their personalities behind a uniform professional or bureaucratic persona, although as noted above they kept to the rules of confidentiality. Margaret's client provided a telling example:

> *So she really keeps to that* [confidentiality]*..... A friend in South Africa her daughter had a kidney transplant and she kept me informed and Margaret said you've got more from South Africa. ... I didn't cry I said 'She's past the crisis point' and Margaret said 'I lost a child with that.' So that is the secret of her caring. I'm telling you that makes her understand if people suffer ... that makes a tremendous difference because as she told me about her child ... I wasn't weeping but I was full ... I saw her eyes and she tossed her head up in the air and she said 'Well that's good. I'm so pleased. There's not a day goes by that I don't miss my child' ... there's mutual respect. I'm satisfied with everything. 100%.*

Organisational issues

It should now be clear that our analysis of the work of home care workers focuses on a conflict of principles. First, there is the need to provide a fair service which responds equitably to a large but fluctuating demand. Even if imperfectly, it provides some response to urgent need. Second, there is a moral requirement to respond flexibly and sensitively to individual clients in the context of a caring relationship. Third, there is the increasing imperative to provide value for money - she who pays the piper calls the tune. For convenience we will call these principles *bureaucratic*, *caring*, and *commercial.*

Pursued to their logical extreme, the principles have implications for the values which underpin the work of home care, the way it should be organised, and the sources of authority for its actions. For example, a fully bureaucratic organisation would emphasise division of labour, detailed rules on what was and was not to be done, little discretion at the front line, a discouragement of risk-taking and a neutrally affective style of work. So it would run counter to the holistic style of work of many home care workers and provide a focus for their dislike of

'treating clients as numbers', care plans proscribing domestic work, rules on doing the clients washing, and discouragement of emotional involvement. It would equally run counter to a commercial approach which treated the client or relatives as a source of authority, valued client choice and was relatively indifferent to issues of 'need'. In the context of such an approach, a client who wanted whisky or cigarettes from the shops would have their wishes met.

Clearly these principles are never pushed to the limit. Organisations are hybrids not pure types. For example, the notion of 'professionalism' involves some attempt to plant ideas of altruism, need and even relationship into the unpromising soil of public bureaucracy. Nevertheless, there is a value in identifying these conflicts for two reasons. First, it may help to lessen the need to blame. Views on the home care service are strongly held. So it is easy to see those struggling to manage the service as heartless bureaucrats when what they are wanting to do is to provide a fair reliable service with distinctly limited resources. Similarly it is easy to see home care workers who go the extra mile for their clients as serving their own needs rather than as caring people acting as good neighbours out of their relationship with clients. A second value in identifying the conflicts is that the actual provision must balance these various principles - whenever one principle is emphasised, it may be well to think how damage to another can be reduced.

In practical terms these conflicts were apparent in relation to a number of distinct areas. In our preceding sections we gave examples of most of these. We will therefore deal with them only briefly below.

First, there was the issue of *values*. Generally home care workers resented being treated as cogs in a machine and monitored like factory workers, clocking in and out of their clients' houses. As we have seen they also commonly found ways round the organisation, doing things for their clients which the organisation proscribed. Such workers took their authority from the clients - if it was good for the clients and the clients wanted it, why not do it? And so these workers espoused a caring principle.

There was also, however, a less marked but contrary tendency. Some workers complained of inequities whereby those clients who shouted loudest got the most, that some workers always volunteered for the difficult jobs whereas others got away with it, that workers did most for the clients they liked, and clients receiving a service on the grounds of dire incapacity were found to have pushed a hoover around during the week. This espousal of bureaucratic principles was also found among certain clients who complained of inequity in service provision. Their needs in their view entitled them to more.

Finally, in certain contexts workers were prepared to espouse a commercial principle. Conscious that their jobs were at some risk, staff in one area were critical of the authority's

willingness to provide a free service. In another authority a focus group of workers became exercised with clients who received services which they did not, in their opinion, need. Their view was that a different approach to charging would sort out who needed the service and who did not. Those who did not would be unwilling to pay the costs.

A second major issue was that of *discretion*. We have already seen how workers and clients often conspired together to get round the perceived straightjacket of the care plan. Here again the relationship principle was at work. Equally, however, workers could value the bureaucratic care plan as legitimising their work, clarifying expectations, and defending them against client demand. They were, however, sometimes critical of the basis on which this plan was made. In their view a half hour assessment made, for example, when the client was discharged from hospital was a weak predictor of what her or his needs would turn out to be. To assess the latter one would need at the minimum to have some sense of the variability of the client's condition, know how the layout of the house impacted on what the client could do, and know something of the client's care network. Moreover, an assessment that was accurate on one day might turn out to be inaccurate on the next because of influenza, the holiday of an informal carer and the many unexpected occurrences we have described before.

For these reasons decisions that were taken close to the client might be seen as more appropriate than ones which, according to good bureaucratic principles, were taken at a greater distance. Certainly workers resented failures to use the close knowledge of the client they felt they had. From a bureaucratic point of view, however, such decisions might be seen as involving specialist skills, an overview of the demands on the budget and the department, and a neutral objective stance to the client which the organisation might require. From a strictly commercial point of view the issue would simply have been whether the client could pay.

The issue of *discretion* was closely linked to third set of issues relating to *familiarity, locality* and *responsibility.* As we have seen a great deal of the discretion exercised by home care workers grew out of their close knowledge of their clients. This enabled them to get the books the client wanted, know which daughter to call in an emergency, and notice changes in the client's condition. This familiarity was facilitated if the worker was also local, with knowledge of the client gained in other ways. It also bred in them a kind of responsibility, an anxiety when they left an ill client at night, a readiness to remind a forgetful client that the rent was due and so on.

These advantages, however, might be seen as bringing disadvantages. Local workers might fall out with the client's informal network. Familiarity promoted a style of caring that fitted uneasily with the task-focussed approach of the care plans. The location of professional responsibility in these plans was, perhaps, unclear, but it was certainly not with an individual

home care worker. Perhaps for such reasons we have heard of authorities (not in our sample) where workers are not allowed to work in the villages where they live, and where workers are deliberately rotated between clients rather than building up a long familiarity with one. All these are further examples of a clash between bureaucratic and relationship principles.

A fourth major set of issues related to *organisational linkage, teamwork and communication.* Both the costs and the potential advantages of local authority home care are closely linked to its location in a large department. This brings overheads, a unionised work force, and potentially high charges. It also offers specialist skills and a guaranteed minimum service. If a neighbour helping an elderly person falls ill, her labour may not be replaced. If a local authority home care worker falls ill, a relief will usually appear. The home care workers are mostly highly experienced and can bring expertise to bear on the client's difficulties. And they are linked to other specialists. For example, clients could in theory be linked to the provision of aids in a way that would enhance their lives and lessen the amount of help they need.

The advantages of teamwork and communication seem obvious. Yet these too could have their 'down-side'. This relates to different views of the service. The worker doing the client's high cupboard or taking washing home is not necessarily keen to let the organiser know of her practice. For her part the organiser is not necessarily keen to know of it either. To do so would be to cause trouble. Moreover, the practice of taking home washing saves time, especially when the alternative is hand washing in the client's own home, when there is little enough time to spare. A key issue concerns confidentiality. Clients with problems over money do not necessarily wish to share these with their workers, however much the latter may suspect what is happening. So social workers may need to withhold information from which home care workers could benefit. Outside the department, medical staff do not necessarily wish to share medical information with home care staff. Practice here seemed to vary, reflecting professional uncertainty. Some workers were able to read records which contained medical details, finding this useful as some clients were uncertain of their own condition. By contrast, others complained of a lack of crucial information. One, for example, had been sugaring her client's tea for two years before discovering that he had diabetes.

So again there is a tension. The advantages of home care stem in part from its bureaucratic nature. Bureaucracies thrive on the orderly flow and processing of information. However, home care may only function as well as it does because some information is withheld.

Two requirements seemed crucial to a high standard of service, whatever the principles against which it was judged. The first was an *adequate quantity of time* to carry out the tasks proposed. The second was a *skilled and motivated workforce*. Even here, however, there is room for doubt over what counts as 'adequate', 'skilled' and 'motivated', and how these qualities are to be ensured. As we have seen, time which was seen as adequate for practical

tasks, did not usually allow for a chat at the end, and this could be important, particularly if the worker was often working in a different room. Rotas which were client oriented (e.g. tailored to the particular time of getting up that the client wanted) might not be the most efficient from the point of view of providing a standard service to a large number of clients. For example, the worker might need to double back rather than going from one to another in a geographically sensible way. Workers who were motivated to provide a holistic service did not necessarily appreciate the implicit prohibitions in the care plan. Workers who were skilled at domestic tasks were not necessarily skilled at personal care.

More generally, workers seemed to modify and adapt the service, generally bending it towards one based more on relationships and what the client wanted and less on the demands of their organisation. In close contact with the client they were able to see what needed doing and quite often they were able to make time to do them. In this way success, as the clients saw it, might depend on the inability of the organisation to control its workers rather than on its capacity to ensure routine and adequate performance.

Conclusion

Home care varies. It may involve twenty years' contact, strong relationships between worker and client, and a holistic style of caring. It may involve brief episodes of contact, in which a relief home care worker undertakes a practical task for someone she does not know and will not see again. Even brief episodes of care, however, repeated over time, give the worker invaluable information on the client's condition, needs and network. In this way, workers are potentially a unique resource for community care. They visit with a frequency that allows a flexible response to changing circumstances. They provide a possible bridge between the informal world of clients, relatives, friends and neighbours and the formal resources of social work, occupational therapy and the medical services. They themselves often have hybrid skills and qualities - the cheerfulness, good humour and practicality of the good neighbour, the respect for confidentiality, knowledge of pressure sores, and sensitivity of the professional involved with old age.

Almost always home care involves practical tasks - domestic care and personal care, sometimes supplemented with some shopping, and collection of pensions and prescriptions. These tasks are judged against criteria familiar from other research - whether the care is given reliably and at convenient times, and changes in response to need. Home care staff themselves are valued if they are obliging, thorough, clean, and tidy in dealing with domestic care and matter-of-fact, skilled and gentle in the delivery of personal care.

In addition to undertaking these practical tasks, many staff provide a standard and breadth of care that goes far beyond what might be expected of them. Their practical care is thoughtful and sensitive to the client's particular needs. They do things in their own time. Their cheerfulness and good humour is an essential part of the client's world. They watch out for difficulties in the client's practical affairs, and physical and emotional state. They intervene tactfully but effectively. And they sometimes form very strong relationships with their clients, analogous to those between friends or relatives. The qualities against which such roles are evaluated are again familiar. Workers who play them successfully are seen as understanding, warm, committed and caring. They also have the experience and skill necessary to keep an eye on the client and take action confidently and skilfully when necessary.

Certain organisational practices seemed likely to encourage success along these dimensions. The worker should be familiar with the client. This saves time, allows smooth performance, enables the growth of relationships and provides the information against which changes can be judged. There should be adequate time so that rush can be avoided. Teamwork is necessary for reliability and to provide support for the worker herself (an issue to which we have not given space). Procedures are required which enable the rapid provision of aids and specialist support and which allow care plans to be changed flexibly when necessary. Communication is required for almost all these practices. Almost certainly the workers were key to any success. Although care is in some respects provided as on a production line, it undoubtedly involves skilled performance by motivated workers. In some routine jobs one worker may easily be exchangeable for another. A description of home care does not suggest it is a job of this kind.

Common definitions of success and common requirements for ensuring it do not imply that home care can be organised in terms of one set of principles. Clients vary in what they want of home care. The service also has to be organised to take account of conflicting principles. A bureaucratic service purely designed to serve large numbers would be heartless. A 'relationship-based' service totally oriented to the needs of its current clients would be inefficient. A purely commercial service would be inequitable. Our qualitative data suggest that staff 'rebalance' the service, softening the impact of its bureaucratic imperatives and making it more responsive to its clients. How far our quantitative data bear out these hypotheses?

4 Process and Outcomes: The Quantitative Data

Introduction

This chapter considers our quantitative data, which we analysed with the help of the *Statistical Package for the Social Sciences* (SPSS Inc., 1988). It has four main aims:

- to develop measures based on the client evaluations.
- to document variations between agencies and units within them. These variations relate to both client based measures and other measures based on staff reports.
- to see whether the way staff describe their units explains in a statistical sense the client responses.
- to see how far client perceptions of service are related to the characteristics of the workers who deal with them.

The basic issue is the same as that tackled in the preceding chapters. How far, and in what respects, is the client's experience determined by the organisation serving her or him and how far by the individual home care staff with whom they deal.

The client's evaluations

Appendix 1 gives the replies the clients gave to our questionnaire in the different authorities and in the independent sector. Such analyses as we were able to do did not suggest serious bias between respondents and non-respondents - a result partly explained by the fact that carers sometimes filled in the questionnaires for those who were confused (see Appendix 1). In one authority it was possible to distinguish between those getting five hours or more care a week and those getting less. We found no differences between the two groups in the kinds of reply given - a result which suggests that the answers are not influenced by the factors influencing eligibility for service (e.g. degree of disability).

As can be seen, the first set of questions mainly related to information. These questions provided evidence of wide variation. For example in Area 4, 43 per cent of the clients did not know how many hours they were expected to get each week, whereas the comparable

percentage in Area 2 was 14 per cent. There was an even more startling contrast in relation to receipt of an information pack about the service. Nearly three quarters of the clients in Area 1 said they had not received one whereas more than eight of ten of those in Area 2 said that they had done so.

The final sets of questions dealt with satisfaction with different aspects of the service. As can be seen from Appendix 1 these gave a very positive picture. Satisfaction was highest with the workers themselves - nearly six out of ten said that they were very satisfied with them. Less than 3 per cent said they were dissatisfied. The satisfaction was somewhat less with others aspects - cost, the timing of the service, its reliability, the kind of service offered and the number of hours received. Here the proportions saying they were very satisfied varied from 37 to 45 per cent. Even with these questions, however, very few expressed themselves dissatisfied, even to a minor degree. The highest level of dissatisfaction was 15 per cent and as this related to the number of hours, it could, in a sense, be seen as a kind of back handed compliment.

Questions about specific aspects of the service elicited the highest amount of dissatisfaction. For example, nearly half the clients agreed with the statement that 'I would like more say in who visits me'. Nearly four out of ten agreed that 'I would like more say about the kind of help I get' and that 'workers seem in a rush'. Just under a third agreed with the statements that 'I hardly ever know which worker will turn up' and 'I need more help than I get at the moment'. A similar proportion agreed that 'workers sometimes arrive late and/or leave early'. Just over a fifth agreed that 'the workers come at inconvenient times'.

Dimensions of satisfaction

As a generalisation, questions about how the workers provided care elicited no significant differences between the authorities. Questions related to the service did identify significant differences. So, for example, the proportion agreeing that workers sometimes arrived late or left early varied from 17 per cent in Area 2 to 39 per cent in Area 3. Appendix 1 contains a number of examples of such differences.

We wanted to know whether these differences reflected specific differences (e.g. in relation to time keeping) or more fundamental differences say in efficiency. For this reason we wanted to know whether different questions in our questionnaire were tapping similar dimensions. A common method of exploring such questions is through factor analysis. This is used, for example, to see whether psychological tests which involve a large number of questions are actually 'getting at' some simple underlying factors - for example introversion or neuroticism.

We used this approach. As can be seen from Appendix 1, component analysis (a kind of factor analysis) identified a number of components in the different parts of the questionnaire.

The first section (Section A) contained three components. The main one concerned the amount of information the clients had about the service - for example, whether they knew what the care workers were supposed to do for them. The second component was specifically concerned with information about costs. The third component loaded very heavily on one question - whether the client had made a complaint.

The second section of the questionnaire (Section B) contained two components. The first of these loaded very heavily on questions concerned with the staff. Typical questions were 'care workers do things thoroughly' or the 'care workers make sure I am comfortable'. We called this the 'care evaluation score'. The second component loaded very heavily on questions concerned with service. Typical questions were 'the care workers come at inconvenient times' or 'I would like more say about the type of help I get'. We called this the 'service evaluation score'. One item, 'the care workers seem in a rush', was significantly related to both scores.

The final section of the client questionnaire (Section C) contained only one component which we called the 'general satisfaction score'. It was strongly related to both the care score and even more strongly related to the service score.

Interestingly, our information scores were only weakly associated with our other outcome measures. General information was significantly associated with the care, service and satisfaction measures, in each case at a level of significance of less than one in a thousand. It accounted, however, for only 3 per cent to 4 per cent of the variation in these scores depending on the variable considered. Financial information was not related to the care score and only very weakly associated with the others. This suggests that the provision of information is indeed a 'good thing'. However, from the point of view of the client it is much less important than other variables in determining the standard of service.

Differences between agencies and units

We looked for variation between these summary scores at the level of the local authority departments (Area 1 to Area 4), the divisions into which they were divided, and the teams. We also looked for variation between teams. We have also grouped together the results from the independent sector agencies and treated them under one heading - 'Independent'.

As might be expected from an examination of Appendix 1, we found large variations in the degree to which clients said they had information in the different departments. These differences applied both to information on charging and general information. In both cases the differences (assessed through a one way analysis of variance) were significant at a level of less than one in a thousand. Much of the difference on financial information arose because Area 1 did not charge for services below a certain threshold (5 hours). Unsurprisingly, its clients expressed ignorance on how their non-existent charges were worked out. Nevertheless, there remained a significant difference between Areas 2, 3 and 4.

Interestingly, these differences did not generally apply at the level of divisions. Only in one authority did we find a significant difference between divisions on an information variable. This related to information on charging in Area 3. In general, however, the main source of difference on information arises at the level of the department and seems rooted in department wide policies.

The differences between departments in our 'outcome' variables were less dramatic. Strikingly there were no significant differences between departments on either perceived carer performance or the overall satisfaction measure. Although the departments organised themselves in widely different ways and were based in localities with different geography and cultures, these differences were not apparently sufficient to produce significant differences in the way carers (or teams of carers) were seen. As these perceptions were very strongly related to overall satisfaction it was not surprising that this too did not vary between authorities.

By contrast there were very highly significant differences on the complaint measure ($p<.001$) and the service measure ($p=.01$). (Unsurprisingly these two measures were associated - clients who said they had complained were more likely to say that they were dissatisfied with the service in certain respects). So perceptions of the service - its reliability, quantity, perceived appropriateness and so on - do seem to be something which different methods of organisation may affect.

What was true at the level of the department was true also at the level of division. The service measure did vary by organisational unit but the measure of carer performance did not. Among the local authorities in the study there were no significant differences within the authority between divisions on the overall measure of satisfaction or on the level of satisfaction with care. By contrast in two of the authorities there were significant differences by satisfaction with service. In one authority the difference was significant at a level of three in thousand and in the other at one in a hundred (one-way analysis of variance). Surprisingly, perhaps, there were not significant variations between divisions in relation to our complaint measures.

The situation was reasonably similar in relation to the independent agencies and companies. Here again there was a significant difference between agencies on the satisfaction with service measure. Here again there was no difference on the measure of carer performance. However there was just a significant difference on the overall satisfaction measure (p=.05) and almost a significant difference on the complaint measure (p=.06).

In two authorities (Area 2 and Area 4), we had additional information on the team by which the client was served. These authorities happened to be the two in which there was no variation by division. There was a small but significant variation between teams in the financial information measure (p=.05, one way analysis of variance). We found no significant variation by team in relation to any of our four outcome measures although there was nearly a significant variation in the complaint measure (p=.08 on one-way analysis of variance).

So the general conclusion seems to be that it is much more likely that organisations influence service than carer performance. A natural question is what kind of organisation produces a better service performance. Before tackling this we need to look at some quantitative measures of organisational difference.

Variations by organiser

The thrust of this chapter, as of the project as a whole, is to 'parcel out' this variation. We want to know how much variation there is between departments, and how far the variation that exists can be explained. In explaining it we are interested in levels. Is it to do with the department, the division, the teams which make up the division, the staff, or the clients?

So far our analysis suggests that the scope for organisational explanations may be quite limited. In relation to information, departmental procedures seem important. Information, however, is not a particularly key part of the service from the point of view of the client. Naturally they are concerned with such issues as the reliability of the service and the kindness of the staff. In this respect our initial analysis suggests that organisational units (departments, divisions or companies) may affect reports of service, but have much less impact on the perceived quality of service of individual staff.

Our next step is to present information on the organisers and staff which might a) help to explain such variability as exists, or b) suggest reasons why there is less organisational variation than might be expected. For these reasons we are interested in similarities and variations between units - where there is little variation it will be hard to pick up unit effects.

We are also interested in general features of the organisers' and workers' situations which suggest that even when variations may exist they may have little impact.

Differences between organisers in different departments

Managerially there were variations in the organisers' responsibilities. Those replying to the questionnaire included managers of specialist hospital teams, teams of 'support workers' and teams serving clients with learning disabilities. Even within more traditional teams there was considerable variation in size. The number of staff in the teams varied from 3 to 200 (although all but 3 fell within the range 3 to 85). The number of care hours varied from 35 to nearly 3500 although again 85 per cent fell within the range of 160 to 1000.

Examination of these figures suggested that the most common size for a team controlled by an organiser varied between departments. In Area 1 the common size was relatively low and delivered between 250 and 500 hours per week. In Area 2 the most common size was rather higher between 500 and 750. In Area 4 the typical size was 750 to 1000. In the independent sector and Area 3, the numbers were either too small or the scatter too wide for a typical figure to be discerned. There was also variation in average hours per client from a low of less than four in Area 1 to a high of just over seven in the independent sector.

In relation to the basic characteristics of the organisers, descriptive information presented in Appendix 1 suggest little variation. The majority are white women aged 40 or over. Most have a formal qualification for the job - in many cases an NEBSM or NVQ level 3 or level 4 or some other specialist certificate or diploma in management. There was variation in the length of time in the job with organisers in Area 4 and the independent sector having spent on the whole less time in the job. However, three quarters had spent ten years or more in home care and there was no sense that they were short of experience.

Other common characteristics of organisers related to the tasks and the problems they perceived. Generally they had access to regular supervision which they described (in the main) as appropriate. Although there were variations in the availability of training it was almost always perceived as appropriate insofar as it was available. They were much involved with supervising staff, with rotas and (except in one authority) with arranging cover when staff were sick. Problems which were almost universal were those of managing times of peak demand, dealing with fluctuations in demand (except in the independent sector), arranging for cover at weekends, recruiting (except perhaps in Areas 3 and 4) (but not retaining) staff, and the poor quality of information received from referrers. Such difficulties no doubt contributed to the generally perceived stresses of the job. However, they did not prevent it from being seen as

worthwhile, enjoyable and fulfilling, a state of affairs to which their perception of generally good communication with their own staff and other organisers may have contributed.

Against this common background there were as shown in Appendix 1 considerable variations between agencies. Some of these differences could be plausibly related to characteristics of the agency - whether it came from the public or independent sector, whether it was rural or urban, the nature of staff contracts, the nature and extent of care planning, size of organisational units (and hence the amount of assistance available to the organiser), recent policy changes (e.g. to reduce domestic care) rendering certain problems more salient. Some variation probably reflected the existence of some 'idiosyncratic' units in the sample (e.g. special schemes for people with learning disabilities, teams of support workers filling in at times of crisis, or hospital discharge schemes). Other variation seemed to reflect differences in the behaviour of surrounding agencies. Some variation seemed to us to arise from differences in the culture and practices of agencies which had grown up over time and were not easily explained by agency characteristics.

Very briefly the differences related to:

- training and support - organisers in the private sector were more likely to claim that they had access to training and that their staff had the training they needed. Support was generally seen as available for organisers except in Area 2 whose organisers apparently felt unsupported by their senior management, and in relation to administrative support - widely perceived as inadequate except in the independent sector, and picked out for particular criticism in Area 1 and Area 4.

- budgetary responsibilities - there was variation in the degree to which organisers felt that budgets were a large part of their job, the only clear pattern being that most organisers in Area 1 felt that this was so, as against hardly any organisers in the independent sector.

- size of unit - there was considerable variation in the 'typical' size of an organiser's unit in different departments. In Area 1 the size was relatively low, in Area 2 intermediate, and in Area 4 high. (In the independent sector and Area 3 there was too much variation to specify.) Larger units were significantly more likely to have clerical support (although almost all units had some) and assistance from senior home helps.

- support for staff - there were wide variations in the frequency and nature of the meetings reported with staff (frequent - more often than monthly - formal meetings for the purpose of individual supervision or training were, however, everywhere uncommon).

- role of the organiser in receiving referrals, making assessments, accepting referrals, refusing referrals, varying the time and number of hours clients received. These variations seemed to reflect a) the nature of care planning - in Area 2 and the independent sector there was less flexibility over varying plans without authority - and b) the presence or absence of senior home carers with organisers without them undertaking more assessments.

- methods of monitoring - as can be seen from Appendix 1 there was considerable variation in the degree to which organisers used or had access to satisfaction surveys, calls to clients to check on carers' whereabouts, time sheets

- liaison with other agencies - perceptions of the efficacy of this varied widely although liaison with medical staff other than community nurses was widely seen as poor.

- flexibility of service to clients - as seen below in Area 2 and the independent sector, staff were much more likely to work unsocial hours and at weekends. In these authorities organisers were more likely to perceive the service as flexible, clients as able to influence the time of visits, and fewer problems of finding staff to work unsocial hours. By contrast, in Area 2 organisers were disaffected with their care planning system and universally reported that plans were reviewed too infrequently and too much time was required to change them. (Except in the independent sector care managers were more likely to be seen as difficult to access than not and this was particularly so in Area 2.)

- reorganisation and worker/client dissatisfaction - reorganisation was almost universally seen as a problem in the local authority but not independent sector - in Area 3 changes of policy over the provision of domestic help probably explains the relatively high proportion of home care staff, relatives and clients who, according to the organisers, felt the service had its priorities wrong.

Variations between home care staff

As in the case of organisers there was considerable similarity in the characteristics of home care staff. They were overwhelmingly female and white. Except in the case of the independent sector, around three quarters of them were over the age of forty. In general they were highly experienced. In the local authorities between 49 per cent and 66 per cent had

spent at least 10 years in the same job. The contrast with the independent sector was stark. Here 79 per cent had spent less than five years in home care and a fifth less than a year.

The workforce was largely part-time. Only a fifth worked more than 30 hours although the proportions working full-time varied between authorities with the largest scatter of hours worked in the independent sector. Despite their part-time status they were more qualified than we had expected. About one in six had an NVQ or City and Guilds qualification, and just over a fifth some other qualification that they themselves considered relevant.

In relation to conditions of service there was again a sharp contrast between the public and the independent sectors. The great majority of those in the public service (96 per cent to 85 per cent depending on authority) had guaranteed minimum hours but this was true of less than a third of those in the independent sector. There were similar contrasts in relation to sick pay, and although the contrast was less pronounced, holiday pay. Workers in the independent sector and in Area 2 were more likely to have worked at weekends or between 8pm and 8am over the previous month.

Typically, staff in the independent sector saw fewer clients in a working week (see Table 2.14 in Appendix 1). In this sector nearly half of them saw five or less - a fact which may avoid the problems of rush for some since they may, for example, have to see only one client for a morning visit. At the other end of the spectrum nearly half the staff in Area 3 were seeing more than 11. The number of clients seen and in particular the number who are not regular clients, has a bearing on the worker's familiarity with what the client needs. The greater the number of clients seen, the less likely were the workers to say they always knew what their tasks were, who else was involved, what the care plan was or the salient facts about the client's condition (all associations significant beyond .0001 on chi-square test).

We asked workers to estimate the strength of their involvement in various activities (Q12). Befriending, personal care, and domestic care were core elements of the job for all carers. Very few reported that they had no involvement in these activities. Between a quarter and four out of ten workers reported that they had no involvement with collecting pensions / prescriptions / shopping (24 per cent), liaising with relatives (27 per cent) and liaising with other professionals (33 per cent). Larger proportions reported no involvement with 'rehabilitation' (41 per cent) or 'medical care' (47 per cent). These latter questions may have been variably interpreted - in one sense 'medical care' is by definition something which home care staff do not do. Nevertheless, sizeable numbers are involved with quasi medical tasks - creaming legs, putting in eye drops, giving reminders over medication This is reflected in the quite sizeable proportions claiming involvement with medical tasks.

There were significant differences between locations on all the variables in these questions. The largest differences arose in response to the question of whether staff worked in their own time for clients. Unfortunately we were unaware when formulating the question that some staff did paid work for their clients. As a result we are uncertain whether the question was interpreted, as we intended, as signifying unpaid work. It was interesting that in one authority 80 per cent said that they were not involved in 'work in their own time' whereas in another, 58 per cent said that they were.

A major difference between the two authorities lay in the proportions working full and part-time. In Area 1 over a third worked less than 20 hours a week whereas in Area 3 only one in 20 did so. This suggested that 'work in your own time' might be more common among carers who worked less than full-time who might use it to supplement their income. A test of this hypothesis showed a very slight association as predicted. However, there was generally no association within local authorities (i.e. workers in, say, Area 1 who worked fewer hours were not more likely to work in their own time than workers who worked longer).

There were some differences between local authorities in the amount of training provided. However, the main difference was between the public authorities and the independent sector workers. The latter were as likely as public sector ones to have had no training before entering the job and were more likely to have had no training since being in it. Workers in this sector also fared rather worse in relation to equipment, being less likely to be given protective equipment or personal alarms (almost all workers received 'guidance notes'). They were also less likely than others to meet face to face with their supervisor and no more likely than others to have contact by telephone. In short, cost pressures or the need for profit have tended to drive down the support provided for workers in the independent sector as they have their conditions of service.

Asked about their organisers, the staff gave them a moderate endorsement. Very few said that they were never available when needed, never acted effectively on requests, never understood their clients, never gave the staff the information they needed and never understood the problems of the job. In each case, however, less than half said that the organisers always succeeded in these respects. For example, in Area 1 fewer than a fifth said that the organiser was always available when needed. By contrast more than half said that this was so in the independent sector. We return to these differences between agencies later.

The independent sector came less favourably out of a question concerned with whether the worker thought of her or himself as part of a team (46% doing so as opposed to 59% overall and 87% in area 4). We have argued earlier that team support was important not only for morale but also to enable problems of sickness, lateness and so on to be dealt with through co-operation and with minimum fuss. So it was, perhaps, disappointing that fewer than half

said that they were 'part of a team of home care staff', and one in seven said that they were not. Four out of ten said that they were 'to some extent'. Workers in the two local authorities where they met regularly were much more likely to say they felt part of a team. Nearly nine out of ten said so in Area 4.

As we have seen, there is a considerable need for liaison between home care staff and other services. The former are in an excellent position to know when their clients are having problems with their families or over money, are depressed, are becoming increasingly stiff, are developing bed sores or need aids to promote their independence. By contacting the relevant services, either directly or through their supervisor, they should be able to improve their clients' lives. Similarly they should be able to make their own job easier, for example by reducing the number of severely soiled beds by contact with a nurse specialising in incontinence. Unfortunately, as can be seen from Tables 2.34 to 2.38 in Appendix 1, home care staff in all authorities generally found it difficult to arrange contacts. Matters were seen as easier in respect of some services (notably community nursing) than others (notably aids and adaptations) and varied to some extent by authority (particularly in relation to social work). On the face of it, however, these figures represent an opportunity missed.

There were also differences between authorities in the degree to which the staff perceived themselves to be in a rush and in danger of being late or missing appointments. In general these problems were seen as an occupational hazard. Most staff saw themselves as sometimes in a rush or late, and one in five even confessed to missing appointments on occasion. A quarter saw themselves as usually or always in a rush. These problems were most commonly attributed to lack of time, although distance between clients and the order in which the workers visited them also played a part. There were some interesting differences between agencies - for example the independent sector, using workers for spot purchased care in scattered locations, was seen as producing problems relating to distance. In general, however (and contrary to the impression given by their organisers), workers in the independent sector saw themselves as being in less of a rush, less likely to miss appointments and less likely to be late.

We asked the workers a series of questions about the information they had when visiting their clients. These covered information on the care plan in general, on the client's condition, on the worker's tasks, and on who else was involved. In general, workers in the independent sector claimed to be better informed on all these issues than workers from the local authorities. One exception to this rule was provided by Area 4. Here the workers claimed to be particularly well informed on the care plan and on their tasks. Interestingly the clients did not share this view. It was in this authority that the highest proportion said they did not know what was in their care plan.

A series of questions on who wanted the work done also showed a sharp contrast between the independent and local authority sectors. In general, staff in the independent sector were much more likely than their local authority colleagues to say that what was done was what the client or relative wanted. Interestingly workers who thought that the organiser's wishes were usually followed were less likely to feel that the client's wishes usually prevailed. We thought this apparent conflict between the wishes of client and organiser would be less apparent in the independent sector, but this was not the case.

Other questions dealt with 'need' and 'confidence'. Interestingly fewer than half the carers said that the tasks they did were always needed. Around a quarter said that the work was at best only sometimes needed. The majority felt usually or always confident about what they did - although a quarter in Areas 1 and 3 did not.

Our final set of questions asked about perceptions of the management of the department, and the support expected by the home care worker. Component analysis of these questions identified three main components. These reflected:

- perceived organisational efficiency - workers who scored high on this component perceived themselves as getting the support and training they needed, that the job was well organised, that they were encouraged to use their initiative, that they had enough time to do a good job, that the care plans matched client needs and that they had enough back up in emergencies ('Good Structure').

- personal satisfaction - workers who scored high on this component felt that what they did was worthwhile, that they enjoyed it, that they got a lot of satisfaction from it and that they were unlikely to leave ('Staff Satisfaction').

- perceived conflict between job and client need - workers who scored high on this component felt that to do a good job you had to bend the rules, that care plans were often out of date and that the job was stressful '(Discontinuities').

On all these components there were highly significant differences between authorities, with workers in the independent sector having the most favourable scores on all three. Among the local authorities, Area 1 workers had very unfavourable scores on the measures of organisational efficiency and on the perceived conflict between the organisation and the needs of the client. By contrast they had the highest local authority scores on satisfaction with the job.

The correlations between these variables and others were as might be expected.

- Workers who thought that their organisation was efficient tended to see their organiser as good, themselves as well briefed, and as having time to do the job.

- Satisfaction with the job was higher when the worker undertook a larger than average number of roles, and perceived themselves as having a good organiser and as being well briefed.

- Workers scoring low on perceived conflict between client and organisational needs reported that they had adequate time, a good organiser, and adequate briefing.

As might be expected, workers who perceived themselves as short of time were more likely to report that they did client's work in their own time. The latter were also more likely to perceive a conflict between the needs of their organisation and those of their clients. One way of managing this perceived conflict may therefore be to do the work oneself.

Variations between agencies and units on staff scores

There were highly significant variations ($p<.0001$ on a one way analysis of variance) between the five agencies (Areas 1 to 4 plus 'Independent') on our five summary scores. Area 1 had on average the most satisfied workers. However, in every other respect it scored 'worst'. Its organisers were seen as least satisfactory, its workers as least well briefed, and the department itself as least efficient. Here too, workers scored 'worst' on the conflict between doing a good job and breaking the rules.

There were also some differences between companies in the independent sector on these measures - specifically on having good organisers and being well briefed. The only other variation at either team or divisional level related to 'having a good organiser' where there were significant differences in Area 4 at the level of division ($p<.01$) and team ($p<.003$).

Organisation and client perceptions

A key concern of the research was to assess the impact of organisation on clients. Our measures of organisation were derived from the home care staff. Our hypotheses were that clients would perceive their experience more favourably when staff:

- perceived themselves as being part of an efficient organisation
- enjoyed their jobs and were satisfied with them

- did not perceive a conflict between the needs of the organisation and its clients
- felt they had a good organiser
- felt they had the information they needed in dealing with their clients
- felt they were part of a working team.

These hypotheses were partly based on the likely relationship between subjective belief and performance. We felt that staff would perform better if they believed they were part of an efficient organisation. It also reflected our assumption that staff would perceive their organisation with some accuracy - for example that staff who believed that they were working in an efficient organisation would in fact be doing so.

We tested the hypotheses using the *MLWin* program for multi-level modelling (Goldstein et al., 1998). Essentially this performs a specialised form of multiple regression. The assumption is that client perceptions will reflect both individual variation - because of their characteristics some clients will be more favourable than others - and group ones - on average clients in some teams will be more satisfied than clients in others. (The program also allows for the possibility that the relationship between client attitudes and characteristics will vary between settings, but we made no use of this feature.) This concept of group and individual effects can be extended higher. Individuals are 'nested' within 'teams' which are nested within 'divisions' which are nested within departments. Variables can similarly be related to levels and the overall aim of the analysis is to parcel out the variation, seeing how much of the variation can be explained by variables at the departmental level, how much by variables at the divisional level and so on.

In developing our model we faced a number of difficulties. It would have been convenient if we could have regarded the authorities as a random sample of English local authorities. The numbers were, however, too small for this and we included them in our analysis as fixed 'dummy variables'.

More seriously, the links that we needed to make between divisions, teams, and individuals could only be made in two authorities. In one authority the union insisted on anonymity for staff. Hence it was not possible to allocate them to any organisational level. A further authority provided information on the divisions within which the carers worked but not on their teams. In the independent sector, divisions and teams did not exist in the same sense - a small agency approximated to a team in size.

Undoubtedly the main difficulty we faced was that the amount of variation at the team or divisional level was small. The main variation was at the individual level reflecting characteristics of the clients, the workers serving them or the interaction between the two. As

we have seen, however, there was some variation at the service level and we exploited this as best we could. In doing so we examined four outcome variables from the client questionnaire:

- *complaint* - a component loaded very heavily on whether the client had made a complaint
- *service score* - the component that loaded heavily on the service questions
- *care score* - the factor score that loaded heavily on questions about carer performance
- *overall satisfaction score*.

We related these four scores to our six explanatory variables, and to information on the departments from which they came. As a check we routinely ran two models. First, we ran a 'three level' model. We treated clients as served by teams and divisions. Where we lacked information on teams we dealt with the two as coinciding (i.e. as being in a division with only one team). Where the results seemed of interest we tested them against a two level model - in this we ignored teams and used average carer perceptions as measures of divisional characteristics.

On our three level model complaints were most efficiently explained by the four items in Table A. (Each item contributes independently after account has been taken of the contribution of the others)

Table A: Items associated with complaints in the 'three level model'

	t	p
Being in the private sector	3.98	0
Coming from Area 3	3.17	0
Being served by a team or division with a low organiser score	2.46	0.014
Being served by a team or division with a high conflict score	1.96	0.05

A possible explanation for these results is that complaints reflect both expectations and performance. In the independent sector clients paying for a service may have been more likely to be aggrieved if they felt it was not value for money. In Area 3, a recent change of policy had greatly reduced the amount of domestic care undertaken and some organisers reported a high degree of resulting dissatisfaction. At the same time service provided by teams without a

'good organiser' or where there was a perceived conflict between the needs of organisation and client may well have been providing a worse service.

The most 'robust' of these findings related to the organiser. Units where the organiser was perceived as 'good' by their staff scored consistently lower on the complaint score. This was so when we looked at the results by division only. The effects of location (independent sector or Area 3) and of the average conflict score were consistently in the same direction but not significant.

The evidence from the three level model suggested that the organiser also played a part in producing satisfaction with the service. The association just fell short of significance, although it was highly significant when only two levels (that of the division and client) were used. In both cases, however, the explanation seemed to be that teams where the organiser was judged to be good were also those where the workers considered themselves to have the information they needed when visiting a client. Carers served by teams which were well briefed as we defined it were more satisfied with the service aspects of their care. The association was highly significant ($t=3.3$, $p=.001$).

Paradoxically, clients felt that the quality of the carers performance was less good where the workers considered themselves well briefed. ($t=2.21$, $p<.05$). The association was in the same direction but more highly significant when we tested it using only two levels ($t=2.38$, $p= .017$). It was in the same direction but not significant when we tested in the two authorities with accurate information on which staff were in which teams. Given its paradoxical nature this finding should be treated with great reserve. It does, however, suggest that the variables which influence perceptions of service do not influence perceptions of care. If in further research the finding was repeated, it would suggest that staff who are not well briefed have greater freedom to respond to client requests and hence are more acceptable to them.

The major influence on overall client satisfaction was their perception of the carers' performance rather than the quality of the service. Here again there was a paradox. In our main three level model clients served by units which their workers perceived as efficient were less likely to think their carer's performance was good ($t=1.95$, $p=.051$). Such clients were, however, less likely to be served by units where staff judged that the organiser was 'good' ($t=1.99$, $p=.015$). These two variables (perceived efficiency and perceived quality of organiser) were positively associated. They only became significantly associated with carer performance when both were entered into the equation in the three level model. Moreover the associations were not significant, although in the same direction when we entered them at two levels only.

As can be seen these findings provide support for few of our hypotheses. Clients served by teams where staff felt a member of a team did not report greater satisfaction overall, with their

care or with the service. They were, it is true, significantly less likely to make a complaint. However, this seemed to reflect the fact that the independent sector scored 'worse' on this variable and was also associated with complaints.

Perceived efficiency, the efficient passing of information, and a perceived lack of conflict between the needs of client and organisation were associated with client perceptions of good service. However, they were not associated with perceptions of good carer performance - if anything the reverse.

The most consistently positive, if weak, effects were associated with the quality of the organiser. This was associated with a lower complaint score, greater satisfaction with the service, and, tentatively, with overall satisfaction. However, the latter association only became apparent when account was taken of the perceived efficiency of the service. Ominously, the more staff saw the service as being efficient, the less satisfied the clients were overall - and this notwithstanding their lesser tendency to complain. Statistically the 'good' organiser appeared as a benign figure tempering the impact of organisational rigour.

Such a conclusion would go considerably beyond the evidence. What the evidence does suggest is that organisational power is limited. The quality of service (quantity, timeliness, reliability and so on) can indeed be influenced at the organisational level. The quality of what goes on within a client's house seems more difficult to affect.

Ratings of staff based on interviews

These data suggest that the organisation has a weak or even negative impact on the performance of individual staff within the client's home. Some aspects of performance - reliability, the number of different staff who visit and so on - can be influenced by policy, resources and organisers. Other aspects - for example, the gentleness with which the worker moves the client or their tact when the client is low - are not. How far are these less tangible matters influenced by the characteristics of individual workers?

The question of the relative impact of staff and organisation was central to our original design. Our aim was to interview 48 pairs of home care staff. Each pair was to have a different organiser and each member of the pair was to serve two different elderly people living on their own. This would yield 24 organisers, 48 staff, and 96 elderly people and all of these would also be interviewed. Combined with our qualitative data this should allow us to see whether the service received by elderly people was similar when they were served by the same organiser and particularly so when they had the same home carer.

Unfortunately the design depended on the availability of elderly people who lived on their own, were lucid enough to be interviewed and received a service from the relevant worker which was sufficiently frequent to enable them to pass some judgement on it. These old people had to volunteer and be paired with staff and organisers who also volunteered. It soon became clear that this plan was impractical. We were simply unable to recruit sufficient numbers who fitted these criteria.

Given these difficulties we had to modify our design, seeking to achieve the same aims but by different means. One aim of the original design had been to tease out the impact of the organiser. This aim we pursued using the large scale surveys that had not been part of the original design. One advantage of this change of tack was that the numbers were large enough to detect some organiser effect - something that would almost certainly not have been the case in our original methodology.

The second aim of assessing the impact of individual workers was pursued as follows. We had 30 members of staff who fulfilled the following conditions:

- they had been interviewed about the service given to a client
- they had been rated by the organiser on their quality as a carer
- at least one client had commented on their performance.

We concentrated on these 30 staff and on measures of their performance. These performance measures were derived from three sources: a) an interview with them which focussed on their work with an individual client, b) ratings of the worker made by their organiser which focussed on their work in general, and c) ratings made on them on the basis of an interview with the index client (in 18 out of the 30 cases the client discussed in the interview with the worker, and in the twelve cases where this was not possible, another client interviewed about the worker). The interview schedules are given in Appendix 2.

Our interviewers asked the workers about a particular client. They used the replies to rate particular aspects of the service given and also to make four global ratings of the staff member's skills and attitudes (e.g. in terms of sensitivity). Clients were also asked about the service they received from the worker which was again rated. (To ensure a lack of 'contamination' we tried to ensure that the interviews with staff and with their clients were not carried out by the same person.) Both sets of measures could be related to the ratings made by the organiser. If some staff are better than others then ratings of their general performance (as acquired from the organiser) should relate to ratings based on our interviews about an individual case.

One problem we faced in carrying out this design related to the quality of the workers' performance. Understandably the organisers found it very difficult to find any fault with the workers in question. For example, all the organisers gave all the workers the highest possible ratings for friendliness and interest in the client. Fewer than one in five were said to gossip, even occasionally. The proportions who failed to get the highest ratings for 'sensitivity'; 'understanding' and 'skill in keeping an eye on clients' (surveillance) were somewhat higher - between one in five and one in three. Only, however, in relation to stress and need for support was there any great spread of ratings.

Such high ratings might perhaps be put down to loyalty. Our interviewers, however, found similar difficulties in finding fault. This was the case whether the measures were based on interviews with the clients themselves or with their workers. Both sets of interviews involved asking the interviewees to talk through the contact between staff and client. The expectation was that although closed questions would elicit conventionally favourable or acceptable replies a more free flowing style of interviewing would elicit dissatisfaction and descriptions of insensitive performance. This expectation was rarely born out.

On the basis of their interviews with the clients the interviewers rated aspects of the service and of the worker's performance. Ratings related to the worker's performance focussed on: negotiating what should happen on the visit, undertaking domestic tasks, undertaking personal tasks, providing emotional support, keeping an eye on the client, dealing with members of the client's network, and leaving in a satisfactory way. The interviewers were asked to rate these aspects of the service on two four point scales - one indicating the degree of the client's satisfaction and one indicating their own judgement. They carried out 55 interviews and in 56 per cent of these **all** the aspects of carer's performance were judged fully satisfactory from the point of view of the client. The comparable rating made from the point of view of the interviewer was only slightly lower (44 per cent). (See Tables B and C.)

Table B: Number of times client judged aspects of performance not fully satisfactory

	Frequency	Percent
None	31	56.4
1	14	25.5
2	6	10.9
3	1	1.8
4	2	3.6
5	1	1.8

Total	55	100.0

Table C:
Number of times interviewer judged aspects of performance not fully satisfactory

	Frequency	Percent
None	24	43.6
1	16	29.1
2	5	9.1
3	6	10.9
4	1	1.8
5	2	3.6
7	1	1.8
Total	55	100.0

Faced with these almost uniformly high ratings of performance we decided to concentrate on those where a) we had some spread of performance and b) we had hypotheses on the directions of the effects (this excluded ratings concerned with 'enjoyment', 'stress' and 'need for support'). We judged that we had some spread of performance when at least a fifth of the carers were judged to have performed less than fully satisfactorily on the variable in question. This left us with a total of 11 measures. These were:

- Organiser ratings of worker skills and characteristics: six ratings covering 'understanding', 'sensitivity', 'reliability', 'care skill', 'surveillance skill' (she watches out for them well) and 'punctuality'

- Interviewer ratings of worker skills and characteristics: two ratings, 'care skill' and 'surveillance skill', together with a summary score based on worker description of their performance (number of times worker judged to perform less than fully satisfactorily over six areas)

- Summary scores of worker performance with individual client: two scores based on counts of less than fully satisfactory performance in seven areas - one score reflecting judgements of client satisfaction and one interviewer judgements of whether performance satisfactory (based on Tables B and C above).

In analysing the data we dichotomised all the variables into ‘perfect performance’ and ‘less than perfect performance’. Table D shows correlation coefficients (Kendall’s tau) between the organiser ratings and our three measures based on the interview with the worker. Two further summary measures are included in the table. Both are based on adding together the other measures in the row or column.

Overall the data show a reasonably high degree of correspondence between the organiser ratings and those based on our interview. Both summary scales relate at a high degree of significance to all the other variables in the set.

Table D:

Correlations between organiser ratings and ratings based on interview with worker

		Interviewer ratings of staff			
Organiser ratings of staff		Care skill	Surveillance skill	Performance	Interviewer summary
Understanding	**tau**	0.904	0.248	0.512	0.677
	n	27	28	30	27
	p	0	NS	0.006	0
Reliability	**tau**	0.321	0.362	-0.313	0.441
	n	27	28	30	27
	p	NS	NS	NS	0.018
Sensitivity	**tau**	0.321	0.411	-0.193	0.472
	n	27	28	30	27
	p	NS	0.033	NS	0.011
Care skill	**tau**	0.37	0.139	-0.071	0.355
	n	27	28	30	27
	p	NS	NS	NS	NS
Surveillance skill	**tau**	0.497	0.248	-0.118	0.527
	n	27	28	30	27
	p	0.011	NS	NS	0.005
Punctuality	**tau**	0.299	0.354	-0.112	0.332
	n	27	28	30	27
	p	NS	NS	NS	NS
Summary (organiser)	**tau**	0.506	0.411	-0.323	0.517
	n	27	28	30	27
	p	0.004	0.017	0.051	0.002

Key: tau = Kendall's 'tau' correlation co-efficient
n = number of observations/cases
p = probability
NS = not significant

The correlations given in Table D (Kendall's tau) give a sense of the consistency and strength of the associations but are probably inappropriate as a guide to their significance. (The

statistic is based on ranks and our data contained many ties). However, the association between the two summary scores is properly seen as statistically significant. Analysis using the Mann Whitney test showed that the interview summary score is significantly associated with each of the organiser variables when these are dichotomised. The organiser summary score is also significantly associated with each of the interview ratings. This pattern of correlations suggests that both sets of ratings are reliable - they are measuring something. All is not measurement error.

On the face of it the measures are also valid - there seems no reason to doubt that what they measure is what they purport to measure. It remains possible, however, that what both measure is skills in presentation, rather than skills in performance, with the client. In order to see whether this is so we need to look at the correlations between these measures and those derived from the interview with the client.

Comparisons between the three measures derived from interviews with the carer and the two derived from interviews with the client showed associations in the predicted direction but none that were significant on a two-tailed test.

By contrast there were significant associations between the summary measure and ratings obtained from the organisers on the one hand and the measures based on interviews with the client on the other. The summary measures and the individual measures for understanding, sensitivity, reliability and surveillance skill were all significantly associated with the two performance measures at significance levels varying between .02 and .08.

These findings suggest the following conclusions:

- judged against reasonable criteria it is difficult to separate the performance of individual workers - most perform well

- some workers are, however, particularly understanding, sensitive, reliable and skilled at surveillance

- these workers can be identified by their organisers whose judgements tie in with those made on the basis of independent interviews with clients and workers.

Conclusions

The quantitative data suggested widespread satisfaction among clients despite major variations in the organisational characteristics of departments and agencies. Satisfaction was particularly high with the performance of the workers. Exceptions to the generally positive picture related to aspects of the service - lack of reliability, rush, the amount of help provided, the difficulty in saying which workers will come and the lack of say over who they are or what they do.

The statistical analysis was more complex than we would have wished and bedevilled by practical difficulties in carrying out the research as planned. Despite these difficulties it provided support for the picture provided by the qualitative data. There are major logistical difficulties in providing the service. These are overcome to varying extents by good organisation, good communication and in particular by the performance of organisers. The performance of workers within the client's home is generally good. Some workers are outstanding. However, it is difficult for the organisation to influence this standard of performance and perhaps unreasonable to require it.

5 Conclusion

Introduction

Our study aimed to describe the role of the home care service and develop measures of its performance. We then wanted to see if some departments, divisions or groups of home care staff were performing better than others. If so, we wanted to explain why.

To achieve these aims we used both qualitative and quantitative data. We began with focus groups with staff and interviews with managers in both the independent and local authority sectors. Our subsequent work was based on guided interviews with organisers, staff and clients and large scale postal surveys with organisers, staff and clients. Our conclusions are based on both our quantitative and qualitative data, which we have used, where possible, as a check on each other.

Before outlining these conclusions we should emphasise their limitations. We carried out the study in four authorities in the north of England and in independent agencies within these authorities who agreed to collaborate with us. The authorities cannot be taken as geographically, socially or politically representative of the rest of England. The companies from the independent sector who chose to participate may not be typical of all those in the authorities. So the purely descriptive parts of the report cannot be taken as representative of either the independent or statutory sector. For example, the proportion of staff who are black or Asian in these authorities is almost certainly less than would be the case in London.

Given this problem we have tried in our research to go beyond description and arrive at an explanation of what we found. For example, we argue that many of the difficulties of home care arrive from the need to serve a large number of very frail clients at the same time (e.g. around 8.30 a.m.). We believe that our explanations, as opposed to our descriptions, do apply widely. Later we give reasons for thinking that they are in keeping with the literature. Readers will have to judge how far the analysis and conclusions apply to their own situation.

That said we have tried to write with confidence and clarity. We cover the analysis we reached, and the recommendations we make, on the basis of this analysis. We hope we have made clear what we think and why we think it.

Findings and analysis

Our analysis stems from the changes that have been required of the home care service. Local authorities have adapted their organisation to these requirements. This in turn has led to a style of service delivery which is reinforced by the organisation and modified by the staff. The resulting problems and performance reflect the influence of both staff and organisation although their influence on difference aspects of performance differs. What follows is intended to fill in the details of this process.

Changes in the role of the home care service

Over the past ten years home care has gradually superseded home help. Prior to 1989 home helps commonly visited their clients once or twice a week and carried out 'domestic tasks' such as laundry, housework, shopping and pension collection. They now undertake personal care such as bathing and toiletting and getting up. These tasks are given priority over domestic care. The clients who need them are frail and vulnerable and often lonely and depressed. Potentially home care staff have additional roles in keeping an eye on their clients (surveillance) and in social/emotional support.

These changes in the actual and potential roles of the former home helps have gone forward at varying rates in different authorities. Even within the same authority some clients receive a more 'traditional' service than others. Varying and to some extent conflicting principles are involved. *Pragmatism* suggests that if a home carer is on the spot and a short domestic task needs to be done he or she does it. *Political considerations* make it difficult to withdraw old style services. (One of our authorities has tried to maintain a 'home help' service). *Bureaucratic requirements* suggest that services should be allocated and delivered on a similar basis to all potential clients on the basis of need. *Commercial considerations* suggest willingness or ability to pay as a basis for rationing services. *Relationships* between staff and clients mean that the former often go the 'extra mile' in providing service.

Related variations are found among the clients themselves. Some place a very high value on their relationships with home care staff. Some look to staff to provide a high standard of domestic service. Some want flexible personal care that is delivered when they want it and enables them to live as normal a life as possible. Others have most of their needs met and want a small amount of care delivered to top up care from other quarters. These variations only partly reflect differences in need (as measured by incapacity). They also reflect differences in the care provided by relatives and others and in client expectations. So they

raise awkward questions about the degree to which the state is entitled to rely on relatives or obligated to respond to client wants.

Local authority adaptions to changes

In practice much of what occurs is dominated by practical considerations. There are severe logistical difficulties in delivering home care. Demand outstrips supply and fluctuates. It is concentrated at peak times but requires 'topping up' with work at unsocial hours, over weekends and at bank holidays. This set of requirements is hard to meet with a limited number of staff working set hours. Local authorities in our study had variously responded by:

- *Renegotiating contracts* - the aim was to achieve a workforce which could be required to deliver personal care at the varying times this was needed

- *Developing routine services* - on the rationale that mass services (e.g shopping schemes, frozen meal delivery schemes) could be delivered at lower cost than by using individual home carer staff to shop, cook etc

- *Using charges to ration and limit service* - charges raised some money but were also believed to separate those who really wanted and needed a service from those who were only taking what was offered

- *Referring clients to domestic services* - clients who might have been eligible for old style home help but were not eligible for home care could be given information on agencies from whom home help might be purchased

- *Exporting difficulties to the independent sector* - independent services driven by market considerations were prepared to take on work at unsocial hours, and were commonly expected to take up work as and when it arrived - for the authorities a convenient method of handling variable demand and bypassing lengthy union negotiations to change roles

- *Developing a particular style of care management* - care managers organisationally located outside the home care service were expected to develop packages which were not only effective but also as economical as possible

- *Tightening controls on the use of resources* - these included block controls (e.g. limits on the use of overtime, or on proportions of expenditure on in-house services) and individual

controls (e.g. allocation of standardised amounts of home care time in blocks of 15 minutes, 30 minutes, 45 minutes, 60 minutes according to tasks to be completed).

From the point of view of local authorities these measures carried two dangers. First, the emphasis on control of costs could lead to a lack of concern with quality. Second, the attractiveness of the independent sector could lead to a drastic reduction in provision by the local authority. This was unpalatable for two reasons. First, the authorities had a natural loyalty to their own services. Second, too great a reliance on independent providers could lead to unreliability (e.g. if providers failed) or to leaving the authority dependent on a monopoly provider. To counter these dangers the authorities emphasised.

- *training* - personal care requires that providers be trained (e.g. in moving and handling) and other forms of training (e.g. in dealing with clients suffering from dementia) were logical given the clientele

- *quality assurance and control* - a variety of methods (e.g. consumer surveys, visits by organisers and care managers) were used and authorities had standards which they expected agencies to meet (thus in some respects driving up costs and reducing the cost advantages of the independent sector)

- *a system of preferred providers* - in three of the four authorities care managers were expected to go first to their own authority for service, in the remaining one the authority was one of an 'elite group' of preferred providers who aspired to common standards. The amount of care purchased from each sector and the price were to a large extent controlled by the authority

Problems arising from adaptations

These mechanisms reduced the degree to which the provision of home care was driven by market forces and cost. Despite this apparent softening tradition and the severe logistical problems almost forced a bureaucratic, impersonal style of delivery which left little time for staff roles not focussed on personal care, and which was 'risk averse'. The problems which arose included:

- *rush and inflexibility* - the tight timing of visits meant that workers were commonly in a rush, that visits (particularly at night time) might not fit the client's schedule and that there was little room for the unexpected in terms of 'accidents', illness and so on.

- *bureaucratic care management* - this tended to deliver standardised care packages which were criticised as slow to set up, as requiring an excessive number of assessments by different people and as inflexible in operation

- *separation from medical services* - both carers and organisers reported difficulties in contacting all medical services, except the domiciliary nursing service, with the result that the home care staff early knowledge of deterioration in their clients may have not been used, while lack of medical cover may have led to an inefficient use of resources (e.g. visits by nurses simply to give a pill)

- *impersonal and role limited service* - rush, emergencies, cut backs, and an organisational culture averse to relationships meant that relationships between clients and staff were not valued, rarely promoted and sometimes abruptly terminated, while the priorities of the care plan did not necessarily allow for the range of roles which clients and staff felt the latter should play

- *cost* - where domestic care was provided the overhead associated with its bureaucratic base meant that its cost was high either to the client or local authority compared with what a client might purchase privately

- *poor conditions of service for staff in the independent sector* - staff had lower wages, more anti-social hours and less security of employment than those in the public one

Staff and organisational influences on performance

Our statistical data suggested that clients judged the resulting performance on two different dimensions. They were concerned about what we called *service performance.* This included the amount of service they had, the degree to which it came at the time they wanted and did what they wanted, the number of different people who visited them, its reliability and so on. They were even more interested in what we called *staff performance* - e.g. the skill with which carers handled the clients, their friendliness, or the degree to which they kept confidences.

Our statistical data suggested that these two aspects of performance were influenced by different factors.

- *service performance* as judged by clients varied between organisational units. It was higher in those units (teams, divisions, companies) where the organiser(s) and communication were judged as good by the staff, and the organisation was judged by

them to be efficient and as defining the staff role in a way compatible with client needs.

- *staff performance* as judged by clients did not vary much by organisational unit and was if anything lower in organisations judged to be efficient by staff although this effect was mitigated by the performance of the organisers ('good' organisers being associated with efficiency as judged by staff and good staff performance as judged by clients). Our data on individual staff suggested that these did not vary much in the performance of standard practical roles but did vary in their capacity to keep an eye on their clients and in their sensitivity in dealing with them.

Qualitative data suggested that some *organisational or team* conditions were likely to promote both kinds of performance. These conditions included:

- *familiarity* - workers who knew the client and their home were able to operate more efficiently and in ways that respected client preferences, were better able to judge deterioration or the significance of changes in the client's network

- *time* - for reasons outlined above adequate time was required for all staff roles

- *teamwork and communication* - these were required, for example, for the efficient handling of sickness, or changes of plan, although they did not appear to enhance staff as opposed to service performance

It seems likely 'good' organisers influenced performance at least partly through their impact on these factors.

The quality of staff performance was almost certainly influenced by the quality of individual workers. Staff softened the organisational regime, creating relationships with their clients and doing their washing in their own machines despite discouragement. Seven out of ten staff said that it was at least occasionally necessary to bend the rules if one was to do a good job. The more the staff perceived the organisation as not working in the interests of clients the more they were prepared to work for them in their own time. There was evidence that some staff were more sensitive than others and better at monitoring the client's situation. The same staff tended to be picked out as having such qualities, whether we used interviews with clients, staff or organisers to do the picking.

One striking feature of these results was the degree to which performance as judged by clients was mediated by individuals at a relatively low level in the organisations - home care staff and home care organisers. Some aspects of performance - for example - the degree to which clients have information on their care plans did seem to be influenced by authority wide

policies. However, variations in perceived service performance seemed to be predominantly determined at a lower level. In particular, satisfaction with staff performance within the client's home did not vary by department or organisational unit. The power of the director of social services stopped at the client's door.

Basic analysis

These findings underpin our basic analysis. We make two distinctions. The first is between a *bureaucratic* and a *professional* approach to home care. The second is between a *practical* (domestic and personal care) focus and an *integrated* (i.e. including surveillance and social/emotional support) focus for this care. In essence the organisation takes a *practical and bureaucratic approach* to care provision. Reasons may have to do with its traditions but also reflect the over-riding need to provide practical services on a fair basis to large numbers of people. By contrast staff and clients take a more 'holistic approach', and one which is more easily compatible with a *professional/integrated approach.* Unsurprisingly the organisation finds it easier to influence *practical* performance than it does *integrated performance.* The latter depends heavily on staff.

Working in these conditions, staff have both the benefits and the stresses of exposure to the clients. Those in local authorities experience their employers as requiring a somewhat uninvolved and rule bound style of work. By contrast they are aware of dealing with some clients who required a more personal service. Staff are also conscious that the job can sometimes only be done well, if, for example, they turn a 'blind eye' to the rule book and take washing home, or clean the tops of cupboards. These contrasting pressures are combined with lack of time for staff, and exposure to death, illness and bodily deterioration of clients.

This analysis is compatible with existing literature and even derives some support from it. Similar distinctions have a respectable pedigree. Our concepts echo distinctions made by Weber (1930,1947) between 'traditional' social arrangements based on social ties and those involving more businesslike, 'rational' arrangements. They are associated with distinctions between the 'instrumental' and 'expressive' goals of organisations and between 'task focussed' and 'emotional work'. We emphasise the altruism behind the behaviour of many home care staff in a businesslike context. This suggestion has similarities to Durkheim's (1957) views on the role of professionals in tempering the 'amoral' operation of industrial society. Our analysis of the role of staff in interpreting or getting round regulations and generally making the system work harks back to sociological work on 'street corner bureaucrats' (Lipsky, 1980) or Gouldner's (1955) analysis of the reactions of staff to 'bureaucracies'. It might also support the emphasis in writers such as Argyris (1957,1960) and McGregor (1960) on the organisational need for appropriate autonomy among low level staff and on the distinction between 'theory X' and 'theory Y' organisations.

Such classical writers provide lines of thought rather than specific predictions. Closer to home there is evidence compatible with ours from medical sociology. James (1989, 1992) drew on a study of a hospice to highlight the importance of low level 'auxiliary' staff in 'emotional work'.

She stressed the role of these dealing with grief and other emotional issues and the fact that this work was mainly carried out by women. She developed an analysis of the skills involved - an ability to understand and react flexibly to the emotional needs of others, an ability to pace work, an ability to respond on a personal level to one individual without neglecting the needs of others. Much of this could be taken without adaptation to the analysis of home care we gave earlier.

Even more relevant are other studies of home care and home help. Clients in our study valued home care for the reasons found in earlier research (Bulmer, 1986;Henwood et al., 1998; Latto, 1982; Levin et al, 1989; Qureshi et al., 1998; Sinclair et al. 1988). The idea that home helps (home care staff) bridged the world of formal and informal care was developed by Philip Abrams (Abrams et al., 1989). In stressing the local knowledge and informal values of home care staff we would probably have his support. Home help organisers also based their allocation of time on tasks to be done (Gwynne and Fean, 1978). Clients and staff then commonly renegotiated the contract within the time allowed (Gwynne and Fean, 1978). Earlier researchers were also concerned about the rules circumscribing what home helps did (Goldberg and Connolly, 1982). So our emphasis on the role of staff as interpreters, negotiators and occasionally benders of rules is not surprising. Finally, and despite the acknowledged variations between authorities in the models of care management, our critique of care management as inefficient and bureaucratic echoes the concerns of others - not least in the Department of Health itself in a series of reports throughout the 90s (Challis et al., 1998; Department of Health, 1993,1995, 1997, 1998a; Hoyes et al., 1994; Lewis and Glennester 1996; Lewis et al., 1996,1997). Our concern with integrating social and health care for older people is also fashionable (Department of Health, 1998b). Indeed the lack of integration of health in assessment has been one of the reasons for the criticisms of assessment and care management.

This analysis underpins the suggestions and recommendations which follow.

Suggestions and recommendations

In terms of strategy authorities seem to have a choice. First, they can continue with the vision of home care that seems implicit in their practice. We call this the ‘practical, bureaucratic option’. It can be implemented by manual workers concentrating on practical tasks. Second, authorities can change their vision to one which values the roles home care staff may play in keeping an eye on clients, linking them to services, and providing emotional and social support. We call this the ‘professional, integrated option’.

In practice both options would require changes. In the case of the first the changes are minor - a matter of 'tweaking' the system in order to ensure greater efficiency. In the case of the second the changes are somewhat larger. However, the second vision in a sense contains the first - no one would suggest that home care staff cease to play practical roles. Many changes made with the context of the current paradigm would build towards the more ambitious second paradigm if desired. Services that were working within the second paradigm would aim to:

- *fit the client's routine* (for example, complementing the care provided by a daughter and not expecting the client to go to bed at six when ten would be more natural)

- *be based on familiarity* (this is a pre-requisite for smooth and efficient care and for monitoring the client's condition)

- *be reliable* - (for example, ensuring that the client did not have to wait for breakfast till 12 on a Sunday)

- *be flexible* - responding both to the client's needs for extra service and to the need on some days to spend longer with the client than others (e.g. because of stiffness, depression, falls or accidents)

- *be inter-disciplinary* (e.g. so that time is not taken up in cleaning up soiled beds because the client has not been appropriately assessed)

- *be holistic* - acknowledging that the client is likely to have a range of needs, some of which may include, for example, living in a presentable house

- *be cost effective* - ensuring, for example, that the client is not charged high amounts for low quantities of domestic care which may be cut at unpredictable points.

Of these aims only those concerned with 'inter-disciplinarity' and 'being holistic' would not fit within the first paradigm. Even within the first paradigm some degree of inter-disciplinarity is required (e.g. to avoid soiled beds as suggested).

We discuss our suggested changes mainly under the headings of the two visions of care that seem to provide them. We also include separate sections on care management, the independent sector, incentives, staffing and measurement. Changes in these areas will also reflect the vision of home care adopted, but the arguments are more complicated and it seemed easier to deal with them under separate headings.

Some implications of practical / bureaucratic model

Most clients were satisfied with and grateful for the practical home care services they received. Nevertheless, reasonably high proportions (up to 40% depending on the question) felt that services were delivered at inconvenient hours, that they had less control than they wanted about which staff they got, less service than they wanted, less control over the kind of service they wanted, and that the service was rushed and unreliable. Aspects of care that therefore need attention within the practical/bureaucratic model include:

- *Timing of visits* - it is a scandal that some clients are put to bed at an hour far earlier than they would wish and that in some places weekend services are inadequate

- *Contracts* - practical home care would most easily be delivered by large numbers of staff willing to work part-time, unsocial hours and split shifts without guaranteed work. So they might serve, say, one or at most two clients at each of the major pressure points in the day (breakfast, lunch, bed-time) and provide sleep-overs. This would deal with problems of logistics - avoiding rush between clients while allowing familiarity and tailoring service to client preferences and needs. This would not be acceptable to many current staff. However, the nature of contracts and the proportions of staff on different kinds of contract needs to be examined with a balance struck between client need and staff exploitation.

- *Supervision* - frequent supervision is neither necessary nor effective in enhancing practical performance (most staff seem to perform well and the poor practice of a minority is unlikely to be detected by supervision) but some supervision may have value in supporting staff, reallocating resources (see below under 'incentives') and ensuring that opportunities for referral are not missed

- *Communication* - good communication and adequate briefing seems to be essential for the delivery of practical care. Technical aids (mobile phones and *good* computerised systems for tracking staff and helping with rotas and crisis management) would help but will only be fully valuable if they are introduced within a climate of trust.

- *Organiser support* - organisers seem important to the efficient delivery of practical care, they will not perform their job well if they have too many responsibilities for the resources at their disposal or are frequently unavailable to their staff. They need clerical support, good I.T. support, and, depending on their responsibilities, support from senior staff (e.g. to assess and monitor). A careful appraisal of the extent of their responsibilities and the

support available to them may be needed and may have implications for the size of their teams (adequate support may only be possible when the team is relatively large).

- *Domestic work* - purely domestic services (including shopping, pension collection etc) were sometimes high cost and unreliable from the point of view of clients, withdrawn in emergencies and charged at rates including overheads. Methods of enabling clients to buy such services from neighbours or other sources are needed.

- *Standard services* - block services (meals on wheels, shopping services, alarm services) were commonly but not always criticised (alarm services in particular were praised). Given their cost advantages methods should be found of mitigating their defects and ensuring that they are deployed with appropriate clients.

Some implications of the professional / integrated model

Home care staff do perform roles which fit with the professional/integrated model. To some extent they are organised to do so. Nevertheless, there are reasons for thinking that the potential of this model is not realised. In our study staff complained that the organisation (and reorganisation) of their work meant that clients were treated as 'statistics'. Questions on the ease with which medical and social work staff could be contacted yielded varying but generally discouraging replies. The staff themselves were on manual grades. They were managed by staff whose responsibilities focussed on rotas and budgets. Social workers, occupational therapists and health workers were generally based in different parts of the social services or health authority.

A change to the second model does not imply that the home care service would become fully professional. The costs of professional salaries would be prohibitive. The time available does not allow some aspects of professional activity (e.g. complex negotiations with other services or with relatives). The width of knowledge potentially required is too wide - both medical and social work expertise are involved. The value of home care staff lies in part in their 'ordinariness' and human approach. In some cases clients may wish to discuss problems (e.g. on debts or abuse) not with a carer but with a more distant professional such as a social worker. So the role of staff is likely to be closer to that pioneered in the Darlington experiment described by Challis and his colleagues (1995) - a kind of hybrid home care worker and auxiliary nurse with consultation available from both medical and social work professionals.

Two factors are crucial in enabling this model. The staff have to be skilled and committed. The organisation has to be appropriate.

Staff, on our evidence, are committed but inevitably some are more skilled than others. So the organisation may have to tackle this variation by developing staff and identifying their strengths and weakness. It is a potential strength of the system that organisers appear to know their staff well. On our evidence they were able to identify those who were particularly skilled. This should make it easier to monitor the strengths of the workforce, to allocate staff appropriate work, and, if necessary, move those who are ill equipped for the work they are doing. As we have seen, clients differ in the kind of care they need and want, although their needs vary over time. These differences should allow some matching of staff and client.

Organisationally this model might be promoted by basing occupational therapists and social workers in the same units as home care staff. Ideally, perhaps, community nurses and their ancillary staff would belong to the same teams or at least be located in the same offices. Such an arrangement was said by an organiser to work well. So too was an arrangement whereby social work assistants were based in the same teams as groups of home care staff. An arrangement whereby one manager at a reasonably low level becomes responsible for thinking about client needs 'in the round' is attractive. This would be particularly so if the manager controlled the range of professionals able to meet client needs.

So there would seem to be scope for enhancing the role of staff in ways that brings them closer to a professional than manual role. This would involve changes in:

- *role of home care staff* - their close contact with clients makes them the natural 'key workers' involved in alerting services to changes in the clients condition, and ensuring that packages fit the system of informal care

- *some flexibility in rotas* - to make use of their local knowledge home care staff must have some flexibility in how long they stay with their clients and what they do when they are there

- *regulation* - current regulations tend to be inimical to staff/client relationships, inhibit flexible care and add costs (e.g. by requiring nursing visits for tasks home care staff could carry out), they should be assessed and reduced where possible

- *training* - if staff are to keep an eye on clients they will require training which not only teaches them how to move and handle etc but also teaches them what to look out for and what kind of assistance can be provided. As many regulations are designed to reduce risk training would also be required to ensure that carers can take a balanced and informed attitude to any risks they decide to take

- *supervision* - contact with clients can be distressing and draining - a new model of care would require more frequent supervision a) to ensure a conduit to extra services and b) to support workers in the face of the stresses and strains that relationships with clients produce c) to guard against dangers of favouritism, exploitation etc which organisers associate with relationships between clients and staff

- *integration* - there is only value in training staff to keep an eye on clients if services respond to their observations; similarly staff can only be expected to carry out limited medical procedures under appropriate medical supervision and authorisation (informal carers do this, why not home carers?). Occupational therapists, social workers and medical staff are key to the operation of community care and should be connected to the home care staff either through organisation (being in the same team) or through agreed, efficient procedures and location wherever possible.

- *research* - the potential of this model of care is untested. There is scope for experiments in which staff are trained and/or invited to identify needs (e.g. for aids) and in which action is then taken (training might also be provided in intervention e.g. in relation to simple interventions targeted at depression). Such small scale experiments could be assessed in terms of the accuracy of the assessments made, outcomes and the capacity of training to affect either.

Implications for care management

Both models of care require arrangements for assessment and care management. At present these are dubiously satisfactory. In our study organisers and staff criticised them for involving duplication and numerous assessors for one case and for being slow, bureaucratic, and inflexible. They argued that care plans were often based on relatively brief assessments, and sometimes on information gained in hospital rather than the client's own home. Clients might change on discharge. Information might become out of date and the time needed for a person to use a commode might vary from day to day. Care plans in such circumstances can only be approximate instruments and ones which it was not always easy to change. A flexible response to client need requires that decisions can be taken close to those in contact with the client and without requiring information to be passed to numbers of people.

These criticisms seem to contradict the pioneering and positive evaluations of care management carried out by Davies and Challis in the 1980s and early 90s (Challis and Davies 1986; Challis et al, 1988; Challis et al. 1995; Davies and Challis 1986). However, these projects differed from current practice in a number of ways. They focussed on severely

disabled older people on the verge of residential care - a concentration currently rare (Gostic et al., 1997). Workers in the projects carried small caseloads and were in frequent touch with their clients. They provided individualised packages of care which often included paying neighbours to, for example, help an elderly person to get to bed. In the later Darlington project the teams included nursing as well as social services skills.

The good results of the projects seemed to reflect this creative and sensitive practice. By contrast, in our authorities care management seemed primarily concerned with financial control and the allocation of services in standard packages (cf Challis 1994c). We doubted that it ensured effective competition, co-ordination or assessment according to need. Such practice cannot be justified by reference to Davies and Challis' work. A variety of criticisms have been made of and already referenced. In the light of these criticisms and ours we suggest that current practice is critically reviewed.

Implications for independent sector

Both models of care will also involve the independent sector. This sector was severely criticised by local authority workers. However, our research did not suggest that it performed any worse than its statutory counterpart. If anything the reverse. Little should be made of this. The independent agencies which agreed to participate were committed to high standards and proud of their achievements. However, it was unlikely that they were a representative sample of agencies in the authorities - let alone the country. Moreover, there were apparent differences in their performance. Similar caveats apply to the local authority sector. So the most that can be said is that both kinds of agency can perform well. Which typically performs better is not a question we can answer.

That said, it is apparent that the independent sector is historically better positioned to meet the practical tasks of home care. Without a tradition of supplying home help, and without union constraints, it has recruited workers on contracts which suit the enterprise of home care, if not necessarily the workers themselves (although the degree of satisfaction among independent sector carers was surprising). The risks to local authorities of relying on the sector are perhaps more strategic than immediate. Potentially such reliance could result in the loss of excellent and experienced staff not all of whom might transfer, vulnerability to the loss of large suppliers through bankruptcy or takeover, and the growth of monopoly suppliers who could set their own price and standards. So it is likely that a practical, bureaucratic vision of home care would result in quite heavy reliance on a number of quality assured companies. However, the local authority may also continue to be a supplier, albeit one that comes more and more to resemble its independent competitors.

At first sight the independent sector is less well positioned to dominate the professional, integrated model of care. It is harder to justify high degrees of training for workers who operate on a very part-time basis. It is not organisationally integrated with social workers and occupational therapists. It usually does not operate on a geographical basis which would facilitate the development of links with G.Ps and other locality based staff. Again, however, there would be risks in ceasing to rely on the sector at all. Good workers might be lost. The role of the sector in promoting efficient, flexible, comparatively low cost services would disappear. Local authorities might become complacent as a result.

What the role of the sector might be in the second model is unclear. It could provide specialist services (e.g. sleepovers, or 'tuck-in' services). This, however, would lead to shared packages of care which were criticised for impairing communication and blurring responsibility. It could broaden its role, for example, by undertaking prime responsibility for service to a locality. It is unclear whether it would have legitimacy in this role. Or it could provide total co-ordinated packages for individuals referred by the local authority. Those independent agencies that already employ nurses might be well placed to undertake this task.

So perhaps the safest way forward would be through the development of the current system. Locally based integrated local authority services would buy in services to an agreed level from a small number of local suppliers. In the second model these services might well contain an integrated 'nursing / home care' component.

Implications for incentives

In one sense neither model has much need of incentives. Staff generally wanted to care and all the providers that we met wanted to provide good services. The problem lies in the incentives to provide services to one group rather than another. The key distinction is between those currently receiving a service and those who might need one. One of the features of the current system is that it commonly splits assessment from the provision of services. A likely consequence of this system is that providers have an incentive to maintain services to those they serve rather than reduce it to accommodate new clients. This is a problem because providers are in much the best position to know whether services can be appropriately reduced.

The independent sector agencies in the study were not responsible for balancing the needs of new and old clients. When the sector was required to do a task by the public sector, the resources came in a sense with the demand. This may have led to a more appropriate relationship between individual need and supply. On average, teams in the independent

sector delivered one hour per client per day. The teams in the local authority sector delivered less than this, down to just under half an hour per client per day in one local authority.

Local authorities by contrast did have to respond to new demands. Indeed they were required to respond to a demand that felt limitless with resources that were strictly finite. This responsibility may explain the lower level of resource to local authority clients. (The historical legacy of the home help service may also have contributed to this). However, the authorities typically (not always) ensured that those exposed to the urgency of new demands were not those responsible for provision. Organisers in one authority had done the assessments of need and found that somehow or other they managed to fit in new clients. A new system meant that they were given requests to provide set amounts of service for clients assessed by others. Quite often they found themselves unable to respond to these requests and a waiting list built up.

On the face of it organisers in both sectors have little incentive to reduce service when clients improve. Organisers in the public sector were concerned about the growth of the independent one and this did make them keener to take on new clients. In other ways, however, there was little to gain by doing so. Fitter clients lessen the pressure on the organisation and make it easier to act flexibly when crises arise (since calls to them may be dropped with less risk). The loss of such clients may simply result in loss of resources (or profit). Carers have little incentive to argue for the reduction of service to a client for similar reasons, and because they may value their contact with them. For their part clients who improve may continue to value the service, enjoy seeing the worker, and fear that if they allow service to be reduced it will not be increased if they get worse.

In this situation services are likely to ‘silt up’ with long stay cases - a situation which may explain the surprising number of staff who said that the service was not always needed by the clients they served. Methods of tackling this problem could include:

- targets for improvement in care plans
- making some charge for visits thus providing an incentive for clients to reduce service
- routinely covering client need in supervision
- providing more flexibility for staff in timing visits (enabling priority for the needy)
- linking payments to agencies to current client need as well as level and quality

- exposing organisers directly to demand from potential clients as well as existing clients

The last suggestion returns to the issue of care management. It is consistent with our view that this should be related to practice (e.g. by making care managers responsible to organisers in integrated teams) and not separated from it.

None of these suggestions should obscure the likelihood that what counts for most in these matters is the values held by the staff. If they balance their commitment to those for whom they care with an awareness of the needs of those seeking service, this is likely to count for more than any simple 'organisational' fix.

Staffing

Our analysis suggested that organisers are crucial to achieving both service and staff performance. Staff are crucial to the latter. Ways have to be found of identifying and rewarding good organisers, for improving the performance of those who are less good, and removing organisers whose performance is poor and cannot be improved.

There is similarly a case for identifying the skills and capacities of staff. (Organisers it seems can do this). It might then be possible to use less skilled staff on jobs within their capabilities.

Implications for measurement

Measures of the performance of the home care service must depend on which model of care is followed. For example, we showed that there were considerable variations between authorities in the ease with which staff thought they could access certain medical and social services. This measure is only of interest if such activities are thought to be part of the role of home care staff.

The approach to measurement is also influenced by which aspect of care it is intended to measure.

- Poor *service performance* in practical roles can be identified by *postal questionnaires to clients*. These seem to be a practical and relatively cheap way of monitoring this aspect of performance.

- *Postal questionnaires to clients* are probably not an efficient method of measuring *carer performance*. In this respect there is little variation between units. Clients are generally served by teams of carers and have difficulty in distinguishing between them. Clients

may not know what to expect and are likely to be unaware of how far, for example, carers are linked to medical services. The small number of clients who are exploited by carers may be too frightened to return questionnaires.

- *Postal questionnaires to staff* can be used to monitor some of the determinants of *service performance.* Their replies to our questionnaires do suggest important differences in the efficiency of departments, links to services, the degree to which they are well briefed, the calibre of organisers, and the degree to which services serve the interest of the client.

- *Organisers* are able to monitor aspects of *carer performance* insofar as they seem able to pick out carers who are skilled in certain respects.

In general, it would be unwise to rely solely on one method of measuring performance. Questionnaires and monitoring by organisers may well not identify examples of exploitation by staff. Other methods (e.g. ensuring that relatives or friends are aware of what is expected and know whom to contact) may need to be used to ensure that such practice is quickly identified. Quantitative measures (e.g. of delays in supply or aids) may be needed to check impressions from questionnaires or provide background information for interpreting them. (For example, it would be possible for an authority to provide an excellent service to its clients simply by ensuring that it served very few.) Observation of process may be needed to check impressions from questionnaires that there is inefficiency or poor practice.

More generally, there is a danger that measurement will be counterproductive. Home care flourishes because of the initiative, common sense, and goodwill of staff. Questionnaires have to be seen as part (but only a part) of a communal effort to learn from experience and improve performance. A creative suggestion by Qureshi and her team is that some interviews with clients should be undertaken by senior managers, who therefore become motivated to act on their experience. Unless measurement takes place within a context of trust and shared values it may simply increase costs and alienate the workforce.

For these reasons measurement has to be seen part of an overall approach. It depends on what the organisation is trying to do. It also depends on the management style within the organisation, on the existence of trust and shared values and on the ability of managers to take action on the measures they have.

Final thoughts

Inevitably our analysis has focussed on difficulties. These, after all, suggest areas where change might fruitfully be made. This focus, however, should not mislead. In the range of services provided by local authorities it seems likely that home care has fewer problems than most - far fewer, for example, than the children's homes we have recently studied. It is appreciated by its clients, considerably so by many. It also contains many dedicated and experienced staff who generally deliver sensitive and committed care.

The final word, therefore should not be about problems. Given its logistical and moral dilemmas the performance of the home care service in our study was, in our view, remarkable. That it was so must be in great part down to the staff. The task for the organisation is to enable rather than inhibit their performance.

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