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COMMUNITY CARE EXPERIMENTS FOR FRAIL OLDER PEOPLE:

TWO CARE MANAGEMENT PROGRAMMES EVALUATED

Thesis submitted February, 2003 for the degree of
Ph.D. in Social Policy

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COMMUNITY CARE EXPERIMENTS FOR FRAIL OLDER PEOPLE:

TWO CARE MANAGEMENT PROGRAMMES EVALUATED

The inadequacy of community-based services for frail older people in the 1970s pointed to the need for providing co-ordinated care responsive to multiple needs. The fully evaluated Kent Community Care Project (KCCP), a care management experiment which pioneered this new approach, successfully maintained users for longer at home with enhanced quality of life at no additional cost.

While the KCCP benefited from intensive support from the evaluation team, there was a need to investigate whether schemes set up in other areas could be successful when the promotion of good practice was limited to that provided by the agency. The schemes evaluated in this study were early replications of the KCCP in two contrasting parts of Kent. County-wide mechanisms were set up to encourage good practice, such as regular meetings of field staff and managers on policy and practice issues, a working group to develop procedures, peer review and monitoring and feedback. A full cost-effectiveness analysis was undertaken on each of the two schemes using a quasi-experimental design with before/after evaluation interviews on matched experimental and control groups over a one year period which was costed.

Both schemes successfully maintained users at home for significantly longer, and achieved significant improvements in quality of life, quality of care and health status, though less striking than in the KCCP, again at no additional cost. However, they differed from the KCCP in causing a considerable shift in expenditure from health services to social services, with a consequent striking reduction in hospital bed-blocking as well as care home use. Cost-outcomes analyses suggested that budget caps were too generous for resources to be deployed most efficiently.

Because this study took place during the early 1980s, it has been treated largely in its historical context. Nevertheless, the investigation also suggests some important ways in which the current practice of post-reform care management might be improved.

COMMUNITY CARE EXPERIMENTS FOR FRAIL OLDER PEOPLE:

TWO CARE MANAGEMENT PROGRAMMES EVALUATED

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PREFACE

This study of two intensively care-managed schemes for supporting frail older people at home is in some respects a replication of the evaluation of the Kent (Thanet) Community Care Project (Davies and Challis, 1986). In view of the importance of the results of this original evaluation, it was clearly imperative that replications were made. Nevertheless, the present study also has many significant new features, both in the underlying two schemes being investigated and in the evaluation techniques employed. Some clarification is therefore due as to which features of this study involved straightforward replication and which were innovative. A few instances in which the work was collaborative are also specified.

Much of Part I (Model, sites and evaluation design) involves setting up the framework for replication. Part II describes the development of the two new schemes and this reflects both how they adapted to cope in two very contrasting parts of Kent, and how the county developed new mechanisms for promoting good practice, in the absence of the intensive support from the evaluation team in the Thanet Project. These mechanisms included the development, in collaboration with Professor David Challis and Professor Bleddyn Davies, of a countywide monitoring system. Apart from a 50/50 collaboration with Professor David Challis in developing the monitoring instrumentation, the author took full responsibility for the operation of the monitoring system, modifications to instrumentation, developing all software for fully automated feedback and performing data analysis and feedback of information to both field staff and different levels of management. This included six-monthly presentations to all Kent care managers, their line managers and the assistant director. Indeed this system flourished for some seven years and attracted considerable national interest, particularly from local authorities (Challis and Chesterman 1985,1986,1987). At the suggestion of the author, new questionnaires were developed, involving a 50/50 collaboration with Professor David Challis, for the author to interview care managers, yielding a rich supply of structured material describing the care management process which has been heavily drawn on.

Part III presents the results of the data analysis. The analyses of outcomes in Chapter 7 and of costs in Chapter 8 are both essentially replications, though in Chapter 7 the follow up of locational outcomes over six years (section 2), the prediction of a move to institutional care (section 2.1), and in Chapter 8 the effect of the schemes in alleviating bed blocking (section 3) and the investigation of the costs of the schemes during the period spent by the user at home, excluding periods in institutional care (section 4), are all new features. The relating of costs to outcomes in Chapter 9 uses the techniques employed in the Thanet evaluation as a starting point, then allows for simultaneity between social services and health service costs. The technique was extended further using a method devised by Professor Bleddyn Davies in which costs for the period spent at home are split into firstly those incurred through the care manager's time use and secondly other home-based service costs (section 3). Chapter 10 is based on a study within one of the schemes of the quasi-informal helpers who provided much of the domiciliary support, with many of its techniques replicating those of a similar study in Thanet (Qureshi, Challis and Davies 1989). However a principal aim was to investigate the effect of recruiting helpers from an essentially working class area with high unemployment, and some of the results showed important differences to those from Thanet.

Finally, in Part IV, particular achievements and issues of the study are discussed in Chapter 11, while the overall contrast with the results of the Thanet Project is developed further in the concluding Chapter 12.

CHAPTER 1

INTRODUCTION

1 The need for effective community care

In Britain during the early 1980s, methods for supporting frail older people at home were normally totally inadequate (Goldberg and Connelly 1982). No comprehensive assessments of user need were made. Moreover, any help provided typically consisted of at most a few services which were poorly co-ordinated, with different agencies insufficiently aware of each other's contributions. When support of this type broke down, long-term residential care in a local authority care home often resulted, a step which many residents later regretted and which was expensive to the social services department.

It was against this background that the argument and design of the Kent Community Care Project (KCCP) were developed to provide support at home for frail older people (Davies 1974; Davies and Challis 1980; Challis and Davies 1980; Davies and Challis 1986). The central feature of the approach was to have a worker, or team of workers. These would be required to have social work and/or other skills and to carry overall case responsibility, authority and accountability, and are referred to here as *care managers* (or case managers). The scheme should be targeted at the cases for whom the benefits of such forms of co-ordination would be greatest. In practice, those targeted were at high risk of admission to a care home. An initial comprehensive assessment of needs and their overall complexity would be made. The care manager, in close consultation with the user, would then devise a package of care to respond flexibly to these particular needs. This package would be interwoven into the existing informal network of care and would integrate contributions from different agencies. Other resources would be mobilised, with payment if necessary, if their use would improve the efficiency and effectiveness of the care. For instance, when appropriate, helpers (paid or unpaid) would be recruited by the worker to respond to personal care and companionship needs at times of the day and week when they were most needed. The care manager would continue to be in regular contact with the older person to reassess for additional needs as these arose and to provide individual support, such as counselling, where appropriate.

These care management principles, when applied to resource allocation for individual users, might not be particularly cost-effective to the agency. Therefore a structure should be created to provide a system of incentives to care managers to focus on the costs as well as the effectiveness of support to facilitate the efficient deployment of resources (Davies and Challis 1986).

This could be achieved firstly, by providing a list of unit costs of the principal substitute and complementary services[1], so that care managers could be aware of the cost implications of different types of intervention. Secondly, the costs of all of the substitute and complementary services to the social services department (SSD) received by the individual user should be included in calculating the total cost to the SSD of the care package. Thirdly, the average service budget for cases was fixed at a level which forced care managers to balance the benefits of alternative types of expenditure. The total budget

[1] These are the services which alone or in combination could be put together in different ways (or provided at different levels) to produce a targeted set of outcomes.

for each case would normally be limited to two-thirds of the cost of a place in a county care home. This takes into account the costs and benefits of alternative care modes: in homes or at home. Also, an excessive concentration of resources on a few expensive users would be avoided. Fourthly, care managers could set up care packages directly. Specially devised resources, such as the helpers recruited, could be paid for directly out of the scheme's Community Care budget. Other resources, such as home help, could be arranged through negotiation with the organiser concerned. The total budget for the services reflected the assumption that caseloads should not exceed 25 to 30 cases, it being judged that the requisite performance of core care management tasks would for these users be incompatible with higher caseloads. Fifthly, in order that care managers could achieve these aims they had to be given overall case responsibility. They could be made accountable for this enhanced autonomy through a monitoring system. As well as logging resource deployment on individual cases, this system could describe targeting and assessment as well as the ongoing activities undertaken. Visibility could also be increased through peer review of individual users.

To illustrate the differences between the KCCP approach and standard provision, Davies and Challis (1986) distinguished three causal processes by which care management intervention could lead to change in the user. Firstly, activities could principally be aimed at improving the morale of the user. Some activities were more likely to accomplish this than others. An example is the time spent by helpers in providing companionship. However, most activities produce multiple outcomes. Secondly, resources could be allocated principally in order to compensate for functional incapacity and the absence of (or strain on) carers, to help undertake or supervise activities of daily living (like personal or household care). The importance of addressing such needs was highlighted in the *Public Sector Dependency* report (Audit Commission 1985). Thirdly, an exchange process was generated by circumstances encouraging collaborations and mutual regard for one another's goals between professions from different agencies. Thus a care manager, aware of symptoms of ill health in the user, could alert the GP who, by providing treatment, might improve the user's capacity to cope at home. Standard provision relied more on the second process. The KCCP increased the emphasis on the first and third. These three causal processes would interact with each other, as well as affecting costs to agencies indirectly such as by delaying or preventing admission to institutional care or affecting survival.

The proposals in the protocol document led to the setting up of the Kent Community Care Project in Thanet, that was fully evaluated (Davies 1974; Davies and Challis 1986). The project successfully maintained a much greater proportion of users at home over one year than a comparison group receiving standard provision. Quality of care and quality of life of users and carers were significantly greater at no additional cost. It was recognised that the cost effectiveness of the scheme would depend on many local characteristics, which could be different in other areas. Such area variation might be expected in the prevalence of certain health disorders and disabilities, and in environmental factors such as quality of housing, heavy traffic and frequency of mugging which would influence the feasibility of care at home. The quantity, quality and flexibility of locally provided resources would vary between areas, leading to different types of care shortfall, as would the strength of local voluntary agencies. Informal support of local communities would also vary. Area differences in the labour market for women would influence the supply of suitable paid helpers including those retired from the caring professions and might affect the level of fees required. These local differences would provide different opportunities for (and constraints on) the mobilisation of the most effective and efficient care plans.

The dependence of cost-effectiveness on this wide range of area characteristics pointed to the need for replicating the Thanet evaluation in contrasting locations. The evaluations of the Community Care schemes in Sheppey and Tonbridge, each set up in 1980 by Kent Social Services Department, were two early examples of a set of replications carried out in contrasting areas.

2 Evaluation objectives

Two issues formed the principal objectives of this evaluation. The previous section described the framework which provided care managers with incentives to deploy resources in an equitable and efficient manner. The first objective of this evaluation was to measure the extent to which these goals of equity and efficiency were being attained, through a quantitative determination of which types of user benefited in what ways at what cost to whom.

The micro-economic theory of production, appropriate for the analysis of the relationships between substitutable and complementary inputs and multiple outcomes, was applied, this being the first thorough-going application of the need/production relations approach, the development and application of which was promised in the protocol for the Personal Social Services Research Unit (PSSRU) agreed with the DHSS prior to its foundation in 1974. The elements as they related to the KCCP were outlined by Davies and Challis (1981). The needs-production relations approach was later christened the *Production of Welfare* approach (Davies and Knapp 1981). It was incorporated in undergraduate texts from 1984 (Knapp 1984). As well as addressing these specific issues, the investigation included for each scheme a determination of the average improvement in a range of outputs relative to a matched *control* (or comparison) group receiving standard service provision and a comparison of the average costs of these two groups to the different agencies. Further data from users, carers, helpers and care managers were used to attain the second objective, by illuminating the process of *how* and *why* these goals of equity and efficiency came to be achieved.

3 Type of evaluation

A full assessment of the older person and any informal carer providing substantial support was made at the time that each user was to enter the scheme *(time 1)* and, where possible, a year later *(time 2)*. The user assessment included their physical and social environment, performance of activities of daily living, help received, health problems, loneliness, morale, depression and cognitive impairment. The informal carer assessment covered the help they provided, the behaviour problems they faced, the disruptive effect on their lifestyle and the physical and mental effects of the stresses caused. The first assessments allowed the initial characteristics of each user and informal carer to be determined. By comparing quality of life and quality of care indicators before and after the evaluation period, a measure of improvement on each indicator could be obtained. In this way 41 users from Sheppey and 33 from Tonbridge were evaluated. In order that a comparison with conventional provision could be made, a similar set of interviews was obtained for comparison cases who did not receive Community Care. This before-after quasi-experimental design used post selection matching, in which pairs of matched cases were selected from the Community Care and comparison groups. The seven criteria for which matching was required were sex, age range, living group (whether alone, with spouse or with others), presence of an informal carer, level of disability, cognitive impairment and attitude to help.

A full picture of costs over the evaluation year was obtained for both Community Care and comparison cases. As well as costs to the social services department and National Health Service, those incurred by the user, informal carer and the private and voluntary sector were determined, and compared for matched groups.

Quarterly case review forms completed by the worker on each Community Care user supplied a flow of information on user problems and social worker activities. In addition, 46 interviews by the evaluator of the helpers recruited by the Sheppey scheme to provide the bulk of personal care and companionship supplied information on the factors leading to their joining the scheme, the tasks they undertook and their experiences of the work. Finally, structured interviews with care managers provided an insight into how they operated at different stages in the care management process.

4 Community Care schemes for frail older people in the UK outside Kent

During the 1980s a number of Community Care schemes for frail older people based upon the same underlying principles were set up both in different authorities within the UK, and overseas. These schemes have had to adapt in different ways to meet the particular needs of the area served as the following examples show.

In Gwynedd, North Wales, a Community Care scheme was set up in 1980 on Anglesey and a patch of mainland opposite the island. The experiment tested whether, in such a sparsely populated area, new ways should be developed for recruiting helpers within easy reach of their users, and whether collaborations developed to delegate some tasks of care management could work as effectively.

The Community Care scheme in Gateshead (Tyne and Wear) came into operation in 1981 and covered part of the inner-city area, and some outlying suburbs. The strong Labour authority provided a generous Community Care budget. However, this had to compensate for rather patchy existing resources, particularly those provided by the National Health Service (NHS) in the inner-city area. The ideology of the Council required that helpers had full employee status, making them more expensive to deploy and less flexible (Challis *et al.* 1998). During the later phases of the project, an arrangement for patients recruited from one general practice was made in which contributions were incorporated from other members of a multi-disciplinary team - a community nurse, a part-time junior geriatric physician and a part-time physiotherapist in addition to the social workers. This allowed the assessment to be more comprehensive (Challis *et al.* 1990). The scheme, which was joint-funded, was particularly suited to cases with significant health problems.

A multi-disciplinary approach to the care management functions was particularly appropriate in an intensive home care scheme with multi-function workers set up by health and social services authorities in Darlington in 1984. The multi-disciplinary team with multiple agency accountability was important because it was targeted at users for whom the alternative was judged to be admission to long-stay hospital wards (Challis *et al.* 1989). In order to reduce the numbers entering the user's home, care staff were used who integrated the roles of home help, helper and community nurse.

A scheme which was introduced into the London Borough of Lewisham in 1990 added to the existing arrangements for assessment a multi-disciplinary team, in the care-managed support of a group of demented users and their carers (Challis *et al.* 1997). Still smaller caseloads of between 15 and 20 were appropriate with this very demanding user group.

5 Community Care schemes for frail older people overseas

The following three examples illustrate schemes developed outside the UK which drew substantially on the principles of the Thanet Community Care Project.

Neighbourhood team model

Case management programmes for older persons developed contemporaneously with the KCCP in the USA. In Rochester (NY), Eggert *et al.* (1991) based on the KCCP their randomised control trial comparing a 'Neighbourhood Team' model with the standard model they had earlier developed. This was user centred and neighbourhood-based with extra support provided to informal carers. Through an intensive approach and low caseloads of high need users, care management tasks were performed directly by a team, giving continuity. This team, consisting of trained and experienced staff, was relatively autonomous, with a budget cap providing an incentive for efficient resource deployment.

The Rotterdam Project

In the Netherlands too, the Rotterdam Project, their first care management experiment, drew heavily on the principles of the Kent Community Care Project, the senior collaborator in the KCCP working in Rotterdam on the design of the programme. The Rotterdam model was interesting because it provided cash to the users, who were free to undertake more of the tasks of establishing and managing care themselves, if they so wished. It was therefore an early example of a 'direct payments' model. Through the enthusiastic support of the national minister, the project aroused the keen interest of field agencies (Davies 1992).

Australian Community Option Projects

The national evaluation report described these as having been based partly on the Kent Community Care Project and partly on the Wisconsin Community Options Programme (Australia: Department of Health, Housing and Community Services 1992). However, the projects were diverse. There were over one hundred by 1991, with a large proportion being evaluated though with only some structures in common. Firstly, there were varying degrees of concentration of responsibility for performing core care management tasks. Authority and accountability were also sometimes concentrated, with varying delegation to front line care managers. Secondly, top-up budgets were available to care managers, with authority to spend up to a budget limit, rather than a total service budget against which all the substitute and complementary inputs were to be charged. Thirdly, they were diverse with respect to socio-geographical environment, agency of location, target group and working practice. It was therefore difficult to make generalisations from the evaluations.

The aim was to maintain users at home in their neighbourhood, supporting existing informal care networks. The projects aimed to develop the commitment of the local network to respond to individual user needs. As well as simply brokering services, Community Options Projects provided essential emotional support to users and carers and facilitated decision making.

The evaluations aimed to assess the extent to which the federal objectives were attained - for example improved assessment, appropriate care packages and improved approaches to care provision. Also, costs to the government were determined. These worked out less than for nursing home provision and were sometimes less than in residential homes. Care management costs were much higher in rural areas.

Generally, both users and carers were very satisfied. Users felt secure and supported, valuing the personalised individual approach and easier access to existing services. The top-up budgets brought major benefits, allowing the filling of gaps and greater consumer control in selecting services, with flexibility to buy better value private services.

The evidence of the Australian Community Options Projects confirmed the importance of a range of aspects of good practice. Firstly, responsibility, authority and accountability should be clearly defined in the performance of care management tasks. Secondly, care managers should have control over resources. Thirdly, there should be support systems for care managers, such as training and support and good information systems to monitor costs and outcomes. Fourthly, targeting criteria should be clearly defined.

6 The Kent Community Care schemes, including Sheppey and Tonbridge

Community Care in Kent had its origins in the KCCP. Designed in 1974, its implementation team was appointed from 1975, with field implementation from 1976 to 1980 (Challis and Davies 1986; Davies and Challis 1986). The research team worked with local headquarters managers and workers in shaping the method by which the project was implemented in Thanet, as was the case in the Gateshead schemes. They may therefore not be typical of schemes which do not have this initial investment. From 1980, the authority decided to extend the scheme in stages until it became part of normal provision for frail older people throughout Kent. This process was complete by 1987. During this period of expansion, all older people being served by the Community Care scheme in Kent were monitored by means of an initial assessment at the point of entry to the scheme, three monthly case reviews giving information on user problems and social worker activities, and quarterly social services cost sheets. The evaluator processed this data and supplied six-monthly feedback forms to individual care managers giving details of their caseloads. The data was further aggregated to provide corresponding material for line managers at different levels in the hierarchy.

The Community Care schemes in Sheppey and Tonbridge were two early extensions of the original project into different parts of Kent, their first cases being taken on late in 1980. Like the KCCP, they operated within the same Tory-controlled authority. However the evaluation team shaped the implementation less powerfully than was the case in Thanet. The evaluations therefore reflect how these schemes fared when running essentially 'under their own steam'. Sheppey was an area of heavy industry and high unemployment where many of the older people had moved on retirement and so lacked an informal support network. In contrast Tonbridge, situated in the London commuter belt, was a relatively more affluent area whose older population was better established and received much more help from friends and relatives.

Because this study took place during the early 1980s, it has been treated largely in its historical context, in view of the major changes in social policy since then. Nevertheless, the investigation also suggests some important ways in which the current practice of post-reform care management might be improved.

7 The foci of parts and chapters

7.1 Part I: model, sites and evaluation design

Chapter 2 expands on the underlying need for Community Care and the principles of the scheme.

The 'Production of Welfare' (POW) approach to the evaluation is explained in Chapter 3. This approach provides a valuable conceptual framework relating improvements in well-being to user characteristics, circumstances and costs. It also allows causal processes in the provision of care to be readily inferred, including the factors which brought about change in practice methods over time. Chapter 3 continues with a description of the two areas, Sheppey and Tonbridge, in which schemes were to be set up.

The type of evaluation undertaken has already been outlined. Chapter 4 develops this further, giving a detailed account of the design and methodology. One of the main objectives of this evaluation, understanding how the scheme operated through the care management process and achieved success, forms the basis of Part II.

7.2 Part II: implementation history and care management process

Chapter 5 presents a history of the two schemes, together with the methods used to develop and maintain good practice through county-wide meetings of care managers and their managers. The stages in the support of Community Care users are described in Chapter 6. This process of 'Care Management' starts with the initial case finding and screening followed by assessment, planning and implementing of care through to its termination. The other main objective of this evaluation, the cost-effectiveness analysis, forms the basis of Part III.

7.3 Part III: statistical outcomes analysis

The improvements in quality of life and quality of care in Community Care, compared with those for standard provision are considered in Chapter 7, together with the locations of both groups after one year.

A comparison of the costs of Community Care and standard provision is made in Chapter 8 for a range of different cost accounts. Chapter 9 considers the relationship between costs, needs and improvement in well-being. It enables the cost of improving well-being by a certain amount to be predicted, for a particular type of user with particular needs.

One key resource used by care managers, the pool of helpers who provided much of the personal care and companionship for the users, is studied in Chapter 10. Much of the evidence used was drawn from the results of interviewing forty-four helpers on Sheppey. A classification of helpers was made, based on their motivations for the work and the rewards they derived from it and factors predicting drop out were identified. Finally information on helper caseloads and pay was obtained from monitoring data.

Part IV completes this study. Chapter 11 examines further some of its achievements and impact, while Chapter 12 draws together and discusses the conclusions reached by this evaluation. Further details on methodology are contained in Appendix 1. The time one interview schedules with user and carer are presented in Appendix 2 and a feedback form summarising monitoring data in Appendix 3. Some studies of problematic cases are included in Appendix 4 and this is followed a reference list and glossary.

PART I: MODEL, SITES AND EVALUATION DESIGN

CHAPTER 2

HISTORICAL CONTEXT AND PRINCIPLES OF THE SCHEME

First, the chapter elaborates the need for a Community Care scheme. In order to understand why the first Community Care schemes for frail older people were set up, it is first necessary to examine the progress of social policy in the preceding few decades (Means and Smith 1998a, 1998b; Davies 1968). After the second world war, several pieces of legislation affecting older people were introduced, owing much to Beveridge. Residential care was made the chief resource available to frail older people, through section 21 of the National Assistance Act (1948). It was the duty of every local authority to provide residential care for those who were in need of care due to their age, infirmity or other circumstances (Means 1997).

At about the time of the Beveridge legislation, surveys of old peoples homes, many being the old workhouses, highlighted the impersonal environment they offered, with overcrowded dormitories (Maclean 1989). The Seebohm Rowntree Committee (1947) responded to this by proposing improvements to the buildings and organisation of homes. A further recommendation was an expansion of the home help and meals on wheels services, though no legislation was introduced for allocating domiciliary services to those who wished to remain at home. Consequently, for the next forty years, the bulk of expenditure on older people was on institutional rather than domiciliary services.

1 The need for a Community Care scheme

During this period, only gradual progress was made in increasing the provision of services at home. The extent of poverty of older people and the scarcity of domiciliary support services was revealed in a number of studies, such as those by Townsend (1957, 1962) and Isaacs *et al.* 1972. Proposals to reduce the level of institutional care and promote community care were set in motion by the Report of the Royal Commission on Mental Illness and Mental Deficiency (1957), which led to a programme of closure of psychiatric hospitals.

Goffman (1961) identified many similarities in the ways that different types of institution malfunction to the detriment of their residents. He saw the source of these problems as being in the structural design common to them all. Thus basic grade staff tended to be employed long-term and were frequently disciplinarian. They frequently demand a show of deference from residents, with attitudes such as insolence being penalised. A high proportion of residents of care homes for older people would prefer to be at home and so tend not to conform to the staff's notion of the ideal resident. Institutions tend to insulate themselves from the outside world. This allows them to adopt a social stripping and levelling process as new residents are admitted. Although this is in a sense democratic and can be a source of support, it is also a form of deprivation. Residents can normally bring with them only a very limited number of their own possessions such as furniture. Although better care homes encourage independence amongst residents where feasible, many do not promote change, leaving residents to deteriorate prematurely. This new understanding of institutional life as a source of multiple forms of deprivation provided policy makers with additional grounds for examining community-based alternatives to residential care.

Subsequently, the government White Paper *Health and Welfare: the Development of Community Care* (DHSS 1963), expressed the need for de-institutionalisation and the

provision of domicialiary care. It reported wide national variation in home help and meals provision and a shortage of staff. In 1968, the Health Services and Public Health Act gave local authorities responsibility for the welfare of older people, including home help provision. In the same year, the Seebohm Committee Report (Seebohm 1968) recommended the creation of local authority social services departments to unite the previously fragmented social work functions of child care, mental health and social welfare and increase the responsibility of the local authority (Means 1997). This recommendation was implemented in three pieces of legislation which radically changed the administration of social work and completed the separation of health and social care services: the 1970 Social Services Act, the 1972 Local Government Act and the 1974 reorganisation of the National Health Service.

However, work with older people still remained a low priority, and the 1976 government White Paper (DHSS 1976) reported continuing shortfalls in home help, meals on wheels and day care provision. Although expenditure on personal social services generally doubled during the 1960s, the resulting increase in domiciliary provision came to an end following the oil crisis of 1973, the subsequent recession leading to spending cuts, while numbers of older people continued to rise. Mistrust between health and social services contributed to a continuing fragmentation of services.

At a time of limited resources, one cause for concern was the inefficient use of the scarce social care public budgets. A growing body of research in the field of public administration focussed on the role of incentives in improving the efficiency of operation of national and local agencies. This work concentrated on the higher and middle levels of management. It became clear that lack of co-ordination between local authorities and health services was a major obstacle to efficiency. During the 1970s and early 1980s, community care initiatives were mainly focussed upon influencing the degree of co-ordination between health and social care through planning processes, financial transfers and financial incentives (Webb and Wistow 1986). These authors argued that through closer co-operation between health and social care, an improved structure of incentives to agencies could help to ensure that older people are wherever possible cared for at home rather than requiring admission to institutional care. Some of these initiatives appeared to assume that the policy process was more rational and amenable to central influence than it really was (Webb and Wistow 1983). Other commentaries have confirmed the difficulties of implementing a co-ordinated approach to care (Hunter and Wistow 1987). These policies failed to address the issue that the factors most affecting costs of outputs and fairness in the deployment of resources are those whose influence on care arrangements is most direct, namely those relating to front line activity (Davies and Challis 1986). The Kent Community Care Project was able respond in this way through the incentives it offered to fieldworkers, made more effective through closer links between health and social care services.

Although the Seebohm Report recommended improved structures of social care provision, it failed to specify how to respond to need. However, the discourse which followed its publication highlighted the need both for a broad co-ordinated community care policy to avoid fragmentation of services, and the involvement of users and their families in the planning and delivery of services. Also, the current operation of social work was increasingly questioned. The Younghuband Report (Younghusband 1959), whose main recommendations had been implemented in 1962, sought to expand social work training to provide increased numbers of generically trained qualified social workers. However, by the 1970s, some began to doubt whether generic social work teams functioned better than

specialist teams, while others saw advantages in the development of patch teams where fieldworkers were able to cultivate strong ties with the local community through operating generically each with their individual small area (Hadley and McGrath 1980). The evaluation 'Brief and extended casework' (Reid and Shyne 1969) highlighted the advantages of *contract* social work over the traditional open-ended approach. A change in the content of the social work process was also under discussion from a narrower counselling function to a broader social care and community function, leading to conflict between different schools of social work.

Despite the Seebohm Committee reforms, there was little evidence of improvement of domiciliary services for older people, which remained fragmented and managed by untrained staff (Webb and Wistow 1987). Assessments were narrow and linked to each separate service (Means and Smith 1998a). One reason for this shortfall was the climate of reduced expenditure at that time, which contributed to disillusionment with the traditional welfare state with its ideals of low unemployment and universalism. In allocating resources, policy makers must choose between a *universalist* approach in which all of a particular subgroup are eligible, and a *selectivist* approach, where only those on low income with low assets are assisted. Davies and Challis (1986) point out that at the time of the Seebohm Report and the birth of social services departments, resources were relatively plentiful providing a climate in which universalist policies could flourish. As resources became steadily scarcer during the economic recession of the 1970s, social services departments still clung to the old universalist policies. However, resources were increasingly targeted at those in greatest need, though this was at the expense of preventative strategies for a wider spectrum of need (Utting 1975). This author pointed to the need for a more focussed approach to SSD resource deployment by such means as meeting special needs with particular skills rather than acting as a general safety net, reducing less essential services to release funding for vital services, withdrawing resources when no longer needed and replacing residential care by community care.

Another reason for the lack of funding to expand and improve domiciliary provision for older people was the rapidly increasing government expenditure on private and voluntary residential and nursing homes. Through the supplementary benefits system it became possible for anyone with less than £3,000 capital and sufficiently low income to apply for DHSS funding in a private or voluntary home. Unlike local authority residential provision, no assessment of need was required (Laing 1993). Government expenditure on these recipients rose from £10 million in 1979 to £958 million in 1988.

Following the Seebohm Report, social policy in the 1970s placed an emphasis on user involvement and the meeting of needs, through a better resourced agency with a broader remit and professional training, leading to a co-ordinated approach to problems and resource deployment. However, no regard was paid to efficiency. In order to achieve holistic needs assessments, taking into account the views of user and carer, and respond more flexibly, it was necessary to delegate responsibility, authority and accountability to the field. To achieve efficiency it was also necessary to offer a framework of incentives for good practice. These incentives encouraged social workers to consider the advantages and disadvantages of substituting alternative services or informal inputs for each other (Davies and Challis 1986) and hence made them conscious of the relative cost of different ways of achieving outputs. It was this argument, at a time of financial constraints, which led to the conception of the Kent Community Care Project in 1974.

Another body of research which influenced the thinking behind the KCCP was that by sociologists of informal care. Abrams (1977) pointed to impressive evidence that care provided by public authorities in the community can erode the informal care offered within that community. However, he acknowledged the need to find ways in which bureaucratic and informal care can coexist. Abrams addressed the issue of the extent to which intervention by a local authority can increase the caring capacity of the community. He saw the undesirability of *commercialising* the caring relationship, with the implication that the caring exchange is not so satisfying when made on a commercial basis. However, he suggested that it was possible to select an appropriate level of payment to act as an effective incentive without commercialising the relationship. Abrams also reported that many potential volunteers lack suitable opportunities. Local authorities could take advantage of this through policy incentives encouraging these authorities to make use of a mixed financing and supply economy of welfare. There was considerable overlap between the work of Abrams and the KCCP evaluation, with Abrams making reference to the project, and the analysis of helpers incorporating some of his arguments (Qureshi *et al.* 1989).

In the USA, Litwak and others maintained that the available evidence suggests that the relationship between the statutory and informal sectors was not inevitably destructive. They argued that they perform best in different ways and serving different functions. Bureaucracies could deal with large numbers of people, draw on professional expertise, though tend to respond slowly and lack flexibility. In contrast, informal carers can provide a personally tailored flexible response to changing situations and act quickly in emergencies, though their resources and range of concern are limited (Litwak and Szelenyi 1965). It followed from the work of Litwak and Falbe (1975) that costs of some types of output should vary more with informal support than the costs of others. Litwak also suggested that agencies need to develop stategies of intervention which are responsive to the particular characteristics of local informal networks (Litwak 1978).

This project was one of a number of responses to the circumstances and thinking of the time and a few others are now briefly alluded to. The main result following from the Seebohm Report was the establishment of social services departments in which area offices acted as bases for a number of *generic* social work teams. These consisted of trained or untrained social workers and a team leader, also a social worker. Social work assistants, trainees, an occupational therapist and a community worker were also sometimes attached. Although social workers who had been transferred from the pre-Seebohm child care, mental health and welfare departments tended to be trained in their previous speciality, many of them took on a more generic caseload. Moreover, with many of the social work courses becoming generic, most newly appointed social workers carried fully generic caseloads (Parsloe 1981).

The Barclay Report (Barclay 1982) described forms of locally based community social work. One of these, the *patch team*, was characterised by the allocation of social work staff to a limited geographical area, where they would preferably be based. The team might include social workers, social work assistants, home helps and street wardens who work together. It could be given a degree of control over resource deployment and welfare priorities. Pinker, in his critique of the Barclay Report, pointed out that this failed to clarify the criteria by which resources were to be allocated both between and within patches, and the ways in which patch teams were accountable to the local authority. Although patch teams were set up in a few areas, they failed to become a part of normal practice.

Nevertheless, organisation of social services departments into patch teams offered some positive features (Hadley and McGrath 1984):

- heightened sensitivity to, and understanding of, local networks;
- responsiveness to local need, opportunities and constraints;
- reaching cases with previously unmet need; and
- improved staff morale.

The second of these is a particularly important requirement of any efficient service for older people. The needs of potential users and the opportunities for support systems vary greatly between small localities. Variations in the opportunities and constraints affect the cost of achieving the same outputs using different resources. The cost-effective support of older people therefore requires responsiveness to local needs (Davies and Challis 1981).

However, decentralisation need not be viewed solely in geographical terms. Resource decentralisation can occur through devolving budgets to front line staff and introducing mechanisms for making these staff accountable for their enhanced powers. Moreover, care of older people can also benefit from specialised knowledge of this user group in such fields as mental disorder and the care of stroke victims. In a patch system, which would normally involve individual generic staff, such specialisation would be difficult to achieve. Moreover, it is hard to see how improved assessment arising through more specialist knowledge and linkages with the health service could occur in a generic work setting (Challis and Davies 1986). The KCCP, as well as benefiting from the four advantages also offered by patch teams which are listed above, was also able to offer devolved budgets and specialist fieldworkers for older people.

Another form of local service described by the Barclay Report is the *resource centre*, typically based in a residential establishment such as an older person's care home or a day centre, and acting as a calling centre for users and a place for users, volunteers, home helps and street wardens to meet. These have been introduced successfully by a number of authorities.

Another type of innovation, the *Neighbourhood Support Unit (NSU)*, was a base for domiciliary services to older people's own homes, as well as being a day centre and a community resource. Teams of community support workers replaced wardens and home helps, as well as undertaking some of the duties of day centre care staff and social work assistants. Holistic needs assessments were made, moving away from traditional narrow assessments relating to particular services. In addition to teams of community support staff, there could be additional support from a multi-disciplinary team, typically comprising community nurses, health visitors, a dietician and an occupational therapist, to provide medical services and advice on aids and adaptations. However, these units failed to become established outside Sheffield. They were unable to survive in their original form, being expensive to run and lacking sufficient commitment from senior management (Walker and Warren 1996).

The work of Goldberg was very relevant to the thinking behind the KCCP, being focussed on the interface between users and the system at the field level. This was particularly true of the study 'Helping the Aged' which examined the costs and benefits of intensive intervention by qualified social workers with additional resources at their disposal (Goldberg *et al.* 1970). It shared with the KCCP an experimental design, a quantitative description of outcomes for users and the use of statistical analysis. Indeed, the data from this study was analysed to illuminate such design issues for the KCCP as sample size and the matching of cases (Davies and Challis 1986).

A prerequisite to providing a satisfactory level of support to frail older people living at home is the use of a method for comprehensively assessing individual needs. Local authority social services departments have traditionally tended to assess for particular types of service, such as home help, meals on wheels, day care and short-term or long-term residential care. However, these may not provide the most effective response to particular user needs. Instead an assessment process is required which takes account not just of physical or mental disability but of the complexity, variety and subtlety of user problems and the user's ability to deal with them. The assessment should also look at the needs of the informal support network. If the assessor becomes aware of the existence of problems which require a specialist diagnosis, the opportunity for further specialist assessments by, say, a geriatrician or occupational therapist should be available.

Even if a comprehensive assessment were made, resources available in social services departments are generally inadequate in meeting the problems identified. There is a need for an increased quantity and choice of services. These should be deployed with much greater flexibility so as to be available at the times of day or night when the user most needs them, on any day (including weekends and bank holidays) and in any part of the region being served. Finally, the different components of a package of care should be knitted together so as to be complementary and provide continuity of care while at the same time being acceptable to the user.

In responding to the need to develop an equitable and efficient means of supporting frail older people at home with enhanced quality of life for both users and their carers, the series of care management experiments in Kent were designed to have the following features:

- Investment in arrangements providing incentives and other conditions for securing the better performance of care management tasks would lead to better and fairer outcomes for a given level of resource deployment.
- These experiments would be the first to develop and evaluate such arrangements.
- Their design incorporated a wide range of theoretical arguments of the day.
- The interdependence of outcomes was taken into account.
- The design integrated the examination of process and outcomes.
- As well as studying averages for broad groups, it was possible to determine what worked best for whom under what circumstances.
- Instead of assuming fixed inputs given user circumstances, it was assumed that care management allowed continuous adjustment at the margin to changes in the circumstances of all users and carers, their costs and budget pressures.

The KCCP incorporated most of these features of design and evaluation, which were replicated in the schemes which followed in Sheppey and Tonbridge. However, the circumstances surrounding these two schemes differed in two respects. Firstly, the evaluation team played a much smaller role both in supporting the care management team and in participating at a management level. Secondly, there was already a feeling both in the Department of Health and amongst some local authorities that this approach was promising. It was therefore important to test its operation using different target groups or different types of system, to investigate the robustness of these techniques. This would extend our understanding of the following two issues:

- the theory of operation of budget-devolved care management;
- the ways in which the relationships between costs, user characteristics and outcomes depended upon the characteristics of the system providing care and of the area in which it was based.

The contrasting nature of both the target groups and the care management approach in Sheppey and Tonbridge contributed to a much better understanding of both these issues.

2 Policy development

By the early 1980s the expansion in numbers of older people, particularly in the over 75 and over 85 age brackets, was well known (Plank 1978). However, the government policy statement *Priorities for Health and Social Services* (DHSS 1978) proposed an increase in the number of residential places for frail older people which did not keep pace with these demographic trends. Moreover local authorities' plans allowed for a still smaller increase in the number of residential places. This situation would clearly lead to an increasing demand on means for supporting older people in their own homes, by reducing cost, while maintaining welfare outcomes at least at or near levels for residential care.

The series of Community Care schemes have been an attempt to respond to this demand. The cost effectiveness of the schemes was politically attractive at a time of budgetary constraint. Moreover, some of the concepts involved in care management in the Kent scheme were later applied in the 'channelling' projects in the USA in the early 1980s. These, like the British Community Care schemes, were grappling with the shortcomings of traditional methods of supporting frail older people. However, authority and responsibility for local systems of funding and supply were much more fragmented and there was neither the will nor the preconditions to reform fundamental structures, in contrast with the UK. The development of care management was a means of overcoming this fragmentation. Features of the channelling projects included having graduate social workers or nurses as care managers, though multi-disciplinary teams were rejected as too expensive. Standards for monitoring quality and appropriateness of services were put in place. A more user-centred approach than was standard in the US ensured agreement over problems, goals, services and charges. Moreover channelling-style care managers in most programmes had no time to work with informal carers, and it was not part of the philosophy to set up pools of paid helpers. Again they had insufficient time for adequate monitoring, activities which require reduced caseloads (Davies and Challis 1986). Nevertheless, the policy goal of attempting to curb the increase in nursing home expenditure fostered the spread of what was thought of as case management over the country, though what was meant by case management differed greatly between programmes.

The need to develop and extend the use in Britain of Community Care schemes for frail older people was made in the Griffiths Report (Griffiths 1988) and later taken up in the Government White Paper *Caring for People* (Department of Health 1989). An evaluation of the importance of care management was included in the reforms in the 1998 White Paper *Modernising Social Services* (Cm 4169, Department of Health 1998).

Clearly, having a single point of intake of referrals to the scheme facilitated the achievement of consistent targeting. The argument for purposive targeting of services and for attention to performing core care management tasks were closely linked in academic, then policy, argument. Although the social services department had control over admission to local authority residential care as well as community care, it could not influence admissions to private residential and nursing homes. This led to some less needy older people on low incomes being admitted to private homes at public expense. By extending the intake system to include referrals to both community care and all residential care, the targeting and assessment process could embrace both these types of care, which could be considered as alternatives for all cases, thus improving the chances of arriving at the most suitable arrangement for each older person. Such changes have been achieved more

recently through the reforms which followed the publication of the community care white paper *Caring for People*. These reforms were sanctioned in the 1990 NHS and Community Care Act and implemented in stages, with care management being introduced in 1993.

3 The Community Care model

In order that a Community Care scheme might be provided which responded effectively to the needs of frail older people, it was helpful to specify the core features of the model as a framework for setting up a scheme (Davies 1974, Davies and Challis 1980, 1981, 1986). As well as being used for the KCCP, this model was also used as a basis for the schemes in Sheppey and Tonbridge. Essentially, a care manager with a budget aimed, by means of a range of specified processes, to maintain a group of frail older people at home with enhanced quality of life. These features are now considered in more detail, starting with resources.

3.1 Model inputs

Care Manager

Older people were to be maintained in their own homes by means of a care manager, an experienced social worker, carrying overall responsibility for a restricted caseload of some 25 – 30 users. The care manager would co-ordinate and develop the formal and informal care network and cope with those parties with conflicting interests, as well as offering, when appropriate, direct help or counselling to users or their informal carers.

Decentralised Budget

To allow care managers maximum freedom in the development of resources for the user, they are provided with a budget which can be used to pay for locally recruited helpers or for any other resources devised to meet the user's needs. Examples of the use of a budget could include the organisation of a lunch club for Community Care users or the purchase of a washing machine to cope with incontinent laundry. In addition, the care manager can negotiate with other parties both within the SSD and in other agencies for additional services such as home help or day hospital.

The worker should aim to distribute his budget and these other resources between his users in an equitable and efficient manner, and to maintain his expenditure to the SSD on each user at a level within two-thirds of the cost of a place in a local authority care home wherever possible. The budget cap and average budget fixed both the likely institutional alternatives and the probabilities of actually going there when home care was no longer feasible.

The location of the worker in the agency

The position of the worker in the department with respect to other grass roots workers, and a line management structure need to be specified. The worker should be integrated into the agency in such a way that communication with others involved with the older person is maximised and the workers receive the right type of supervision and support. One way of contributing towards this integration is by ensuring that the worker's patch is coterminous with those of others with whom he is involved both within the SSD and, where possible, in the NHS.

Target group

In order for the project to take maximum advantage of the savings obtained by preventing or delaying admissions to residential care, users selected for the scheme, whilst wishing to

remain in their own homes, were required to be sufficiently needy to be otherwise eligible for a place in a local authority care home.

3.2 Model process

Detailed assessment

A comprehensive assessment by the worker should be made of the user and their social and physical environment. This assessment should not be confined to a process of screening for a limited variety of services. While care is being provided the user should be continually reassessed in order that the scheme can respond effectively to the user's changing needs. Such a thorough process may appear at odds with a reality in which care managers in many parts of the country carry high caseloads and have little selection or quantity to offer in their deployment of resources. Nevertheless, as will been seen in the recent model of home care in Kent, described in Chapter 11, current care management arrangements, although not intensive, may nevertheless still be quite expensive. Thus, use of private agency help is likely to be rather more expensive than was the case with community care helpers. Hence, in view of its efficiencies, the intensive care management approach should not be ruled out as a squandering of resources. Without the regular reassessment of users and their environment, care packages can rapidly become inappropriate, leading to either a resource shortfall and hardship for the user or a wastage of resources and insufficient encouragement to the user in maximising independence.

When examining general care management practice in England and Wales, despite an improvement in the proportion of cases being reviewed between 1985 and 1995, Bauld *et al.* 2000, in their ECCEP study of care management, identified forty per cent of users as still not having had their case reviewed six months following assessment, suggesting room for improvement. The 1998 social services White Paper argues: 'Once services are provided, they are often not reviewed. This again contributes to a culture of dependency rather than one of enablement. A great deal of effort is put into initial assessment of care needs, but after that there may be very little review of progress to see whether the user's needs have changed or whether the services are providing the best outcomes' (Department of Health, 1998a). The White Paper proposed that reviews following the initial assessment should be required to take place every three months, a view which has been supported more recently by the Royal Commission Report (1999).

Care planning using a user-centred approach

Once the process of assessment has yielded a picture of the user's needs, the worker, in close consultation with the user, should draw up a plan of how best to meet those needs in a way which is acceptable to the user. Because of the extra flexibility obtained from having a budget, the worker is able to respond more effectively to the user's needs through setting up an 'individually tailored' care package. This helps to make the use of a more comprehensive assessment more effective. The increasing range of services offered by a variety of providers from which the care manager can choose also makes a holistic assessment more valuable. Indeed, users' increasing expectations of receiving services responsive to their requirements indicates the need for a wide-ranging assessment. A worker would define each goal in terms of meeting a particular type of need rather than providing a certain service. Thus, aiming to ensure that a user obtains an adequate diet allows greater flexibility than maintaining that a user requires meals on wheels three times weekly. The former method does not constrain the thinking of the worker and allows him to choose between, and if necessary, experiment between different methods of meeting this goal.

The user-centred approach was maintained throughout the involvement with a case. Thus the suitability of housing was gauged largely in terms of its perception by the user, when any question of rehousing was considered. Finally, the older person played a central role in any termination of care and in any decisions regarding a move to institutional care.

Community Care intervention and the informal caring network
An important aspect of the Community Care approach with many users is in giving support to family, friends or relatives who are involved in helping the user. It is desirable that at the stage when the scheme first becomes involved, intervention should seek to build around the informal support already there rather than to take its place. Substitution should only occur in so far as regular relief during the week or periodic breaks of several days or weeks are needed by the informal carers to offer them respite and avoid their having to neglect other responsibilities. In practice this is not always possible. Sometimes a carer is so over-strained as to be unable to continue even when offered regular relief. Care management can then provide a means for allowing the user to remain at home once the carer has withdrawn. Alternatively, a carer may be preventing a user from exercising their independence. Negotiation between the care manager and carer may then enable the carer to 'let go' some of their control.

Menu of unit prices
In order to enable the worker to allocate resources in an efficient and equitable manner, he is provided with a list of the unit price of each type of service. These prices should represent the cost to the local authority of providing an additional unit of the resource. Such 'shadow prices' are not always the same as the costs of services determined by local authorities.

The knowledge of shadow prices enabled resources to be deployed more efficiently for individual users and their carers, by allowing the care manager to select which of a number of possible combinations of resources was likely to be most effective, given the total service budget. There was also an individual budget cap set at two-thirds the cost of a place in a county care home. This proportion took account of costs of care met by social services in residential care but not home care such as food and accommodation (Davies and Challis 1986). It applied to the total individual SSD cost excluding care management time. The cap prevented too high a proportion of resources being spent on individuals at the expense of caseload size and other recipients. Moreover, it also meant resources utilised for the whole scheme caseload could be deployed in a more efficient and equitable manner by allowing the care manager to weigh up the alternative benefits of distributing resources between users in different ways, with a second constraint of an overall total scheme budget cap. The care manager's own time represented a third resource constraint and needed deploying equitably across the caseload. Clearly these three constraints are inter-dependent.

Use of helpers
At the time that the early Community Care schemes commenced, existing domiciliary services were limited in the support they could provide. The home help service did not normally respond to personal care needs and was usually only available from mid to late morning Mondays to Fridays, and excluding bank holidays. Home helps, who were paid for a fixed number of hours each week, were unable to respond to the fluctuating nature of user needs. Moreover they could only meet the need for companionship insofar as they could provide this while performing domestic care tasks. Community nurses were over-stretched. They would see to some personal care tasks but often not at a time convenient

for a user. Thus arthritic users in pain through stiffness might have to wait hours before a nurse arrived to toilet them and help them get up in the mornings. Day care could provide some supervision and relief for informal carers, but this would be limited to daytime hours Monday to Friday.

The Community Care scheme was designed to cope with this need shortfall through the use of helpers who would be paid according to the tasks they performed rather than by the hour, for increased flexibility, these tasks being specified on a contract. They would not hold full employee status but could offer their time more flexibly according to the varying needs of the user. They would be matched to each user according to their suitability. However, helpers were not an essential part of a package of care. The use of helpers is considered further in Chapter 6, sections 3.1 and 4.2.

Setting an administrative framework
Since the County Council would have overall responsibility for the scheme, various administrative procedures and safeguards would need to be introduced. These would include helping to prevent fraud and allowing the correct procedure for deducting income tax and national insurance contributions to be instated.

Accountability of the worker; the use of a monitoring system
Accountability refers to the process by which a person in a subordinate role is held responsible to an individual, group or community. The employee is required to meet certain standards, laid down by management, in the work they perform. In social services departments, social workers are responsible to senior management and, ultimately, to the social services committee. Moreover, in the case of social workers, the Barclay Committee Report (1982) pointed to their need to be additionally accountable to users and their informal carers for their actions and decisions, though with primary accountability remaining to the elected members. Thus they were not uniquely but multiply accountable. However, in his critique of the report given in Appendix B, Pinker commented that it did not make explicit how any conflict of interest was to be resolved, for instance between user and informal carer, simply stating that the social worker would have 'the burden of managing ensuing tensions'.

The user centred approach adopted by care managers in Kent, in which a package of care had to be acceptable to the older person and take into account the needs of informal carers, contributed to their accountability to the community. The requirement that users should have access to case records was another aspect of this.

Because each worker would have access to a budget of £20,000 at 1981 prices, there was a particular need to make them accountable to management for the way they selected users for the scheme, the activities they undertook on their users' behalf and their method of targeting resources on them, in a way which maintains maximum freedom for the worker. At the same time, while encouraging individual workers to respond in their own style to the particular needs of their area, it is desirable to ensure that there is some uniformity of approach across the county. In KCCP and its descendants these aims were to be achieved through some kind of monitoring system, to provide information to care managers, their line managers and senior managers on the types of case being targeted, review the activities undertaken, and specify the resources deployed. By passing this information to the social services committee to assist in their decision making, the department would be fulfilling a requirement of social services legislation. Through being elected, committee members were in turn accountable to the general public.

A monitoring system can help in managing a decentralised budget (section 3.1) by clarifying both the relative costs of different resources being used for a particular case, and on how resources are being distributed between cases. These two ongoing processes allow the care manager to establish efficiency and equity respectively in the trade off between resources within a caseload. Such a procedure would be subject to budgetary constraints applied both to individual cases through the 'two-thirds' limit, and to the caseload as a whole.

Collegiality

Various types of meeting involving care managers and/or management provided a means for encouraging good practice and offered overall direction to the development of schemes. They facilitated an exchange of ideas both bottom up and top down. Thus, in the KCCP, regular meetings between the divisional director, a senior manager and a PSSRU representative closely monitored the project development, offering direction when needed. As the scheme expanded into other areas, six-monthly meetings of care managers, line managers and senior managers reviewed policy development. Monthly meetings of care managers improved practice and worker morale through discussion and sharing of issues, peer review through case presentations and talks by outside speakers. A working group of experienced care managers contributed to county-wide good practice by compiling a procedures manual.

3.3 Final outputs

Using the principles of equity and efficiency, care managers aimed to improve a range of aspects of quality of life. These included satisfying basic needs for warmth, cleanliness and security, responding to personal care and household care needs, reducing risk to an acceptable level while encouraging independence and addressing social isolation, loneliness, depression, low morale and physical ill-health. Meeting such needs could sometimes be facilitated by collaboration with other professionals. Thus, health needs could be met either directly or through liaison with the health service. Support or relief was provided to informal carers to reduce stress. With respect to efficiency, care managers sought to prevent or delay an admission to institutional care which was likely both to reduce costs and improve the user's quality of life.

4 Impact of the Thanet Community Care Project evaluation

The Thanet Community Care Project was the first to adopt these principles. Three findings from its evaluation were particularly striking. Firstly, a significantly greater proportion of users remained in their own homes after one year (69 per cent) compared to a matched comparison group receiving traditional services (only 34 per cent). Secondly, the improvement in quality of life and quality of care of users was significantly greater than for the comparison group over a range of indicators including loneliness, depression, morale and need for help with personal care and housework. There was also some evidence for a corresponding reduction in the stress and burden on the majority of informal carers, and despite the small sample size this was significant for subjective burden. Thirdly, these benefits were achieved for most categories of user at no greater cost to the social services department, health authority or society (Davies and Challis 1986). It was the overwhelming success of this project which led to its extension into remaining parts of Kent, of which the Sheppey and Tonbridge schemes are two early examples, as well as the principles being adopted in other new schemes both in the U.K. and overseas.

CHAPTER 3

THE PRODUCTION OF WELFARE APPROACH TO EVALUATION AND CHARACTERISTICS OF THE IMPLEMENTATION AREAS

In order to assist both in the study of how a system of welfare operates and in its evaluation, it is useful to have a theoretical framework as a basis for an understanding of the causal processes and for performing statistical analyses.

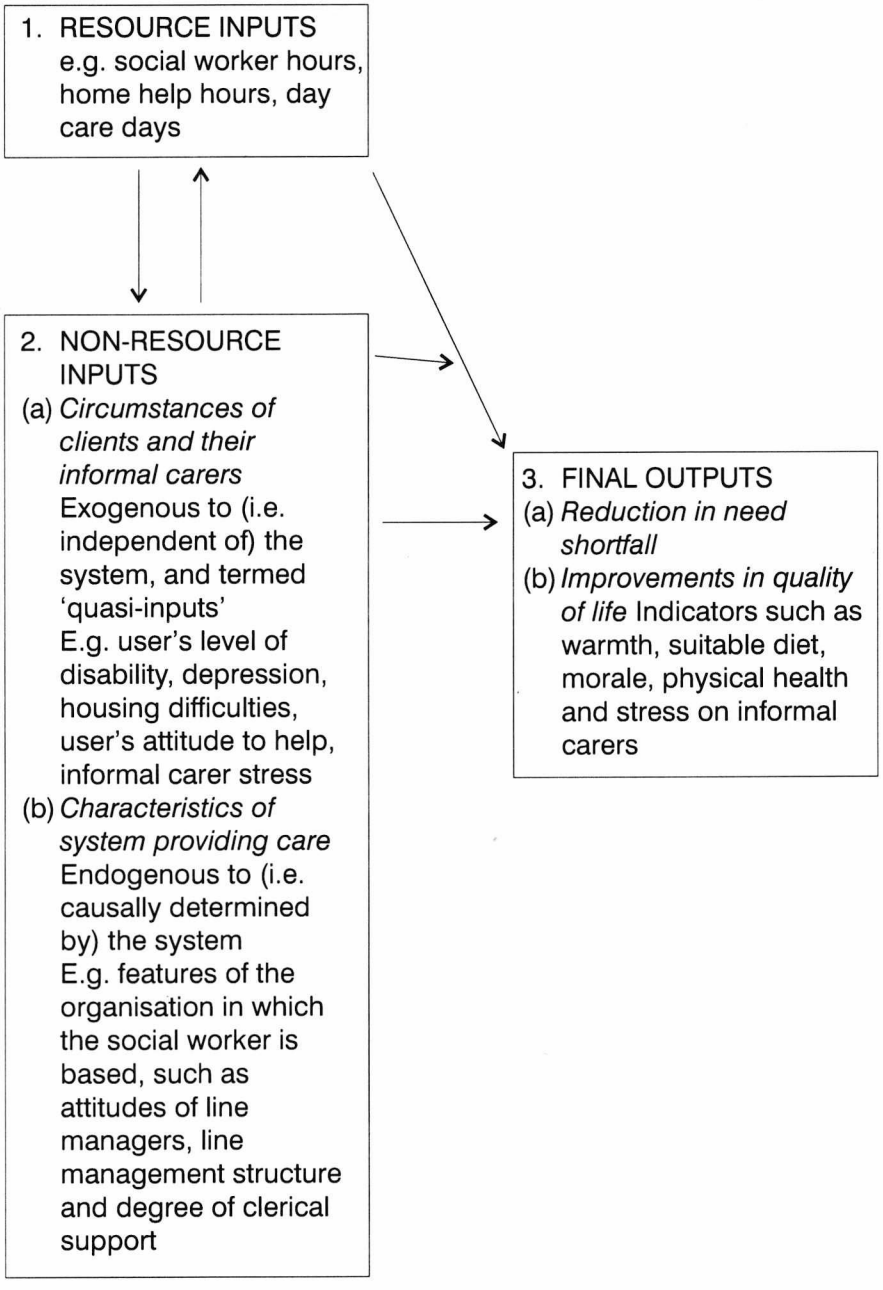
The investigations carried out in this study made use of the 'Production of Welfare' approach, described by Davies and Knapp (1981) and Knapp (1984). This essentially provides a theoretical framework for both understanding and quantifying the contribution of resources to outputs allowing for the effect of other inputs. The approach, although based on micro-economic theory, can accommodate the uncertainties of measurement involved in processes concerning people rather than inanimate commodities. It can also take on board many of the complexities involved in welfare situations. Thus the production of welfare model can provide an insight into causal processes, such as the effect of substituting different inputs on outputs and hence on attempting to maximise outputs for a given budget. The model also assisted in the evaluation, reflecting the unit mission laid down in the original unit protocol by allowing a number of different types of quantitative relationship to be investigated, such as the responsiveness of quality of life to increases in total resource inputs. It provides a repertoire of modelling techniques. Applications of the production of welfare approach in social services have been very successful (Davies and Knapp 1978; Knapp 1984; Davies and Challis 1986; Davies *et al.* 1990; Davies and Fernández 2000). Different researchers have applied the model in a variety of ways. Thus, in the welfare situations investigated by Knapp, it was normally appropriate to include *intermediate* rather than *final* outputs.

A technique for applying the production of welfare approach to a Community Care scheme is offered by Davies and Challis (1981). Its full use in evaluating the Kent Community Care Project is described by Davies and Challis (1986).

The production of welfare model is represented in Figure 3.1, which shows the main causal links between inputs and outputs illustrating the case of a scheme which provides care to people in need. It can be seen that there are two types of input. *Resource inputs* comprise the numbers of units of different types of service received, each of these having a particular unit cost, which allows total costs to be determined. *Non-resource inputs* – need-related circumstances, risk factors and system characteristics – are likely to influence the impact of resource inputs on outcomes, as well as these outcomes directly. *Final outputs* include reductions in need shortfall and improvements in the quality of life of the older person and any carer benefits brought about by the inputs.

Figure 3.1, through showing how inputs feed through to outputs, represents an economist's model. Firstly, it provides a means for understanding qualitatively the causal processes linking inputs to outputs and this will be considered in more detail in section 3.3. Secondly, it could allow statistical methods to be applied for predicting outputs in terms of inputs: the so-called *production function*. This study has not pursued this last method any further, since another method of relating inputs to outputs was found to be more useful. This is now described.

Fig 3.1 The production of welfare model

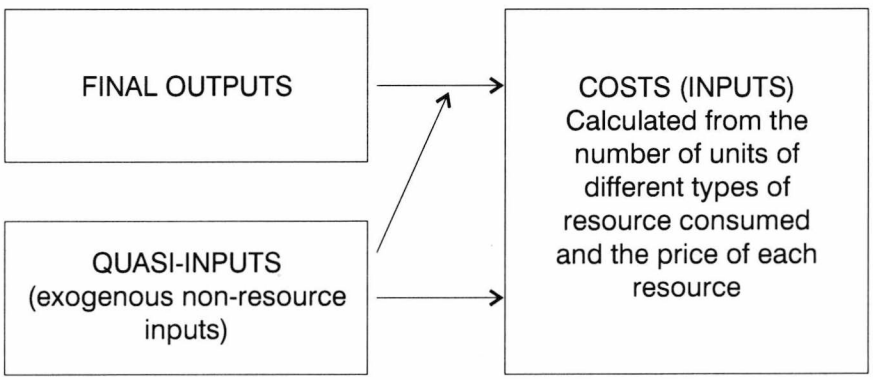


1 Outcomes analysis

Figure 3.1 suggests that outputs should be predictable from mixes and levels of resource and non-resource inputs by means of a production function. However, the evaluations of KCCP and its descendants were not designed to allow them to be estimated, despite their greater power. The reason was that the designer of the evaluation was concerned lest the *measurement* of the inputs from quasi-informal and formal sources would actually affect their levels and nature (Davies and Challis 1986). Therefore the evaluation was instead designed to estimate *cost functions* for that purpose (Figure 3.2). Here, the arrows do not reflect causal processes, as was the case in the production function, but simply indicate the dependence of costs when predicted from the values of outputs and quasi-inputs in the modelling process. Quasi-inputs, as well as influencing costs directly, also affect the relationship between outputs and costs. The repertoire of model forms allows the testing and estimation of many of the features of the production of welfare, though not of substitutability and substitution.

> With a knowledge of the measured values of all cost components, quasi-inputs and outputs for each case, it was possible to use the technique of *ordinary least squares* (OLS), sometimes termed *multiple regression analysis*, to establish the underlying relationship expressing overall cost (the dependent variable) in terms of quasi-inputs and outputs (the predictor variables)[1, 2]. This was achieved by assuming that cost may be expressed as a linear sum of terms involving individual quasi-inputs and outputs including squared and product terms and each with a positive or negative coefficient; then using stepwise multiple regression analysis to obtain a set of coefficients offering the best fit to the data. A simple example of such a linear sum of terms would be:

Fig 3.2 Production of welfare as applied to the prediction of user costs



Annual cost (£) = 5 x (age) - 20 x (whether female) +3M +2Q+600,

[1] When the observed values of predictor variables and the dependent variable are known for a number of cases, the method of OLS determines the linear relationship between the dependent variable and each of the predictor variables that minimises the sum of the squares of the errors. The error for each case is defined as the difference between the actual value of the dependent variable and its value predicted by the linear relationship.

[2] The predictors should also include the *prices* of inputs, but those which are measurable do not vary between cases and so are excluded from the estimation.

where M and Q are two outputs giving improvement in morale and quality of care respectively. This relationship would tell us that on average each additional year of a person's age would add £5 to the annual cost, that females would cost £20 per annum less than males, that each unit of improvement in morale would cost £3 per annum and in quality of care £2 per annum.
A more complex linear sum of terms might be:
Annual cost (£) = 5 x (age) - 20 x (whether female) $+2M^2 - 3MQ + 4Q^2 + 540$.
In this case the best fit was obtained by including squared terms in M and Q. Taking the M^2 term, in order to double an improvement in morale, the increase in cost would have to more than double; that is, the law of diminishing returns, which would also apply to Q. The negative product term or *interaction* term, -3MQ, implies that the cost of achieving an improvement in both morale and quality of care is less than the sum of the costs of obtaining either separately. To illustrate this, expenditure on a home help, while improving quality of care, could also improve a user's morale at no additional cost. This phenomenon is referred to by economists as *joint supply*. The stepwise technique allowed terms which would not enter the equation at a two-tailed significance level of at most 10 per cent to be excluded [3]. This type of cost function analysis forms the basis of all the equations predicting cost given in Chapter 9[4].

Because quasi-inputs affect the impact of resources on outcomes, it is also necessary to postulate product terms between outputs and disability levels, of the form 'C.Q.D', where 'C' is a coefficient (constant), 'Q' is the output and 'D' the disability level.

In analysing cost functions in this study, it has always been necessary to predict the cost to two different accounts, such as that to the SSD and NHS. It was always the case that one type of cost could be influenced by the other and vice-versa. Because of this simultaneity, the method of OLS could no longer be applied. Instead it was necessary to adopt *two stage least squares* or 2SLS (Johnston 1991). To illustrate this in the above example the predicted value of NHS cost from the second equation was included as a predictor in the first equation for SSD cost, while the predicted value of SSD cost from the first equation was a predictor in the second equation. The method will be taken up in Chapter 9.

The experimental design used allowed the quantities represented in the three boxes of Figure 3.2 to be readily measured, making use of various scales of measurement. Each of these boxes will now be considered in more detail; inputs in section 3.2.1, quasi-inputs in section 3.2.2 and outputs in section 3.2.3.

[3] The effect of relatively low sample sizes was to reduce the statistical significance of each term. Therefore although research studies frequently adopt 5 per cent as a cut off, the 10 per cent level was used here so that terms which were significant at almost the 5 per cent level were not omitted.

[4] Note that the non-resource inputs which were characteristics of the system providing care have been omitted from this relationship, although included in the full production function model. This omission is because system characteristics tend to be largely independent of user characteristics for a particular area. They might be important when cases from different areas within authorities or differing authorities themselves are considered together. In such cases, area differences in system characteristics could have been allowed for by including area indicators as predictors in the cost function. However, no such area effects have been investigated in these analyses.

1.1 Resource inputs

Resources are the commodities used to reduce need shortfall. They can often be expressed in terms of the number of units consumed; e.g. hours of home help, days in day care. Sometimes it was more convenient to measure the usage of a particular resource directly in £ sterling. This applied, for example, to the work of Community Care helpers, who were paid according to the type of task which they performed rather than by a flat hourly rate. When expressed as units of consumption, these could be converted to cost for a particular resource through multiplying by its 'unit cost'; e.g. the cost of one hour of home help. These unit costs were fixed at a price base corresponding to costs for the financial year April 1982 - March 1983. Social services department unit costs for this financial year were fixed on 1st December 1981, the price base for SSD costs, while NHS unit costs for the same financial year were fixed on 1st March 1982, the price base for NHS costs. Where costs were measured directly in £ sterling, these were reduced to their level on 1st December 1981, using an appropriate price index. Care had to be taken over how unit costs were defined, this depending on how they were to be used.

Agency revenue costs

From the point of view of a particular agency, costs could usefully be expressed in the familiar form in which they were presented in budget statements. Thus, the unit *gross* cost of one hour's home help was calculated by dividing the total wages paid to home helps over the county by the total number of hours they worked and adding a notional amount for central recharges and administrative overheads. By subtracting the average user contribution per hour, the *net* cost per hour was derived. It was sometimes possible to refine these county unit costs by adding further elements which had been ignored; for example, the weekly cost of a place in a county care home had omitted the salaries of the residential services manager and staff. By adding all the component costs to the social services department for a particular user, the total gross and net revenue costs to this account could be arrived at, in a form of use to the social services department.

A similar exercise could be performed to calculate the cost for that user to the NHS, in a form of use to that agency. This would be calculated in a rather different way. Firstly, debt charges on capital expenditure are ignored in NHS cost accounts in calculating the revenue costs of in-patient hospital care and day hospital. Secondly, since there is no charge for NHS resources, the average contribution would always be zero.

From the point of view of a care manager, the sum of the revenue costs to these two agencies would represent the combined cost as used in agency accounting. However, for the researcher this combination lacks meaning, since it was obtained inconsistently through the quirks whereby individual agency costs were derived. It was therefore useful to draw upon the economic concept of *opportunity costs*.

Opportunity costs

This study involves comparing the costs of the Community Care group, involving mainly domiciliary resources, with the costs of a comparison group, for whom long-term institutional care was frequently provided. For such comparisons to be meaningful, it is an advantage for costs to be calculated in a way which allows an examination of the effect of substituting one form of care -e.g. institutional care - by another type - e.g. a domiciliary care package. In order to achieve this, it was helpful to apply the economist's concept of 'opportunity cost'. This expresses cost in terms of the opportunities forgone in consuming a particular resource. As an example, the weekly cost of a place in a residential home could be expressed in terms of the number of visits by a Community Care helper which

the same money could have purchased. This is a rather crude example of the type of decision which managers in a local authority need to tackle. A more thorough treatment of opportunity cost is presented by Davies and Challis 1986.

In the absence of Community Care, the increasing population of frail older people would require the building of new homes for older people. The cost of each additional place in a county home, referred to by economists as the *marginal* cost, would therefore be that of a new home. By deploying some money on a Community Care scheme, the effect should have been to reduce the rate at which new homes were built. If this argument holds, cost comparisons should include the unit cost of a new home rather than an average home. In reality, the situation was slightly different. Although, during the evaluation period, there was no official policy of meeting increased demand for residential care by using private residential homes, a trend in this direction had certainly begun. Once this policy had taken over, the cost of an *average* rather than *new* residential home would have been appropriate. During the intermediate period, the truth probably lay somewhere between these two extremes.

In opportunity costing it is helpful to distinguish two time horizons. The most immediate is the *short-run* period within which decisions and plans are constrained by certain resources being fixed. In the *long-run*, the employment of resources can be varied by the provider.

When comparing costs of experimental and control groups using opportunity costing principles, it is necessary to include all relevant components of cost. The type of costing carried out by individual agencies such as the SSD or NHS frequently omit some of these components. It was therefore not always possible to derive unit costs directly from agency accounts. These would sometimes require modification to include 'hidden' costs.

Discounting

When calculating opportunity costs it is sometimes necessary to consider the effect of making an investment of capital. For example, in building a new care home a loan would normally be taken out on which interest is paid together with some capital repayments over the lifetime of the home (say 60 years). These loan repayments would constitute part of the opportunity cost of a place in a care home. As another example, if a commode typically lasts for ten years, the annual opportunity cost of providing it to a user would be the annual interest and repayments on the initial loan needed to purchase the commode, if the loan is to be repaid in ten years. However, this argument so far overestimates the annual cost, since inflation reduces the amount of money in real terms to be repaid. Therefore, in calculating the net loan repayment use is made of the *discount rate* (Knapp 1984), which is calculated as the interest rate for loans after subtracting effects of inflation on capital. This rate is calculated periodically by the Treasury and was in the range 5 to 7 per cent during the evaluation year.

The different agencies and cost accounts covered in this study are now considered. At the time of the study there was little collected information available on the unit costs of services, so these were calculated from a variety of sources. More recently, Netten and colleagues have been publishing an annual bulletin of national average unit costs of health and social care (for example, Netten *et al.* 1998), making the process of obtaining unit costs much easier.

Calculating unit costs of services

Allen and Beecham (1993) have proposed an approach to costing welfare services, considering both the ideal requirements and what is possible in practice. They suggest some general issues which need to be addressed:

- A decision must be made as to whether costs should refer to local levels or be applicable more widely, such as nationally. In this study, the unit costs calculated referred specifically to Kent SSD and SE Thames regional health authority.
- Service costs should include all service elements. Thus the SSD subsidy to voluntary agency provided day care gives the cost to the SSD but not the total service cost. Concentrating on 'in-house' costs may lead to overall inefficiency in service provision.
- Costs should ideally be calculated as the long-run marginal cost of an appropriate service unit. In practice, the short-run average cost, including revenue and capital elements, usually approximates to the long-run marginal cost.
- Long-run marginal costs should be disaggregated as much as possible; for example by distinguishing hospital in-patient costs by type of hospital.
- Costs need to be reduced to a common price base, using appropriate deflators.

There are two obstacles to achieving an ideal costing:

- Scarcity of resources, including time, with which to undertake the costing.
- The lack or inaccessibility of data.

Compromises may therefore be necessary, though more effort is needed when a unit cost makes up a large proportion of the total cost of a care package.

Allen and Beecham suggest four stages in determining unit costs:

- Describing the service elements;
- Chosing and calculating the service unit;
- Identifying the cost implications;
- Calculating the total and the unit cost.

Identifying and describing the service elements

A detailed description of the service is required, including the building used, the staff employed, subsistence and travelling expenses, number of users catered for, the elements provided by another agency and elements with no cost relevance. There are two types of service with different costing strategies: facility based services, located in a building, such as day care, and peripatetic services operating either from a clinic or through domiciliary visiting, such as social work.

Chosing and calculating the service unit

These need to make sense; for example, measuring day care in attendances and social work by the hour or by visit.

Identifying the cost implications

As an example, a building in which a service is located is designed as an investment to last longer than one year. In contrast, running costs are ongoing and can usually conveniently be presented annually. Staff costs include salary and employer's national insurance contributions, and direct management costs. The relevant data must then be collected, and where not available, estimates should be made.

Calculating the unit cost

The service description and the collection of the cost information allows the total cost of the service to be calculated (Netten *et al.* 1998). The unit cost can be obtained by dividing this total by the number of units provided. In this study, SSD unit costs were normally calculated from the Kent annual budget return. Thus, the cost of one hour's home help was calculated by dividing the total staff costs for the county by the number of hours help provided in the year. NHS unit costs were generally calculated from the SETRHA annual cost returns.

Facility-based services involve both capital and revenue costs:

- Capital costs of buildings can be determined by calculating the annual loan interest using the discount rate which applied at the time, ranging between 5 and 7 per cent.
- Revenue costs were determined from the annual budget accounts, to which are added costs born by other agencies. Other elements need to be subtracted to avoid double counting: thus, rent should be subtracted from the revenue cost if the cost of capital investment is already included.

Peripatetic staff need to be costed with respect to salary and overheads:

- Salary-related costs include employer's national insurance and superannuation contributions, together with travelling and subsistence expenses.
- Overheads include an office or clinic base with capital and revenue costs, and clerical support and supervision.

Finally, there are sometimes hidden costs which need to be included. One example is KCC administrative overheads. These were calculated as a constant percentage 'add on' for all SSD services.

The different cost accounts

Data was collected which allowed costs to be determined for a number of cost accounts of particular interest. These were:

1. The social services department.
2. The National Health Service.
3. The combined cost to the SSD and NHS.
4. The cost to the private/voluntary sector.
5. The cost to informal carers.

The main components which make up the first two of these cost accounts, and techniques for estimating costs to informal carers are now considered in turn.

Cost to the Social Services Department

There were many possible contributions to cost, which could be classified under four headings, residential care, day care, care manager/social worker time and domiciliary services. The unit costs are tabulated in Table 3.1.

a. Residential care

The components of revenue cost were calculated by elaborating the calculation used in the KCC Financial Statement for 1982-83 in order that the unit cost reflected more closely the actual expenses involved. In discussing opportunity costs earlier, it emerged that when

Table 3.1 Unit costs to the social services department, £ at 1982 prices

	Revenue cost		Opportunity cost Discount rate	
	Gross	Net	5%	7%
	£	£	£	£
Residential care	107.69	77.64	16.48	122.85
Day care centre, per attendance	16.26	15.61	16.34	16.79
Day care in an old people's home	4.19	3.81		
Age Concern day care	2.28	1.90		
Care manager, per hour	6.55	6.55		
Assistant care manager, per hour	5.06	5.06		
Area team social worker, per hour	5.06	5.06		
Home help, per hour	3.36	2.81		
Meals on wheels, per meal	0.90	0.52		
Lunch club, per attendance	1.00	0.62		
SSD occupational therapist, per visit	13.28	13.28		
SSD telephone rental, per week	1.19	1.19		
SSD sheltered housing subsidy, per week	3.94	3.94		

making cost comparisons by group, there was some advantage in using the unit cost of a place in a new local authority care home. This was because, until the use of private homes became significant, a Community Care package could be seen as substituting for and hence reducing the number of admissions to residential care, and hence the need to build as many new county homes. Unfortunately, the county budget statement only provided figures for an average county home, so these had to be used instead. Since places in an average home would be rather cheaper than in a new home, this could have the effect of reducing control group costs more than Community Care costs when group comparisons of revenue costs were made, since admissions to residential care would be more frequent in the comparison group. Thus the cost advantage to the scheme would be greater than would be apparent from the results.

The following calculations show how the revenue cost of a place in an average county home for older people in Kent was calculated:

		£(1982 prices)
Per resident week:	Employee costs	64.50
	Running costs	20.84
	Loan charges	9.14
		94.48
	Add 7% central administration	6.61
Average gross weekly revenue cost given by Kent budget statement		101.09

This figure was further refined as follows:

Add maintenance costs	0.76
Add cost of residential services manager	2.61
Total	104.46
Assuming 97% occupancy, gross revenue cost per resident week	107.69
Subtract resident contributions	30.05
Net revenue cost per resident week	77.64

Although revenue cost comparisons are of interest to social services departments, a more meaningful basis for comparing groups is by considering the opportunity cost to the social

services department. This was calculated by replacing loan charges in the expression for gross revenue cost by the capital costs of buildings and land at two alternative discount rates of 5 per cent and 7 per cent. By providing figures for a new home, these discounted capital costs offer a measure of the replacement cost of the home. They were obtained by updating the costs of buildings and land for a county residential home in the Thanet Community Care Project (Davies and Challis 1986) using appropriate price inflators for buildings and land. This gave

Gross opportunity cost per resident week,		£ (1982 prices)
discounting capital costs at	- 5 per cent	116.48
	- 7 per cent	122.85

Setting the 'two-thirds' limit

According to opportunity costing principles it follows that a two-thirds limit should be calculated with respect to the gross *opportunity* cost per resident week. However Kent County Council Care Managers budgeted in terms of the gross *revenue* cost per resident week, which was somewhat less. Their choice of gross rather than net cost implied that expenditure was considered with respect to its joint effect on both the local authority and the user who provided the contributions, which makes good sense.

Although the evaluation made use of the same unit cost of care in a local authority residential home throughout the period of the study when reduced to the common price base for 1982, care managers were presented with a new unit cost for each financial year, corresponding to the price base for that year. This cost was not calculated in a consistent manner; nor did it vary in a manner which was similar to the appropriate price index, which was taken here to be the General Government Final Consumption Index (GIEG). Table 3.2 shows how this unit cost, and the corresponding figure for Kent, varied over time.

It can be seen that in the most recent financial year of the evaluation period (1984-85), the unit cost was based upon the projected budget for that financial year, which is more relevant. Although in that particular year there had been a sharp fall in costs compared to the previous year, the effect of the revision was to make this fall less pronounced.

It can be seen that after reducing the Kent unit costs to their 1982 levels, their values were always somewhat less than the opportunity costs calculated by the evaluator. These values ranged from being 11 per cent less in 1983-84 to 24 per cent less in 1982-83. The higher values of the gross opportunity costs relative to the gross revenue costs arose because firstly, while opportunity costs included capital costs based upon the estimated cost of a new building, the debt charges associated with revenue costs were based upon an average home, and following a period of comparatively high inflation these loans were relatively low. Secondly the opportunity cost estimate had included maintenance, residential services costs and a 97 per cent occupancy rate, all omitted from the revenue cost. The third difference between opportunity costs and revenue costs, a result of the discount rate of opportunity costing being lower than the rate for repayment of debt charges, would have been to have reduced the difference between the two unit cost estimates.

Table 3.2 Comparing the unit cost of local authority residential care as determined by the county council[1] with the corresponding opportunity cost

Financial Year	Method of calculating Kent gross unit cost	Kent gross unit cost of residential care per resident week		Gross opportunity cost of residential care per resident week[2] at 1982 prices	
		Before reduction to 1982 prices £	After reduction to 1982 prices £	Capital costs discounted at 5% £	Capital costs discounted at 7% £
1981-82	used figures for	86.80	97.85	116.48	122.85
1982-83	approved budget for	88.06	88.06	116.48	122.85
1983-84	previous financial year	112.00	103.62	116.48	122.85
1984-85	used figures for projected budget for current financial year	108.00	93.48	116.48	122.85

Notes:

1. It was the county council figures from which the two-thirds limit used by care managers was derived.
2. Opportunity cost was calculated by the evaluator.

b. Day care

i. Day care centre

As in the determination of the unit cost of residential care, that for a day care centre in Kent may be calculated as follows:

Per attendance:	£ (1982 prices)
Employee costs	8.12
Running costs	4.76
Loan charges	1.10
	13.98

This figure was further refined as follows:

Assuming occupancy of 92 per cent, unit cost becomes	15.20
Adding 7 per cent central administrative costs	1.06
Total corrected gross revenue cost	16.26,
which is £2.28 greater than the figure estimated by Kent.	
Subtracting user contributions	0.65
Net revenue cost per day centre attendance	15.61

When alternative uses of resources are being considered, the opportunity cost of day care should refer to the cost of a place in a new day care centre, since the increasing numbers of frail older people in the community have required systematically building new centres. Employee costs and running expenses were only accounted for an average day centre, so had to be used instead of figures for a new day centre, causing a slight underestimate in overall cost. However the capital element of the opportunity cost of a new centre may be obtained from the capital costs of buildings and land at two alternative discount rates of 5 per cent and 7 per cent, by updating the costs for the Thanet Project using the price inflators for buildings and land respectively. This capital cost can then replace the loan charges in the calculations of total opportunity cost. Hence the opportunity cost per attendance became:

discounting capital costs at- 5 per cent : £16.34
- 7 per cent : £16.79

ii. Day care in a care home

The view adopted by both KCC and the evaluator was that employee costs, running expenses and loan charges were zero, since these were all required in supporting residents. In other words, the marginal cost of these components of day care in a care home was zero. However, some extra items of expenditure should be included associated with transport, a midday meal, a snack, a chair in the lounge and a small share of activity costs, estimated to amount to £4.19 per attendance gross,

less user contribution for meal £0.38,

leaving £3.81 per attendance net.

iii. Age Concern day care

Day care centres run by Age Concern were assigned an average cost per attendance calculated from the SSD subsidy to Age Concern.

Gross cost per day	£2.28
Subtract user's lunch contribution	£0.38
Net cost per day	£1.90

c. Care manager/social worker time

Costing care manager time

In Sheppey and Tonbridge, the care manager's time was apportioned between the users in the caseload according to the number of contacts made with the user, his family and others by the care manager over each three-monthly period as indicated on the case review forms. Once caseloads had built up to a steady level of around 30 for a care manager and around 20 for an assistant care manager, each contact could be associated with an amount of time such that, in any one week, the contacts involved with all cases in a particular caseload would add up to a 37 hour week.

The cost per hour of care managers and their assistants was determined using the costing principles later described by Netten and Beecham (1993) for peripatetic staff. These authors identified four different types of cost. Firstly there were salary-related costs: the salary scales, the employer's national insurance contributions (Netten and Smart 1993), travel and subsistence payments. Secondly there was the cost of occupying an office. Thirdly, there were building-related expenses: power, rates and maintenance. Fourthly service-related expenses covered supervision and clerical support. In the case of care management in Sheppey and Tonbridge, the second and third items were covered in a five per cent addition for overheads. An allowance for central administrative costs (five per cent) was also included, although omitted by Netten and Beecham. Supervision costs were calculated assuming a principal social worker's time was shared equally between eight fieldworkers. Clerical support corresponded to the cost of the half-time clerk.

Thus, the cost per hour of a care manager was calculated as follows:	*£ (1982 prices)*
Basic gross salary: care manager (level 3 social worker)	3.60
Basic gross salary: half-time clerk	1.02
Basic gross salary: total	4.62
Seven per cent employer's National Insurance contributions	0.32
Travelling expenses: 20 miles per day at 17p per mile	0.46
Five per cent overheads for buildings and maintenance	0.23
Five per cent allowance for central administrative costs	0.23
One eighth of the time of a principal social worker	0.68
Total cost per hour of care manager	6.54

Assistant care managers were on a level one salary scale as were the area team social workers for the comparison group and had similar overhead costs. These assistants were therefore assigned the same unit cost as for social workers, calculated below to be £5.06 per hour.

No attempt was made to allow for the Tonbridge area being relatively rural compared to Sheppey. During most of the evaluation period the Sheppey care manager's office was six miles from Sheerness, where most cases were located. The extra motoring which this involved was felt to roughly balance the extra mileage due to rural visiting by the Tonbridge care manager. The average motoring of 20 miles per day was regarded as being representative of both areas.

At a resultant hourly cost for care managers of £6.54 and £5.06 for their assistants, each care manager contact was equivalent to a cost of £7.14 while for their assistants the cost was greater at £8.28. This anomaly was brought about since, although the salary of assistants was not as great, their caseloads were much less, as was their number of contacts, making each contact more expensive. Thus the appointment of assistant care managers was probably inefficient. Not only was the cost of their time per user more expensive, but they could not be expected to have the expertise of care managers. Additionally care managers had to spend time in supervising their assistants which could otherwise have been used in taking on a bigger caseload. The deployment of assistant care managers was implemented by Kent management, despite these arguments about the inefficiency of such an arrangement having been voiced by the county-wide group of care managers who met monthly. Perhaps its rationale was that it provided some internal career structure. Those appointed as assistant care managers were frequently promoted to home help organiser and later to care manager. However an initial appointment of qualified social workers as care managers would have been much more appropriate.

The effect of the deployment of assistant care managers on the evaluation was presumably to make the scheme appear less cost effective. Fortunately the assistants were involved with a small minority of contacts in Sheppey, these amounting to some 5 per cent of the cost. However in Tonbridge these made up 39 per cent of the cost: a substantial proportion. Because many Tonbridge cases spent only a proportion of the evaluation year with an assistant care manager and the remainder with a care manager, it was not feasible to test their relative cost-effectiveness.

Costing area team social worker time

The vast majority of area team social workers were graded at level 1. As both comparison group areas included rural elements, the same average mileage of 20 miles per day was used in calculating travelling expensed that was applied in the experimental areas. The cost per hour of these social workers was therefore calculated as follows:

	£ (1982 prices)
Basic gross salary: level 1 social worker	2.83
Basic gross salary: quarter-time clerk	0.51
Basic gross salary: total	3.34
Seven per cent employer's National Insurance contributions	0.24
Travelling expenses: 20 miles per day at 17p per mile	0.46
Five per cent overheads for buildings and maintenance	0.17
Five per cent allowance for central administrative costs	0.17
One eighth of the time of a principal social worker	0.68
Total cost per hour of area team social worker	5.06

As there was no monitoring data available for comparison cases, a different method had to be adopted for estimating social worker time use with each user. Firstly, area team case notes were examined to identify the number of visits recorded each month. Other information on the file pointing to use of area team social workers time was also noted: meetings could involve the care home priorities panel, case conferences or supervision, while administrative tasks included telephone calls, applications, letters and case notes. Secondly, social workers were interviewed regarding each evaluated user to determine the proportion of visits recorded, the length of visits (including travel time) and the time taken with the meetings and various administrative tasks already identified from case records. Using this information, the identifiable time spent by social workers for each user evaluated could be estimated in monthly blocks.

Other studies have shown that in the process of estimating time use, the total time spent on tasks is systematically underestimated. From two relevant studies undertaken by the National Institute for Social Work (Carver and Edwards 1972) and by the City of Manchester SSD on hospital social work (City of Manchester 1981) it seemed appropriate to multiply the estimated time by a factor of two to obtain the overall time used.

From the above considerations, it is clear that some bias could emerge in comparing costs for experimental and control groups. Firstly, the use of predominantly care managers at level 3 in the Community Care group but social work assistants at level 1 in the comparison group meant that experimental costs would appear artificially high in comparison (although the service they were providing should have been better). Hence the comparison would tend to underestimate the cost advantage to the experimental group. Secondly, while the estimate of time spent by care managers with the experimental group was unlikely to be systematically in error, since time spent on the full caseload was set at a 37 hour week for each full-time care manager, the factor of two used in revising social work time estimates with control cases was approximate, and could have been on average somewhat more or less than this, introducing some bias either way. However, because area team social work costs were likely to constitute a much smaller proportion of total SSD costs for comparison cases than care management costs were for Community Care cases, any bias was unlikely to be serious.

d. Domiciliary services

i. Home help

The calculation of gross unit cost was essentially that of the Kent Budget statement used by care managers, though with an additional 7 per cent to cover central recharges and 9 per cent for administrative overheads.

ii. Sheltered housing
The average SSD housing subsidy per sheltered housing unit per week was calculated from the Kent budget statement. This item had been excluded from the care managers' Menu of Prices.

iii. Remaining domiciliary services
Meals on wheels, lunch club attendances, visits by an SSD occupational therapist and an SSD telephone rental were given the same unit costs as those used by the care managers.

Finally, SSD domiciliary services arranged by the care manager included the provision of Community Care helpers. Because one of the aims of the scheme was to pay these helpers according to the type of task which they performed rather than the time it took, it was not feasible to use a unit cost in the way which was done for home help. Instead, the fees and expenses paid to helpers for each four weekly period were summed for each case, then reduced to the common price base using the General Government Final Consumption price index. The level of fees was determined to an extent by the market forces of supply and demand, so represented an opportunity cost. This was particularly the case in Sheppey, where the level of unemployment was high and applications for work as a Community Care helper were plentiful though not always suitable. Here helpers organised themselves into a pressure group to periodically petition for increased rates of pay.

Cost to the National Health Service
NHS costs, when coupled with those incurred by the SSD, constituted the bulk of agency costs. Health services costs could conveniently be considered under hospital costs and domiciliary services.

a. Hospital costs
The unit costs of hospital services were estimated from the Summary Cost Statements issued by the South-East Thames Regional Health Authority (1982-83). In-patient attendances were classified into district general, small/mainly/partly acute, long-stay geriatric and psychiatric, while out-patient attendances fell under medical and physiotherapy. Day hospital attendances were geriatric only.

The cost statements did not include an allowance for the capital cost of hospital buildings. The method of Davies and Challis (1986) was used, adopting estimates of the capital costs by Wright *et al.* (1981) based on the cost of buildings estimated by the DHSS for March 1977. Capital costs were based on the assumption that existing buildings had been upgraded, costing £12,000 per bed at 1977 prices. This cost was updated to 1982 prices using the public sector building tender price index and discounted over 60 years at two possible discount rates of 5 per cent and 7 per cent. This capital cost could then be added to the revenue cost of a hospital in-patient or day hospital place to obtain the corresponding opportunity cost (Table 3.3).

Table 3.3 Hospital unit costs, £ at 1982 prices

Hospital type	Revenue Account Cost per patient day	Additional capital costs per patient day Discount rate	
		5%	7%
	£	£	£
District general	79.32	3.13	4.22
Small/mainly/partly acute	43.61	3.13	4.22
Long-stay geriatric	28.82	3.13	4.22
Psychiatric	29.21	3.13	4.22
Geriatric day hospital	8.12	3.13	4.22

Since the day hospitals concerned were attached to hospital in-patient facilities, capital costs for in-patient beds were assumed to apply, in the absence of more specific information.

While Community Care would be expected to reduce the rate at which new county homes for older people were built, the same was not true for the building of new hospitals. Even the upgrading of existing hospitals was unlikely to be affected by the scheme. Although the scheme aimed to prevent or delay some admissions to long-stay geriatric or psychiatric hospital, these hospitals were already in process of being run down. Community Care should therefore accelerate this process.

When hospitals are run down, the capital costs remain (unless all or part of the hospital is sold). In fact, the relative importance of the capital costs increases until a stage is reached where the hospital is closed or used for something else. It was therefore considered reasonable to use hospital revenue cost to which the capital cost had been added.

Hospital out-patient appointments were costed using the SETRHA summary cost statements for 1983. They were classified into two main types, both costed at the same rate:

Medical/physiotherapy out-patient attendances £16.30

b. Community health costs

i. Community nursing

The community nursing service was provided by a combination of SRNs, SENs and nursing auxiliaries. For costing purposes, it was assumed that these different grades of nurse were present in the same ratio as was applied to the Thanet Community Care Project (Davies and Challis 1986), namely 6:2:3. Updating the overall unit cost for Thanet using the general government final consumption price index, a figure of £3.14 per half-hourly visit at 1982 prices was obtained. This cost included an allowance for visit time, travel time, central administrative overheads, drugs, dressings and telephones.

ii. Community Psychiatric Nurses and Health Visitors

The unit costs of CPNs and health visitors was based upon the assumption that service was provided by an SRN at sister grade, each visit being assumed to consist of 20 minutes visiting time and 20 minutes travelling time. This amounted to £5.04 per visit at 1982 prices.

Table 3.4 Community health service unit costs

	£ at 1982 prices
Community nursing per visit	3.14
Community psychiatric nurse, per visit	5.04
Health visitor, per visit	5.04
Chiropody, per appointment	2.04
NHS occupational therapist, per visit	13.28
Geriatrician, per visit	14.20

Cost to informal carers

Unpaid informal care is widely acknowledged as being of fundamental importance in welfare (Griffiths 1988, Cm 849 1989). As Parker (1991) points out, a major reason for the increased interest in informal care is cost. Changes in policy orientation from providing residential care to providing community care, although probably reducing health and social services costs, increase the cost to the informal sector. Recognition of this fact is implicit in the increased policy emphasis on supporting carers (Cm 849, 1989).

Informal carer costs are estimated as opportunity costs. In families, members may spend time in providing support to other members through commodities such as housework and nutrition. The phenomenon to be costed is the extra informal care that results from one member (the user) being disabled. The ability of the household to provide this support is limited by a number of factors such as concern for the welfare of other family members. Families can usually cope with short-term problems using their own resources. However, long-term progressive disability can place intolerable strain on a household, and other informal carers may then contribute to a network to help out. Additionally, formal services may then be introduced to supplement informal support.

Netten (1993) classifies cost of informal care into five types:

- Direct financial expenditure on goods and services;
- Non-waged time;
- Waged time;
- Future costs;
- Accommodation.

No attempt was made in this study to cost non-waged time. Clearly, in many cases only leisure time will have been forgone, which would have little or no effect upon the productivity of the household. However, the cost to the carer in terms of carer stress and quality of life is taken into account in the carer outcomes measures.

Direct financial expenditure on goods and services

These are the costs to the informal carer which would not have been incurred in the absence of the disability.

Waged time

Informal carer commitments can result in considerable reductions in earnings. This is one of the main ways in which a policy to reduce levels of institutional care leads to increased costs in the informal sector (Muurinen 1986).

In estimating such costs, it is important to be clear as to what the impact of caring has been on earnings. The opportunity cost is then the loss in wages, less tax and national insurance.

If the time off work has not resulted in lost pay, the employer has born the cost rather than the carer. When a carer has given up waged work entirely, they may be eligible for invalid care allowance and other benefits. These need to be deducted from any lost wage income.

Future costs
Caring may lead to missed job opportunities, as the carer may be limited to work in the immediate neighbourhood and perhaps to flexible hours. An estimate is then needed of the reduction in future earnings caused by caring. This needs to be discounted back to the present time to give a weekly expected loss.

Accommodation
When a user and carer share a household, this has usually been the case long before the onset of any disability. There is then no accommodation cost, since no change has occurred through disability. In other cases it may be necessary for the carer and user to move in together. If the user moves in with the carer, the cost could be the rent of a single room which the carer had forgone. Other arrangements are more complicated. The cost of a 'granny annex', for example, would depend on who made the purchase and the expected distribution of the estate. When the carer moves into the user's home, the carer would have given up much more than a room's value as regards space and privacy. However, the carer would probably have expectations in terms of the future ownership or tenancy. Details of these arrangements would allow the opportunity cost to be estimated.

In general, the costing of informal care can involve complex calculations. The numerous assumptions made include restricting the calculation to what is feasible, and further limiting them to the information available.

1.2 User characteristics and circumstances (quasi-inputs)
The information gathered at the time of the initial interviews of the older people and their informal carers provided a 'snapshot' of circumstances at that point in time. The variables used in recording these circumstances were referred to as quasi-inputs. They could mainly be grouped under the headings of :

a. Health and dependency
b. Social support
c. Personality and attitudes to help
d. Physical environment and other factors
e. Level of well-being
f. Effect on principal informal carer.

Some of the main quasi-inputs used in analysis are summarised under these headings in Table 9.1. The types of scale used in measuring quasi-inputs are described in Chapter 4.

1.3 Final outputs
In this study, outcomes were represented by the improvements in aspects of quality of life or quality of care (measured in terms of need shortfall) of the older person, and the quality of life of their informal carers. In the study of the impact of social services department resources on frail older people, Challis (1981) recognised the broad consensus in the literature of social administration, social work and government policy statements about those dimensions of the quality of life where intervention is considered appropriate, and those who are the expected beneficiaries of intervention. The three main parties concerned were the older person, the immediate family or carers and the community as a whole. He identified seven broad dimensions upon which the effects of services may be assessed for these different parties:

a. Older person

1. Nurturance: the most basic needs of the older person for comfort and security, arising from self-care difficulties.
2. Compensation for disability: the treatment of illness or disability.
3. Independence.
4. Morale.
5. Social Integration.

b. Immediate family or carers

6. Family Relationships.

c. Community as a whole

7. Community Development.

While some of these dimensions directly affect quality of life of the older person and their carer (3, 4 and 6), others had a more indirect effect through influencing quality of care (1, 2 and 5).

In the present study, the first six of these dimensions were investigated as measures of output. In particular, the first two were combined to give reduction in need shortfall, while the fourth yielded improvement in morale. Changes in community development were beyond the scope of this evaluation, so were not measured. Box 3.1 shows how the outcome measures used in this study can conveniently be classified in terms of the first six of these dimensions.

2 Process evaluation

It has already been pointed out in section 3.1 that the production of welfare model, illustrated in Figure 3.1, is of use not only in statistical modelling, but also in understanding qualitatively the causal processes linking inputs to outputs in the implementation of Community Care. This can be particularly useful in the consideration of system effects, such as features of the organisation in which the scheme was based. To illustrate this, suppose the effects of the location of the care manager in the organisation in Sheppey were being considered in terms of the production of welfare model shown in Figure 3.1. Referrals were raised by the area team social workers, who were given guidance in how to judge cases as suitable. Hence there was a high level of efficiency in targeting suitable cases, with few drop outs, and this would help to shape the 'quasi-inputs' (Box 2(a)). It also released more care management time for direct contact with users (Box 2(b) -> Box 1). Although not providing regular supervision, the principal social worker gave advice to the care manager in problem solving, and this would contribute towards final outputs (Box 2(b)->Box 3). The location of the care manager in the team facilitated the deployment of SSD resources such as home help, meals on wheels, day care and residential care on Community Care cases, featured in Box 1 (resource inputs), and this in turn affected final outputs (Box 3).

Box 3.1 Measures of outcome used, classified according to six dimensions of effectiveness[1]

1. **Nurturance**
   - Need shortfall: (a) rising and retiring (b) personal care
   - Reliability of help[2]
   - Effectiveness of help[2]
   - Sufficiency of help[2]
   - Need for extra services[2]
   - Isaacs and Neville disability index[2]
   - Activities of daily living score[2]
   - Activities of daily living impairment rating (OARS)[2]
   - Risk of falling
   - Incontinence of urine
   - Number of severe life events within past year.

2. **Compensation for disability**
   - Need shortfall: (a) daily household care (b) weekly household care
   - Self-rated degree of ill-health
   - General health problem index

3. **Independence**
   - Felt capacity to cope
   - Felt degree of privacy

4. **Morale**
   - Anxiety
   - Depressed mood
   - Wakefield depression score
   - PGC morale score
   - Overall dissatisfaction
   - Dissatisfaction with life development
   - Boredom[3]

5. **Social integration**
   - Loneliness
   - Going out/social visits per week
   - Social resource impairment (OARS)

6. **Family relationships**
   - Involvement - rising and retiring
   - Change in amount of care given (hours)
   - Support from others within household
   - Lifestyle problems
   - Backstrain through lifting
   - Mental health problems
   - Malaise score of at least 7
   - Expressed burden
   - Level of strain
   - Warmth expressed towards older person

Notes:

1. The six dimensions were identified by Challis (1981).
2. This outcome should also be included under 'compensation for disability'.
3. This outcome should also be included under 'social integration'.

3 Effects of local variation on care management intervention

Before considering the individual characteristics of the two areas of implementation, Sheppey and Tonbridge, some more general sources of area variation will be considered, which could occur either between schemes or within them. These variations may affect the care manager's intervention.

Firstly, there are variations in need, such as the quality and availability of local housing or levels of unemployment. Secondly, there are differences in the strength of the local informal network. Factors such as stability and age homogeneity (Karn 1977) can facilitate making friendships. Class differences can also be important, with friendships and social integration featuring as more important amongst the middle classes and family ties more important amongst the working classes (Hellebrandt 1980). Urban/rural variation can also influence the strength of informal networks, with social encounters in urban areas tending to lack emotion in comparison to those in rural areas (Wenger 1984). Thirdly, service availability can vary, together with the willingness of agencies to co-operate. Care managers should exploit local opportunities while having the ingenuity to find ways of compensating for resource shortfalls. Fourthly, local community resources can vary. Thus, the availability of people retired from the caring professions can affect the supply of suitable helpers, as can the willingness to do voluntary work in preference to paid employment. The strength of voluntary groups and the availability of private sector care may also vary between neighbourhoods.

4 Sheppey and Tonbridge schemes in context

The Sheppey and Tonbridge schemes, set up in the early 1980s, were located in Kent so, like the Thanet Project, were based in a Conservative local authority. As in Thanet, helpers were recruited on a quasi-informal basis, making them a relatively cheap and flexible resource. However, unlike Thanet and Gateshead, support and guidance from the Personal Social Services Research Unit (PSSRU) at the University of Kent were minimal, with the social services department instead developing techniques for promoting good practice. Gwynedd was another example of a scheme with minimal support from the PSSRU but based in a rural area. Sheppey, like Thanet, was a seaside retirement area with poverty and poor housing, while Tonbridge was more prosperous with users receiving more informal and voluntary support. The particular features of the two areas are now discussed in more detail.

5 Characteristics of Sheppey and Tonbridge

5.1 Appearance, population and industry

Sheppey

The Isle of Sheppey, extending some ten miles from east to west and seven miles from north to south, is situated to the north of the Swale estuary on the North Kent coast. Most of its population is concentrated in the north-western part of the island. Here the pleasant open agricultural country and marshland found over the rest of the island gives way to large patches of industrial wasteland and areas of housing, much of it rather shabby.

The Office of Population Censuses and Surveys (OPCS) report for 1981 was the source of population statistics used in this chapter (OPCS 1983), giving the population of the island as 33,411. About one third of the population was situated in the main town, Sheerness, located in the north-western corner of the island with about half this number in Minster, just to the south-east of Sheerness. Halfway and Queenborough, situated to the south of Sheerness, accounted for a further quarter of the population. Some basic descriptive

statistics have been summarised in Table 3.5. It can be seen that the proportions of older people in different age bands were close to the averages for Kent.

Most of the industry was to be found not far from the railway line along the western coast of Sheppey which faces onto the Medway estuary and the Isle of Grain. The main sources of employment were the imposing steelworks and the docks, both located in Sheerness, and the chemical laboratories in Queenborough. A number of smaller concerns included factories for electricals, locks, glass and lavatory pans. Although a high proportion of the workforce was employed in manufacturing, there was also much unskilled work in shops. The islanders were substantially less skilled than the nation as a whole. The proportion of economically active males on Sheppey in partly skilled or unskilled occupations was 37 per cent, and only 17 per cent were in Social Class categories I and II. Moreover, the level of unemployment, at around 13 per cent, was the highest in South-East England. This offered a financial incentive to some wives of unemployed men to seek work as Community Care helpers. The percentage of middle or upper class households, shown in Table 3.5, of 12 per cent, was well below the overall figure for Kent of 20 per cent.

The steelworks, and the power station across the Medway on the Isle of Grain, both billow out smoke onto the island. The stream of heavy lorries, some piled high with scrap metal bound for the steelworks, are an additional source of pollution and noise. One main road carries the bulk of the traffic between Sheerness and the mainland via the lift bridge across the Swale, which is the only road and rail connection with the island. Some people are said to have been born and bred on the island and to have never left it. Although a coastal dyke has been built around some of Sheppey, parts of Sheerness are still at risk of flooding at times of freak tides. A substantial number of householders, including a number of older people, could remember having been flooded a few years previously and this is a continuing source of anxiety for them. Evidence of this, in the form of 'high water marks', damp walls and discoloured carpets, survives as a reminder within the home. Shouts and screams from youths at the time the pubs close is a worry to local residents, particularly those older people living alone, and mugging is not uncommon.

To the east of the island, Leysdown and Warden Bay provide holiday facilities during the summer months with a network of pubs, clubs and amusement arcades. This was established as an area to provide cheap holidays to London's 'East Enders' who often rented a chalet. Indeed many of the older people who later retired to the island were introduced to it in this way.

Tonbridge

As in Sheppey, the OPCS 1981 survey has been used as a source of population statistics. Table 3.5 allows some basic descriptive statistics to be compared with both Sheppey and the whole of Kent. In comparison with Sheppey, the Tonbridge and Malling area was substantially more affluent. Thus in 1981 74 per cent of households in Tonbridge and Malling owned a car, compared with only 60 per cent on Sheppey. Also 36 per cent of economically active males were in social class categories I and II compared with only 17 per cent on Sheppey. Consequently, many Community Care helpers were attracted more by the nature of the work than the financial incentive. Moreover, only 17 per cent were in partly skilled or unskilled occupations compared with 37 per cent on Sheppey. At the same time the population of 93,485, was three times as big. The Tonbridge and Malling areas were quite distinct so are described separately.

Table 3.5 Basic descriptive statistics of older people and the housing and institutional resources available to them in Sheppey and Tonbridge in 1983 , compared with Kent overall

	Sheppey %	Tonbridge %	Kent %
Age distribution:			
Percentage aged 65-74	9.7	7.8	9.7
Percentage aged 75-84	5.1	3.9	5.2
Percentage aged 85 and over	1.2	0.8	1.3
Socio-economic status:			
Percentage middle/upper class households[1]	12	25	20
Housing:			
Percentage retired in owner occupied housing	76	58	63
Percentage retired in council rented housing	14	28	22
Availability of institutional care (beds per 1000 population over 75):			
Local authority residential care	35	44	29
Priv./voluntary residential care county registered beds	4	13	45
Geriatric hospital	15	18	20

Notes:
1. Middle/upper class signified that the head of household was an employer, manager or professional worker.

Tonbridge had a population of nearly 40,000. Although, like Sheppey, it is situated on the River Medway, this is little more than a meandering stream which splits into a number of tributaries as it weaves itself from West to East across the town. A ruined castle is located to the west of the town, surrounded by an attractive park. Its rail link with London which provides a regular service and journey time of only 40 minutes, coupled with its pleasant, rural surroundings, has made Tonbridge a popular residential area for commuters. Moreover, the Tonbridge bypass provides quick access to the M25 London Circular. In addition, some employment is provided locally through light industry. This is mainly found on the Vale Road industrial estate located in the low-lying eastern central area of Tonbridge near the river. A popular shopping centre which runs the length of the High Street also provides employment. The level of male unemployment at under 6 per cent was less than half that found in Sheppey.

The Malling area is predominantly rural with orchards and hop fields, and is bordered to the north by the North Downs. Most of the population is located in small towns, like Ditton, Larkfield, Snodland, East and West Malling, and villages such as Eccles, Burham and St. Mary Platt. These are all characterised by an attractive and historic centre surrounded by more modern housing developments. The level of unemployment in Larkfield and Ditton was low, running at some 5 per cent; these towns adjoin the Quarry Wood Industrial Estate and further employment is available in Maidstone only a few miles away. In contrast, East and West Malling are more isolated and here the level of unemployment was around 10 per cent. These two small towns also had a much higher proportion of retired people, which amounted to 12 per cent and 18 per cent respectively. Some of the smaller villages were quite isolated and remote from larger centres of population, making the provision of resources for older people such as day care, day hospital, meals on wheels and voluntary clubs difficult to arrange.

5.2 Housing

Sheppey

Sheerness has a high proportion of owner-occupied but rather poor housing, built in the mid-nineteenth century. Although a number of homes have been modernised, many still remain without a bathroom or indoor lavatory. This is partly due to the age of the inhabitants. In more than one half of the houses in the Marine Town area (East Sheerness) the owner or tenant had no earned income, and over 20 per cent of the residents in Sheerness were of pensionable age. On Sheppey as a whole 67 per cent of dwellings were owner occupied and only 23 per cent council rented. For retired people a still higher proportion, 76 per cent, were owner-occupiers, with only 14 per cent in council rented accommodation. In Sheerness, council property often took the form of blocks of flats several stories high, the only access to upper floors being by stone staircases. These were mainly located in the 'Mile Town' area of Sheerness, where council property accounted for some 60 per cent of dwellings.

Rather better quality housing is found in Minster named after its fine old church, built on a small hill, which overlooks much of the town. Here 85 per cent of homes were owner occupied. However many of the roads were not maintained and severely pot-holed. This placed considerable restriction on the access of some properties to local transport, such as mini-buses for day care, making the flexibility of a Community Care scheme a great asset.

Tonbridge

Like Sheppey, Tonbridge had a high proportion of owner-occupied housing (63 per cent), much of this dating back to Victorian times. Some of these homes still lacked a bathroom or indoor lavatory. Some were on three or four floors connected by steep staircases and access to the road or back garden was often by steep stone steps which could render the occupant housebound and socially isolated. Community Care could often respond very flexibly under such circumstances. Heating was expensive and often inadequate. The main area of council property was in Tench, in North-Western Tonbridge. This housing included a number of old people's flatlets. Other older flats were in blocks of two or more stories and some only had access via a stone staircase. These flats were often cold and draughty.

In the Malling area, the original old village cottages represented only a small proportion of the total housing available. A proportion remained without modern amenities. Of the more modern housing, Larkfield and Ditton had predominantly owner-occupied housing (around 77 per cent). However, council property predominated in East Malling (64 per cent). West Malling was intermediate with 56 per cent owner-occupied and 27 per cent Council rented. Most housing in the Malling area had adequate amenities.

Warden supervised flatlets were available both at Hildenborough near Tonbridge and at Ditton in the Malling area.

5.3 Community life

Sheppey

The local culture of Sheppey has been described by Pahl (1984), who sees it as dominated by the family, which acts as a framework for social support. Social life is bound up with family obligation, which might take the form of a married daughter taking her mother shopping or a nephew decorating his uncle's house. In this way some older people receive help from their daughters and sons. Many of those who were born on the island come from large families of ten or more children. However other older people, particularly those who

retired to the island, have no such means of support. The companionship offered, where appropriate, by Community Care helpers could then be invaluable.

The way of life is traditionally working class, with the husband regularly spending evenings out at the pub or working man's club and the wife meeting up with local friends. Unfortunately this peer group culture has tended to undermine family life.

Corner shops are open for long hours and are invaluable for those people who buy in small quantities and who would find access to the main shopping centres difficult. For those people who are more mobile, there is a vast network of alley-ways across Sheerness and most people walk everywhere.

Tonbridge

Family support figured much more highly in Tonbridge and Malling than was the case in Sheppey. Although this meant less social isolation amongst older people, there was a greater need to provide relief to stressed informal carers. Moreover, in the rural areas, services like meals on wheels and day care could not always be offered, increasing isolation. When appropriate, Community Care could respond effectively in either case, by providing support and relief to informal carers or in providing meals and companionship. In the Tonbridge area voluntary organisations were quite active in providing lunch and social clubs for older people.

5.4 Health and welfare facilities

Sheppey

Social Services provide support on Sheppey through a generic team of social workers with a home help organiser headed by a principal social worker, in which the care manager was located. During the early 1980s this team was based at Sittingbourne, some ten miles from Sheerness, though a sub-office located in Sheerness had a social worker on duty at times during the week. This meant that the team had difficulty in responding quickly in an emergency, and it was more difficult to forge links with the local community. Two local authority care homes served the island, a modern 40 bedded home in Minster and an ancient, grim 34 bedded home in Sheerness. Towards the end of the evaluation period both the Sheppey team and the older local authority home were transferred to a new building in Sheerness, which they shared. This made it much easier for Community Care helpers to obtain support. The availability to older people of a selection of important resources in the Community Care and control areas is shown in Table 3.5. The number of local authority residential care beds per 1000 of the population aged over 75 in Sheppey was 35, a little greater than the overall average for Kent of 29. In contrast, the corresponding number of private residential care beds was only 4, far less than the average for Kent of 45. Consequently long-term care places in the two county homes were scarce, increasing the need for a Community Care scheme, though short-term care was much easier to arrange. There were no county homes available specifically for the older cognitively impaired.

Initially most of the day care for older people was provided by Age Concern, where there was a daily attendance of 70. The local authority home in Minster also offered a few day care places. However, soon after the beginning of the evaluation period a brand new day centre was opened in Sheerness. This was joint-financed between Social Services, the NHS and the housing department and offered many of the facilities typically provided by a day hospital so was a valuable resource for care managers. It was attached to a block of sheltered housing flatlets which were opened at about the same time, though its system of

fire doors and lifts led to some residents becoming flat-bound and depressed. Older sheltered housing flatlets were available in Sheerness and Halfway. Old people's bungalows were also available in Sheerness and Minster, though not all these were warden supervised.

A small general hospital located in Minster provided acute care for 100 in-patients. A wider range of facilities was provided by a larger hospital with 208 beds, though this was located some 15 miles from Sheerness. Moreover most of the in-patient psychiatric care was provided in a hospital some twenty-five miles away and so was extremely inconvenient for friends and relatives to visit. Long-term geriatric care was available at a hospital located on the mainland some six miles from Sheerness providing 114 beds. The number of geriatric hospital beds per 1000 of older people aged over 75 was 15, a little less than the average for Kent of 20.

Most GPs were opposed to a Community Care scheme and felt their users should be admitted to residential care.

Tonbridge

In 1981 the Tonbridge and Malling area was covered by social services teams based at an area office in West Malling. Older people were served by a 'resources' team which included social workers for older people, home help organisers and social work assistants and in which the care manager was located. Because Tonbridge and Malling cut across two different area health authorities, it was decided in 1983 to redefine the social services team boundaries. This was carried out as part of a county-wide restructuring of the department. Tonbridge became part of the Sevenoaks area served by a Sevenoaks office where a new care management team was set up, while Malling amalgamated with Maidstone, where the Malling team including the original care manager eventually moved. Thus at no time did Tonbridge have a social work office near at hand, though initially the West Malling office was centrally placed for the Malling area.

Tonbridge was served by two modern local authority care homes with 56 beds and 40 beds respectively. Malling had three modern 40-bedded homes based at Larkfield, Snodland and near East Malling. A day centre with 30 places in the same grounds as the larger Tonbridge care home was opened in 1981. Although this did not offer weekend day care it was a valuable means of providing relief to informal carers. A serious service deficiency was caused by the delay in obtaining an Occupational Therapist's assessment. This typically took six months and users had frequently died before an aid became available to assist in daily living.

Tonbridge came within the Tunbridge Wells district health authority. Of the two district general hospitals involved one (with 379 beds) was located some 4 miles south east of Tonbridge and the other (with 222 beds) in Tunbridge Wells, 5 miles to the south of Tonbridge. Additionally there were two small acute hospitals with 28 beds and 26 beds respectively, both on the outskirts of Tonbridge. The mentally ill were mainly served by a large psychiatric hospital in Maidstone with 907 beds and 15 miles from Tonbridge, though a few attended a much smaller psychiatric hospital with 77 beds which was 10 miles away. The local psychogeriatrician in Tonbridge was very supportive and responded quickly, though the GPs did not always see it as appropriate to refer to them. In such cases it was usually possible to arrange for an excellent community physician to visit.

Malling was covered by Maidstone district health authority. The district general hospital in Maidstone had 162 beds, with a geriatric hospital to the south of Maidstone providing 222 long stay beds and the mentally ill once again being served by the large psychiatric hospital in Maidstone. These three hospitals were each located a few miles to the east of the Malling area. Day hospital places were provided in both the Tonbridge and the Malling areas. A psychogeriatrician was only appointed in Malling after the evaluation period. Although there was a good incontinence laundry service in Tonbridge, this was lacking in Malling. There was also a shortage of bath attendants in Tonbridge. The flexibility of Community Care helpers meant they could respond to these resource shortfalls where appropriate.

GPs in Tonbridge and Malling were generally receptive towards a Community Care scheme and were a regular source of referrals, in contrast to Sheppey.

There was a reasonably good network of voluntary agencies which the care manager could draw on for support. In Tonbridge the probation service offered valuable support in gardening, and in Malling the churches offered much support, particularly in villages where other forms of help might be less accessible.

CHAPTER 4

EVALUATION METHODOLOGY

The essential characteristics of the methodology of the evaluation have already been summarised in Chapter 1, section 3. In order to measure the effectiveness of the schemes in Sheppey and Tonbridge, the progress of a group of older people in each scheme, the *experimental* or *Community Care* groups, was compared with that of two similar groups receiving standard services, the *control* or *comparison* groups. To ensure that the experimental and control groups were similar, ideally cases in each area could have been randomly allocated to the two groups to avoid systematic differences. However, such an arrangement would have posed a number of problems both to the evaluators and the implementation team.

The solution in Sheppey was to adopt a *quasi-experimental* approach, in which control group cases were drawn from a neighbouring area, Faversham, with no scheme of its own. The method for selecting these control cases was similar to that in Sheppey, via the area social work team. Although Sheppey and Faversham were administered by the same social services divisional office, ensuring some compatibility, many of the SSD resources available were not shared. Moreover, since the two areas were located in different health authorities, they did not share the same NHS facilities. Hence, allowance had to be made for area differences in resource availability.

In Tonbridge, it had not been possible to obtain a comparison group via a social work team in an adjacent area. Instead, control cases were selected from referrals made to a Tonbridge day centre. This arrangement had the advantage that these cases had similar resources available to them as the experimental cases in Tonbridge. Bias in the control group towards the need for day care was minimised by including referrals which had been rejected as unsuitable by the day centre.

The methods for selecting experimental and control cases are now described in detail. This is followed by a discussion of the different types of measurement scale used in the evaluation interviews. Copies of the time 1 interview schedules for the user and any principal informal carer are included in Appendix 2.

1 Selection of experimental cases

Sheppey

The first 41 cases to be substantially helped who were taken on by the scheme were evaluated, the initial assessments being made during a period of two and a half years. The evaluator normally made an assessment visit once the area team social worker had carried out a screening interview. The purpose was partly to collect the rich data required for the evaluation. Comparability between experimental and control users in the style of the collection was sought by having the same person undertaking the interviews for both. Another purpose was to double-check the targeting of the team, though actually all cases visited were judged by the evaluator to be suitable for Community Care. The criteria for suitability were essentially those described in Chapter 2, section 3.1. Cases selected were those who could be helped within the limits of the caseload size and the average budget available to the care managers for each older person. They needed to be at risk of admission to long-term institutional care. Being generally at risk or having a carer who

could benefit from support by the scheme would be factors contributing to their general suitability.

The care manager normally made an initial assessment visit soon after the evaluation interview. Only eight of these cases (20 per cent) had an informal carer who was interviewed. In addition to these 41 cases, one was interviewed by the evaluator but fell and was admitted to long-term hospital care before the care manager could visit. A further eleven cases were interviewed by both evaluator and care manager but were not significantly helped and therefore were excluded from the analysis.

Tonbridge

The Community Care cases evaluated were drawn initially from the Tonbridge and Malling social services division. Two years into the evaluation period, an administrative reorganisation of the social services department brought the social services boundaries closer to those dividing the district health authorities in which Tonbridge belonged to Tunbridge Wells while Malling was part of the Maidstone authority. Further Tonbridge cases were then obtained for evaluation from the new Sevenoaks and Tonbridge social services office, and additional Malling cases from the new Maidstone and Malling office.

In contrast with Sheppey, evaluations were only performed on every fifth case entering the scheme over a three and a half year period, resulting in 35 cases. All of these were judged by the evaluator as being suitable for Community Care. However, two cases were excluded from the analysis as they had received Community Care for less than a fortnight before being admitted to long-term institutional care. This left 33 Community Care cases available for evaluation. Another point of divergence from the Sheppey evaluation lay in the evaluator not making the initial assessment until shortly after the care manager's initial interview. Although this was simpler for the Community Care team to arrange, it had the disadvantage that any initial changes to the older person following contact with the care manager, such as an improved level of well-being, would remain undetected. Consequently, overall improvements over the year might be underestimated. Fourteen of the evaluated cases had an informal carer who was interviewed, a much higher proportion than in Sheppey.

Follow-up interviews were carried out a year later in both Sheppey and Tonbridge. This simple before-after design was chosen in preference to more frequent evaluation interviews to allow the evaluator more time to gather the larger number of cases necessary to tackle the main evaluation questions. There are established patterns of change in quality of life as a result of social work intervention, with the timespan of these changes tending to vary between cases (Davies and Knapp 1981). However, the quasi-experimental design used in this study could only identify overall changes over the evaluation year and not their time dependence.

2 Selection of control cases

Sheppey

Control cases were obtained via the area social work team for a neighbouring area on the mainland opposite Sheppey. In order to obtain comparability between the two groups, a similar process for recruiting cases was used to that adopted in Sheppey. Firstly the evaluator regularly checked through the case notes on older people which had recently been allocated to the team in addition to those for on-going cases. For those cases which appeared potentially suitable, the social worker concerned was asked whether they judged the case to be appropriate for Community Care; in particular whether it was at a level of

eligibility for institutional care. Secondly, when the evaluator made an initial interview, unsuitable cases were screened out. After screening, a pool of 58 control cases remained.

Tonbridge
In contrast to the procedure adopted for Sheppey, control cases for the Tonbridge and Malling Community Care group were obtained through referrals to a particular social services day centre based in Tonbridge. However, some of those cases were likely to be characterised by a rather different range of needs than those referred to the care manager who was based in a social services resources team. Moreover, although the superintendent made an initial shortlist of cases which were felt to be at a level of eligibility for institutional care, the superintendent was naturally less familiar with this selection process than was the care manager. It was therefore necessary for the evaluator to be far more selective in screening out inappropriate referrals than had been the case in Sheppey. The result was a control group of 36 cases.

3 The matching of experimental and control groups
By using the criteria referred to in Chapter 1, section 3, matched pairs were drawn from the experimental and control groups. In order to correct for residual differences between both unmatched and matched groups, subsequent analyses controlled for the variables for which there were group differences.

Sheppey
From the pool of 41 Community Care cases and 58 control cases, 27 matched pairs were obtained. By testing whether any of the remaining Sheppey cases could be matched against Tonbridge control cases left over after the Tonbridge matching process, a further five pairs resulted, making 32 pairs in all.

Tonbridge
The 33 Community Care cases and 36 comparison cases yielded 17 matched pairs. A further six pairs were obtained from matching six Tonbridge and Malling cases with six of the Faversham control cases left over after the Sheppey matched pairs had been selected. Thus in all 23 matched Tonbridge and Malling cases resulted.

The numbers of user and carer interviews in Sheppey and Tonbridge at time 1 and time 2 before and after matching are shown in Table 4.1.

Further details on the procedure for selecting control cases, the screening process for each group and an account of differences between the experimental and control groups and the resource availability in the two areas are described in Appendix 1.

4 Use of measurement scales in the interview schedules
Measurement in the social sciences is frequently subjective and subject to error and it is important to be clear about the techniques adopted and assumptions made. Scales used can be of four types (Stevens 1946).

Nominal scales simply classify into groups without attempting to sequence them.

Ordinal scales allow users to be classified into groups which can be arranged in a sequence, though the differences between adjacent groups on the scale may vary.

Table 4.1 Numbers of interviews with older person and informal carer by group in Sheppey and Tonbridge at time 1 and time 2 before and after matching

Type of interview	Sheppey		Tonbridge	
	Community care	Comparison group	Community care	Comparison group
Older person				
Time 1				
Before matching	41	58	33	36
After matching	32	32[1]	23	23[2]
Time 2 - community				
Before matching	24	34	20	21
After matching	19	15[3]	16	11[4]
Time 2 - residential care				
Before matching	6	7	4	6
After matching	5	6[5]	2	5[6]
Informal carer				
Time 1				
Before matching	8	27	14	18
After matching	8	9[7]	10	11[8]
Time 2				
Before matching	4	17	9	15
After matching	4	6[9]	8	9[10]

Notes:

1. Includes 5 cases drawn from Tonbridge comparison group.
2. Includes 6 cases drawn from Sheppey comparison group (Faversham).
3. Includes 2 cases drawn from Tonbridge comparison group.
4. Includes 3 cases drawn from Sheppey comparison group (Faversham).
5. Includes 1 cases drawn from Tonbridge comparison group.
6. Includes 1 cases drawn from Sheppey comparison group (Faversham).
7. Includes 3 cases drawn from Tonbridge comparison group.
8. Includes 5 cases drawn from Sheppey comparison group (Faversham).
9. Includes 2 cases drawn from Tonbridge comparison group.
10. Includes 4 cases drawn from Sheppey comparison group (Faversham).

Interval scales are ordinal scales in which adjacent points are equally spaced, though the absolute value on the scale has no significance; only the differences between particular points are fixed.

Ratio scales are interval scales whose absolute values are fixed, so relative magnitudes can be compared. Thus, in measuring time spent by the informal carer in caring, one spending twelve hours per week can be said to take three times as long as one spending four hours per week.

In this study nominal scales were useful in the classification of users and carers. For those characteristics which vary in magnitude, interval scales enable them to be measured. This allows the average values of two groups to be compared, and the change in value of a particular group over a time interval to be measured (the outcome).

In order that scales were useable, they needed to be both reliable and valid. A *reliable* scale is one for which repeated measurements made under constant conditions will give

the same result. *Validity* is the extent to which a scale measures what it sets out to measure.

In order to construct a scale, a group of simple questions is assembled which help illuminate the characteristic to be measured, and to distinguish between a favourable and unfavourable condition. Next a pilot study can show which questions do not hang together with the group, and these items can be removed. Thirdly, a representative selection of questions is made, using the pilot study as a guide, to form the final scale. This can then be checked for reliability and validity before being used.

In this particular evaluation all the scales used were ones which had been constructed for other studies, so their reliability and validity had already been established. Their acceptance as standard measures allowed comparisons with other studies to be made. The scales used here, constructed using three types of scaling technique, are referred to as rating scales, Guttman scales and Likert scales (Moser and Kalton 1971).

Rating scales allow an item to be measured by choosing one of a number of levels of varying intensity. In these evaluation interviews the respondent was normally asked a general question on the item, and the interviewer then rated the response on the scale. For example, the answer to the question

'Do you find that you get lonely?'

would be rated by the interviewer as one of:

'Most of the time'
'Often lonely'
'Sometimes'
'Rarely'
'Never',

where each level was defined. Some items were only rated after the interview, based on the interviewer's observations. One example was the user's attitude to life, coded as:

'Content'
'Fairly content'
'Neither content nor discontented'
'Discontented'
'Openly unhappy'.

The number of scale points used needed to be optimised to allow sufficient sensitivity in measurement while enabling reliability in usage. Some scales range from very favourable to very unfavourable. In the above example there are an odd number of categories, the middle one being neutral. In other instances using this type of measure it might be desirable to have an even number of levels, to force a response which was either favourable or unfavourable. The interviewer coded responses in a way which allowed the extreme categories of the scale to be used with a comparable frequency to the inner categories, so that the full width of the scale was exploited, avoiding the *error of central tendency*. The interviewer would also try to judge whether the responses were coloured by *leniency* (where the respondent disliked being critical) or *severity* (where they set high standards), and eliminate these errors by probing.

A weakness of rating scales is that they are frequently based on just a single response where selection of an appropriate level may be fairly subjective, even when this is achieved through the interviewer's judgement. The other two types of scaling technique used are based on a number of responses.

Guttman scales consist of a number of questions relating to a range of extremes of a particular dimension. For example, the interviewer rating of depression was measured on a four-point scale, whose levels were defined as:

'none - no symptoms'
'mild - gloomy attitude, sadness'
'moderate - tendency to weep, considerable pessimism'
'severe - extreme symptoms of depression'.

The four items were arranged in this order because it is found by experiment that subjects at a particular level on the scale tend to show the characteristics of the items on and below that level but not above that level. This definition requires Guttman scales to be ordinal. Moreover, if the separate items on a Guttman scale appear to form a steady progression from mild to severe symptoms, they can be assumed to approximate to a linear scale. This would imply in the above example that a deterioration in depressed mood from 'none' to 'mild', 'mild' to 'moderate' and 'moderate' to 'severe' would all be roughly equivalent.

Suppose it is required to measure the average reduction in depressed mood over one year for cases receiving Community Care, and to compare this with the corresponding reduction for control group cases. Then by assuming the scale is approximately linear, the mean reduction in score for each group can legitimately be compared. An alternative method might be based on whether each case is at least moderately depressed. The net reduction in the number of cases satisfying this condition could then be compared between groups, with no assumptions regarding linearity having been made. Although this method is more rigorous it is less sensitive, so less likely to indicate significant group differences when these exist. Therefore, in this study, all Guttman scales used have been assumed to be approximately linear.

In order to make the allocation of cases to points on Guttman scales as precise as possible, each level was normally defined in terms of objective criteria, as illustrated earlier in the measurement of depressed mood.

Likert scales consist of a series of rating scales, each with a similar set of scale points. For example, the Wakefield depression scale consists of twelve questions, each of which has the following codes:

Yes, definitely
Yes, sometimes
No, not much
No, not at all.

Ensuring that a high score always denotes severe symptoms, the scores for each item are added to give a total score.

Although Likert scales behave as reasonable ordinal scales, they cannot generally be assumed to be interval scales. However the two main ones used in this study, the PGC

morale scale (Lawton 1975) and the Wakefield depression scale, do approximate to linear scales. Changes could therefore be measured by subtracting two scores.

When designing Likert scales, it is desirable that the questions be split fairly evenly between those enquiring about the unfavourable aspect and those with respect to the favourable aspect. This encourages the respondent to listen carefully to each question and respond appropriately. It avoids a *halo* effect caused by interviewees responding to the overall dimension rather than to each individual item.

A special case of the Likert scale occurs when each item is measured on a two-point yes/no scale. The most important example in this study is the Malaise scale (Rutter *et al.* 1970) used for measuring the stress experienced by informal carers. Fourteen of the twenty-four questions were taken from the Cornell Medical Index Health Questionnaire, whose score of emotional disturbance agrees fairly well with independent psychiatric assessments. The Malaise score was assumed to be approximately linear.

The results of analysing the data are now presented. These consist essentially of a comparison of outcomes, costs and their interrelationship for experimental and control groups.

PART II: IMPLEMENTATION HISTORY AND CARE MANAGEMENT PROCESS

CHAPTER 5

IMPLEMENTATION HISTORY AND DEVELOPMENT

In Chapter 2 the principles of the schemes were explained and in Chapter 3 the characteristics of Sheppey and Tonbridge described. The present chapter gives an account of how this set of principles was put into action in setting up schemes in these two contrasting areas, and the subsequent development of the schemes.

1 History of schemes and organisational locus of care manager

Following the decision to extend Community Care for frail older people in Kent from the original project in Thanet to other parts of the county, divisional officers in other parts of Kent were invited to apply to start schemes in their areas. Successful applicants were rewarded with extra funding for the schemes. This was not necessarily an arrangement likely to attract the divisions able to set up the best schemes since it was not based upon having a commitment to the Community Care model. Moreover it failed to meet the standards proposed more recently by the Department of Health in setting up care management pilots (Department of Health 1991a). Two out of the first three new schemes were in Sheppey and Tonbridge, the subjects of this evaluation. The history and development of each of these schemes is now described.

Sheppey

A care manager, appointed to the social work team for the island of Sheppey, started work in October 1980. This fieldworker was supported by a half-time clerk and was responsible to the principal social worker for the team which, together with two similar teams for neighbouring areas on the mainland of Kent, were under the overall management of a divisional director. The first cases were taken on in the following December. Two years later when the caseload had reached its full capacity of about 25, the care manager was joined by a half-time social work assistant whose caseload eventually reached 12. The two workers could discuss cases together and provide each other with relief when necessary.

The initial geographical location of the care manager was rather remote from Sheppey and was based with the social work team in the divisional office at Sittingbourne on the mainland. It was only after the evaluation of most cases had been completed that the social work team moved, in May 1984, to a new building in Sheerness shared with a county home for frail older people, and the Community Care Scheme could benefit from this more central location. Community Care helpers could call in to discuss problems directly with the care manager or payment problems with the clerk. Users also felt more secure in the knowledge that the care manager was based locally. Better relationships with local workers from other agencies such as Community Nurses who could also visit was possible in this informal atmosphere. However, these benefits would have come too late to affect the users being evaluated.

The initial reaction of many of the local workers in other agencies concerned with older people to the appointment of the care manager had been one of feeling highly threatened. The care manager responded by spending much of the first few months in explaining the scheme to the local statutory and voluntary agencies. Through building up good relationships the care manager was able to maximise the cooperation of different agencies in the support of individual cases.

Tonbridge

After a period of some six months when an inappropriate care manager was in post who subsequently left, the Community Care Scheme in Tonbridge and Malling came into operation at about the same time as the Sheppey scheme with the appointment of a new care manager attached to the resources team, consisting of social workers for older people, home help organisers, a social worker for the blind, an occupational therapist and a technical officer. The care manager was supported by a half-time clerk. The team was based at the divisional social services office in West Malling which was rather remote from much of the older population, particularly that located in Tonbridge, some ten miles to the south. The care manager was responsible to the principal social worker for the resources team. A year later, when the caseload was over 20, the care manager was joined by a half-time assistant. After the scheme had been in operation for two years, the care manager's caseload peaked at 35 and then levelled off at around 30, with the assistant supporting 12 cases. The peak appears to have been caused by a high proportion of relatively lightweight short-term cases which were taken on in the early stages of the scheme when the care manager's screening skills were underdeveloped.

Some six months later, following an administrative reorganisation of the social services department, the care manager continued to be based at the same office. While maintaining the scheme in the Malling area, new cases from Maidstone were taken on. At the same time all Tonbridge cases were transferred to a newly appointed care manager for Sevenoaks and Tonbridge, based in the Sevenoaks office. The half-time assistant left the scheme at the same time, but was replaced nine months later by two full-time assistants based at the Malling office. These subsequently took over all remaining Community Care cases in Malling after the sudden death of the care manager. After one of the assistants had left, the other became acting care manager of the entire Community Care caseload for Maidstone and Malling of 30, no further referrals being taken on. Because the principal social worker left at this point there was no supervisor or guidance available. The leaderless 'development team' in which the Maidstone and Malling care managers were based had no significant team cohesion, and included a social worker for the blind, another worker for the blind and a technical officer. There was therefore little team support. The care manager was made to feel the need to prove that the scheme would be successful with the team's users. Once users and social workers from other teams were satisfied about the effectiveness of the scheme, Community Care became more acceptable, though this took some time to achieve. Regular joint visits between care manager and the home help organiser helped to improve communication and understanding. Eventually the scheme became accepted as a standard part of domiciliary provision for older people. By the time a new care manager had been appointed, together with a second assistant, and the Community Care team had moved office from West Malling to Maidstone, the evaluations were virtually complete.

Despite the high rate of staff turnover combined with patchy team leader support Malling, there was no evidence from case review material or interviews with fieldworkers to suggest that care management practice had suffered to any extent. When staffing levels were depleted, the care manager coped by not taking on new cases, the assessment process being very time consuming. Moreover, when the sensitivity of cost and outcomes relationships to being evaluated in this unstable period is tested in Chapter 9, no significant effects were found, suggesting that the benefits of the scheme are reasonably robust with regard to staffing levels and turnover.

While the scheme in Malling had been experiencing this unsettled two year period, the situation for Tonbridge cases, following the appointment of the new care manager in Sevenoaks as a result of administrative reorganisation, was much more stable, and in addition to maintaining the scheme in Tonbridge, the scheme was extended into the Sevenoaks area too. In October a full-time assistant was appointed, both posts being joint-financed. As in the Malling office, the care manager and assistant were located in a specialist team for older people covering the whole of the Sevenoaks and Tonbridge areas, under the supervision of a principal social worker. The specialist team included, in addition to the care managers, two social workers, four welfare assistants and three home help organisers, and was very supportive towards the Community Care team. This contrasts with the constant criticism experienced earlier in the Tonbridge and Malling team. Although that care manager was located in a similar type of team, the personalities of the home help organisers had been antagonistic towards the scheme. Being located in a specialist team for older people, as found in Sevenoaks and Tonbridge, had advantages over a generic team. While in Sevenoaks and Tonbridge the team was very supportive, a generic team, such as that in Sheppey, tended to become polarised between those working mainly with older people and the rest. Being a member of a specialist team improved everybody's knowledge within the team. There were good opportunities for discussion and the team was able to tolerate negative feelings about work or each other.

The principal social worker used to supervise cases while the care manager for Sevenoaks and Tonbridge was on leave until the assistant was appointed who then took over this task. In contrast, the lone acting care manager at the Maidstone and Malling office, who had no principal social worker, found leave-taking difficult. The care manager remained on call so that the clerk could telephone when problems needed solving.

In Sevenoaks and Tonbridge, a majority of the social workers for older people and home help organisers had a good understanding of Community Care, though a few remained antagonistic. The situation improved as the care manager continued to work with the team. The principal social worker was very committed to the scheme, had an excellent understanding of it and was very supportive.

2 Referral routes

Sheppey

Referrals to Community Care were made through the social work area team who had to sift through many cases. Referrals were obtained at intake meetings after a preliminary discussion with the care manager. The social worker would make an initial visit and screen out the referral if inappropriate for the scheme. Because social workers had a clear idea of the level of need required for users to be eligible for a place in a county residential home, they were effective in referring well-targeted cases to the care manager. Only four cases were not taken up during the first five years of the scheme and most of those accepted by the care manager subsequently proved to be appropriate.

The principal sources of referrals were the area team social worker (54 per cent), home help service (15 per cent) and district nurse (10 per cent). Although only 15 per cent of all referrals were from the NHS (including hospital social workers), these cases had substantially higher ADL scores, averaging 3.3, than remaining referrals (2.1). This may partly reflect that while the main body of SSD referrals were of cases at a level of eligibility for long term residential care, some health service referrals would have been acceptable for long term hospital care. While referrals from the home help service had

ADL scores slightly above average (2.3), those from area team social workers had below average scores (2.0).

Tonbridge

The method of raising referrals in Tonbridge and Malling was quite different from that used in Sheppey, being made directly to the care manager without any prior screening by other team members. This meant that more time was taken up in making assessment visits to potential cases which turned out to be unsuitable. However, when cases had been referred by a social worker, a joint visit was generally made in order that the care manager gain as much information as possible. The close cooperation during the interim period allowed a smooth change over of case responsibility to be achieved.

While a new case was being assessed by the care manager, it was necessary to arrange for a period of up to two weeks before the care manager could take on overall case responsibility. During this time, the care manager would make the initial assessment visits and contact members of the user's formal and informal network and this was time consuming. Meanwhile the referee or social worker would need to carry on with the case and would work closely with the care manager. Home help organisers, who were used to having home helps lined up to visit new cases straight away, had difficulty in grasping this care management approach. However, it was important that the scheme not be seen as a crisis intervention service. Through a process of educating referral agencies as to the types of case suitable for Community Care, the efficiency of the referral process was improved.

A referral form was developed which was sent to the referee for more details, including the reasons why the referral was made, why at that particular time and whether a psychiatric or occupational therapist's assessment had been made. Also information was requested which it might be difficult to obtain directly from the user. In a covering letter, the criteria for a suitable referral were stipulated. Most referees welcomed the form as it clarified what was wanted, and they were able to respond more professionally.

In the earlier stages of the scheme many inappropriate referrals were taken on. Although these would frequently have been suitable for other team members, it was often easier for the care manager to continue with the case once the initial assessment had been made particularly since the user had an expectation that the care manager would follow things though. An early closure would then be arranged. This led to a fairly high turnover of shorter-term cases. In order to improve the efficiency of the screening process, the care manager in Sevenoaks and Tonbridge took to initially discussing each case with the principal social worker for the team, who could then refer it to another team member where appropriate. If a case then appeared likely to be suitable for Community Care, an assessment would be carried out by the care manager or assistant. By this means over 90 per cent of cases taken on were appropriate. If there was doubt over suitability, the care manager would probably still make initial enquiries and do an initial assessment, but would make it clear to the referee that no further action was likely to take place at that stage.

The main sources of referral were area team social workers, including social workers for older people (30 per cent), home help service (24 per cent), hospital social workers (12 per cent) and GPs (12 per cent). The proportion of referrals from the NHS, including hospital social workers, of 27 per cent was greater than in Sheppey (15 per cent), reflecting the different mechanisms for raising referrals and screening. However, the ADL scores of the health service referrals (2.00) were substantially *less* than remaining referrals (2.88), the

reverse to the result for Sheppey. Those with highest ADL scores were from the home help service (3.25) and hospital social workers (3.00). Area team social workers provided referrals with scores slightly below average (2.30) while those from GPs were far below average (1.25).

Thus referrals from the home help service, as well as making up a quarter of all referrals, had high ADL needs. In addition, their level of cognitive impairment was high. Although the home help service initially perceived the scheme as being a threat, it appears that they came to see it as a means of providing support to cases with complex needs, which would not adequately be met by the service and for which no other agency wanted responsibility.

3 Team setting of care manager

Sheppey

The social services team operated in the same area as the care manager, who therefore had the advantage of having to deal with only one set of people; one principal social worker, about five social workers and one home help organiser. Although this made the process of explaining the principles of the scheme less time consuming and more effective, some of the team, particularly those without social work qualifications, could only grasp the service aspect of the scheme and not the care management aspect. This caused the care manager to feel isolated until the assistant care manager was appointed.

Tonbridge

Although most referrals came via the specialist team for older people in which the care manager was based which served the entire division, some came via the generic teams. Both before and after reorganisation the area served by the scheme covered four generic team patches which meant having to explain the scheme to a large number of social workers. This made the process of education as to the types of case suitable for referral more protracted and less effective. In this respect the scheme was at a disadvantage compared to the one in Sheppey.

4 Nature of target group

The characteristics of the types of case taken on by the scheme are now discussed in more detail. The most important criterion which applied to all cases was that they were sufficiently needy to be eligible for at least a place in a county residential home, and sometimes even for a place in long-term hospital care. These older people were normally unable to manage at home with existing support from informal carers and the statutory and voluntary sectors.

There were other criteria which made cases particularly likely to benefit from scheme intervention, though were not sufficient reasons for involvement. A need for extra flexibility regarding the time at which help was offered could often be met by the scheme. Thus, in the absence of the scheme an older person with incontinence pads and transfer problems might have to wait until mid-morning for a community nurse to get her out of bed and change her wet pads. By visiting early, a Community Care helper could avoid this uncomfortable start to the day. The contributions of help from different agencies and informal carers often needed improved co-ordination, and the scheme could respond by constructing a weekly timetable showing the times of visits and tasks undertaken by all those providing support. By this means both gaps in the care needed and any duplication by different workers could be identified, allowing a more suitable package of care to be negotiated. When the demands placed on informal carers had led to an intolerable level of stress, this could provide grounds for the referral being taken on, when the alternative

might be a breakdown in informal support, leading to an admission to institutional care. When there was a need for counselling help for the older person or their informal carer, this would provide additional grounds for taking on a case, as other services and agencies could not normally provide such support. The need for an older person to talk through the experience of loss due to their failing physical and mental capabilities or bereavement, or the need for carers to talk over their feelings of anger and guilt at the demands placed on them by the older person are examples of where counselling might help. The counselling offered by care managers to users might typically involve building up a relationship of trust; allowing them to talk through the experience of loss and the implications of that loss for their lifestyle; allowing users to express their anger, frustration and grief at this loss; and enabling the user to accept their loss as part of the aging process and to accept that others may now take on any role which the user has had to relinquish.

Referrals for which the main problem was severe risk of falling were not regarded as suitable for the scheme unless these older people were also needing extra help in performing essential activities of daily living which existing services could not provide and which therefore rendered them eligible for long-term institutional care. Indeed many of the cases taken on by the scheme were regarded as suitable because of their complexity in addition to a high level of need. In these cases the care manager could provide the detailed assessment and coordination needed.

Cases were not taken on if it were felt that an alternative form of care would be more appropriate; for example, if an older person were expressing a genuine wish to enter a local authority care home for which they were eligible, Community Care would not normally be considered a suitable alternative. The older person's attitude to receiving help at home formed a crucial part of their suitability for the scheme. If the person were wary about accepting help, a decision would have to be made as to whether they might be enabled to receive help, before taking on the case. Some prospective cases with personality disorders tended to be dependent and demanding, yet hostile and rejecting towards any help offered. Such cases were often unsuitable for the scheme. They could result in a rapid turnover of helpers as a reaction to the older person's rejecting attitude. Such users were not normally supported by the scheme, since the benefits would be limited and the demands on the helper pool would deprive other potential users who could benefit more. The implication of this policy was that a greater proportion of such cases were admitted to institutional care without receiving community care. This would make the scheme appear more cost-effective than would otherwise have been the case. The results of applying these targeting criteria in Sheppey and Tonbridge can be seen from Table 5.1, which summarises the main characteristics of cases assessed in the initial evaluation interviews, carried out at the point of entry to the scheme. Although the general targeting criteria described above were applied in both schemes, different emphases can be discerned.

However, the level of informal support was substantially lower in Sheppey than in Tonbridge, with 88 per cent living alone in Sheppey, compared to only 64 per cent in Tonbridge, where a much larger proportion of cases lived with their spouse. Also only 20 per cent had a principle informal carer in Sheppey, compared to 46 per cent in Tonbridge. It can be seen that over 80 per cent of cases were female in each area. This meant that more user needs were met informally in Tonbridge than in Sheppey. To compensate for this most indicators show Tonbridge cases to be in greater need than those in Sheppey. The contrast was particularly strong for feeding self, preparing meals, severe risk of falling and presence of a confusional state. However, incontinence of faeces was slightly more

frequent in Sheppey. Also, in view of the low level of informal support in Sheppey, it is hardly surprising that these cases were more frequently lonely.

Examining the aspects of need which were common to the two schemes, many needed help in the early morning or late evening with getting in or out of bed and dressing or undressing. At least 15 per cent needed help in getting to or using the toilet, which might require helpers going in at regular intervals throughout the day. Most cases needed help with cleaning, shopping and meal preparation. Many suffered from problems of incontinence; the Community Care Scheme (CCS) could offer effective means of managing this problem.

Table 5.1 Characteristics of older people supported by the Community Care scheme in Sheppey and Tonbridge

	Sheppey	Tonbridge
Mean age	83	81
Sex		
Male (%)	17	18
Female (%)	83	82
Living group		
Alone (%)	88	64
Spouse (%)	2	21
Family (%)	10	15
Activities of daily living - needing help with		
Getting in and out of bed (%)		
Getting in and out of chair (%)	32	30
Dressing/undressing (%)	5	12
Moving indoors on level (%)	46	58
Feeding self (including cutting up food) (%)	7	12
Getting to/using toilet (%)	10	42
Managing medication (%)	17	15
Bathing (%)	32	42
Preparing meals (%)	85	82
Making hot drinks (%)	68	91
Cleaning (%)	37	39
Shopping (%)	98	91
	90	94
Incontinence		
Urine (%)		
Faeces (%)	42	42
	24	15
Risk of falling (severe) (%)		
Presence of confusional state (%)	20	30
Behaviour problems (%)	20	36
Depressed mood (%)	24	19
Frequently lonely (%)	44	49
Presence of principal informal carer (%)	56	49
Carer under stress (%)	20	46
	50 (of 8 carers)	36 (of 14 carers)
Sample size		
	41	33

Both schemes proved to be particularly effective in coping with the cognitively impaired, for whom the other community and residential services available were often inadequate. Indeed all agencies had expressed their difficulties in coping with this user group, for

whom suitable resources were frequently lacking. Although there was a specialised EMI residential home in the Tonbridge area, there were none in Sheppey. The care management teams responded by giving such cases a high priority for support, particularly in Tonbridge. For example, although informal carers were often badly in need of relief from such cases, day care could often not cope with them adequately. Nevertheless, care managers could respond by arranging for helpers to visit the home and provide supervision allowing the informal carer to go out and get a break. One case in five taken on in Sheppey and more than one case in three in Tonbridge were moderately or severely cognitively impaired, and about one case in five in each area showed behaviour problems such as wandering, being noisy at night or creating fire hazards at the point of referral. Coping with such cases at home necessarily involved a degree of risk. Those prone to wandering by day or by night were at risk from traffic. Others might cause risks within the home. Thus one older lady supported in Sheppey left piles of newspaper in her living room near the gas fire, putting both herself in danger and causing serious concern to neighbours in adjoining homes. These risks could usually only be somewhat reduced by scheme intervention. Referrals were not turned down as a result of such risk taking unless it was felt that the dangers to the older person or others were severe. In view of the savings which this policy of targeting the cognitively impaired made to the NHS through preventing or delaying admissions to psychiatric hospital, an application was made by the Tonbridge division to the health service for joint funding of care managers' salaries. Although this was not initially forthcoming, the later appointments of care manager and assistant care manager in the Sevenoaks and Tonbridge office were joint funded.

In addition, nearly half of the cases taken on in each area were clinically depressed, a rather higher proportion than the average for this age group which would typically be one case in three (Kay *et al.* 1964). The scheme also took on a few older people suffering from paranoid delusions. Through building a stable relationship with the care manager and one or more helpers, these cases could be greatly assisted through their improved self-confidence. Also, about one half suffered from frequent periods of loneliness, which the Community Care scheme could often effectively relieve, generally through the companionship provided by a helper.

5 Managing pressure of referrals

Sheppey

The social work team in which the care manager was based had unrealistically high expectations of the number of cases which could be served by the scheme. In practice, because of a relatively low turnover of some 1-2 cases per month, the care manager and the assistant care manager were unable to take on all the potentially suitable referrals. During the same period, the remainder of the team would take on some 140 older referrals as well as home help referrals, and this understandably caused some resentment. The care manager would explain that with a combined caseload of some 40 cases, they were effectively looking after a care home 'in the community' between them. If their users had all been in residential care, far more staff would have been required. Suitable cases which could not be taken on immediately by the care manager but which were sufficiently needy were put on a Community Care waiting list in order of priority, with the social worker making intermediate arrangements. The care manager periodically reviewed these cases, which helped user, social worker and referee feel that an interest in the case was being maintained. By this means the care manager retained a degree of credibility with referring agencies. However, social workers still became frustrated, and also found it difficult to accept the time required to build up a pool of helpers which could be suitably matched to users. The pressure from social workers eventually led to the care manager ceasing to

complete assessment and case review forms in order to release 2.5 to 3 more hours each week to take on additional cases. This reduced the degree to which the care manager was responsible to the authority and meant that the target group and care manager activities could no longer be compared with other schemes in Kent. Fortunately only a few of the evaluated cases were affected by this.

Tonbridge
In resisting the pressure to take on new cases, it was important to spell out the criteria for suitable cases. Thus, the scheme should not be seen as a top up service for the home help service and should resist the pressure to take on such cases. There were times when suitable referrals could not be taken on when caseloads were already at maximum levels. The turning down of such cases could be quite stressful for the care manager, as the referee could put on pressure. Area team social workers and home help organisers had a general lack of understanding of the need to maintain caseloads at a low level, and GPs and community nurses could be very demanding. In some cases the care manager would visit to see whether the user met the criteria of suitability for Community Care, and then put the user on a waiting list. Through being fairly consistent in the types of case taken on in the procedure for accepting new cases it was possible to maintain some credibility with referring agencies and prevent false expectations from being created. The care manager in Sevenoaks and Tonbridge was able to maintain a certain detachment from the work and not become too emotionally involved or take on too much. This was invaluable in keeping an effective role in managing the caseload.

6 Relationship with team members, in particular the home help organiser
Sheppey
The home help service felt threatened by the scheme and the home help organiser was initially antagonistic, though the situation improved once home helps took on personal care tasks, following a change in their job description.

Tonbridge
As in Sheppey, there was a good deal of initial scepticism about the scheme expressed by others involved from both within and outside the social services department. The home help organisers were initially very uncooperative, regarding Community Care as yet one more service, another face for the user to cope with. They wished that the Community Care budget had instead been available for improving the home help service. However, as the scheme gained in credibility, these feelings diminished. Many social workers did not like the idea of paid volunteers visiting the older person. At first they saw Community Care as being just another pilot and expected it to fail. However, they too came in time to acknowledge the value of Community Care and that the pressure on places in the local county home for older people was falling rapidly through Community Care cases being maintained at home.

Although it was useful for care managers in the West Malling office to be located in the same building as the Occupational Therapists, the two still had difficulty in understanding each other's roles. It appeared that these community based OTs were concerned primarily with the provision of aids and adaptations rather than with assessment and were consequently of only limited use to the care managers. These SSD OTs adopted the same narrow perception of the scheme as that of the home help organisers and social workers for older people, of CCS being a 'gap filler' for other services. They were unsure of the types of case targeted by the scheme and the types of task undertaken. This pointed to a

need for better training and oversight of SSD based OTs, and for care managers to spend more time explaining their role.

7 Cases requiring intensive nursing care

A few of the Community Care cases taken on in each scheme were already requiring too much nursing care to have been suitable for a place in a local authority home, and would have been eligible directly for a long-term geriatric hospital bed. Moreover, as cases already receiving Community Care tended to deteriorate over time, many who were initially eligible for local authority residential care subsequently became eligible for long-term hospital care. It was the policy of the care manager to continue to maintain these older people in their own homes for as long as was feasible, and this frequently allowed them to die at home. Sometimes this required helpers to provide personal care at frequent intervals during the day and occasionally night sitting as well. Because these high-need cases tended to take up more of the care manager's time, not many new referrals of this type were taken on. If a greater proportion of these cases had been supported, this would have required maintaining a lower caseload at around 15-20 cases instead of 25-35 cases.

Moreover, because cases requiring a lot of nursing care were so time consuming, the teams in Tonbridge and Malling eventually tightened the criteria for taking on new referrals to exclude intensive nursing cases. Although an upper spending limit on such cases was arguably two-thirds of the cost of a place in a geriatric hospital bed, almost twice that used for other cases, the district health authority was not prepared to provide any additional funding.

8 Caseload size

Sheppey

Ideally, the care manager liked to maintain some 25 heavily dependent cases, some of which required nursing care, together with perhaps 5 lighter cases. This allowed time for carrying out the different aspects of care management, including such time consuming activities as dealing with solicitors, coping with property problems and the placing of a user's dog, as well as the supervision of the assistant. In practice, as a result of pressure from the area team, the caseload reached about 34, the majority being highly dependent, though not until all the researched cases had been evaluated. This meant that some important aspects of care management were not adequately dealt with. For instance, contacts with the wider family might be neglected, and slips might occur in coordinating particular helpers, such as forgetting a weekend helper arrangement. The part-time assistant care manager's caseload eventually reached 12

Tonbridge

As in Sheppey, care managers generally found a caseload of between 25 and 30 to be ideal for doing the job properly, and although after the scheme had been running for two years the care manager's caseload reached 35 for a few months, it was usually kept within these limits. Moreover, this peak at 35 was partly caused by a high proportion of short-term cases which were inadvertently taken on during the early stages of the scheme. It was these relatively lightweight cases which appear to have made Tonbridge caseloads initially greater than those in Sheppey. However, even with a caseload of around 30, a problem arising with just one case can mean that the care manager has less time than desirable to manage the caseload effectively, and the care manager for the newly created Sevenoaks and Tonbridge office preferred to keep a caseload at 25 when feasible. Also the part-time assistant care manager's caseload was maintained at around 12.

9 The adequacy of budgets

Sheppey

During the evaluation period the total budget held by the care manager did not act as a serious restraint on spending. Although this would have allowed more scope for buying in expensive services such as day and respite care, it would have reduced the incentive of the care manager to distribute resources amongst users in the most efficient manner. However, after the scheme had been operating for several years and the caseload continued to age, leading to escalating costs, the county started setting budget limits which did bite. The spending ceiling on individual cases of two-thirds of the cost of a place in a residential home would have encouraged a more efficient use of resources for high cost cases, though it was not allowed to cause otherwise suitable cases from being turned away or prematurely closed, and the rule was always waived in such instances. This was acceptable as it did not result in caseloads unduly dominated by high cost cases.

Tonbridge

The Community Care budget did not act as an undue constraint on spending and, as in Sheppey, the spending limit of two-thirds the cost of a place in a county home for older people was not allowed to cause otherwise suitable cases to be turned away or prematurely closed.

10 Tapping into local resources

The principles of the Sheppey and Tonbridge schemes were essentially those described in section 1 of Chapter 1. They involved the same series of care management tasks as that described in other schemes of this type (Challis and Davies 1986; Challis *et al.* 1990).

The care managers in each scheme applied these principles in a way which would both maximise the advantages of the area while taking account of local constraints. The ways in which this was undertaken in different aspects of the work are now described.

Sheppey

Firstly, advantage was taken of the services offered by local voluntary organisations. Some of these were initially concerned that they would lose volunteers to the scheme, though this did not materialise. The most important was Age Concern, who ran a day centre for older people which included lunch club and social club facilities. This provided a valuable point of social contact for a number of older people in the scheme, and the few who were sufficiently mobile could use it as a pop-in centre. The WRVS, with a subsidy from the social services department, offered a good Monday to Friday meals on wheels service which provided freshly cooked meals through the use of frozen meals and a microwave oven. Contact with churches was maintained in connection with some seven specific cases. This might involve the vicar in periodically visiting an older person and perhaps giving communion at home. This was valuable for those whose immobility prevented them from attending church.

Secondly, contacts were forged with staff of local statutory organisations, particularly in the health service. The initial reaction of many agencies to the scheme had been one of apprehension. Many health service representatives felt that promises made by the social services department would not work out; there was a history of suspicion. The housing department were worried that a long-term effect of the scheme would be to make residential care no longer available, leading to more housing problems in the community, such as for wardens of sheltered accommodation.

The first inter-agency group for older people which the care manager took part in after appointment initially interrogated the care manager about aspects of the scheme. The care manager felt that this was of limited value and was eventually able to widen the area of discussion regarding older people. After one year it became a true liaison group, bringing in more medical personnel including clinical workers. It eventually included all agencies concerned with older people: a community physician, representatives from Age Concern and WRVS, a health visitor, community nursing officer, psychiatrist, housing manager, home help organiser, Crossroads organiser, the nursing officer of a local hospital, a hospital administrator and workers concerned about dementia. The group were all at management level except for the home help organiser and care manager and met at two-monthly intervals. The group clarified who could do what. Often a problem was found to be common to all concerning a particular user and this would lead to a user discussion. Also, times for hospital discharges were talked through. In this form, the group was very helpful.

The care manager had useful meetings at two-monthly intervals with a group of health visitors and community nurses to discuss general issues. Misunderstandings between agencies could then be sorted out and their capabilities and limitations clarified. Once the social work office had moved to Sheerness, informal meetings with individual community nurses could also take place to discuss individual cases. The increased face to face contact now possible between the care manager and workers from other agencies facilitated the development of good relationships. Attempts to build contacts with local General Practitioners met with only very limited success. Out of 19 GPs, the care manager could only have useful discussions with 5, and of these only 2 had any real understanding. The general feeling was that the Community Care cases should have been in residential care. It was difficult for the care manager to cope with the family when a GP took this line, as it would undermine what they were trying to say. This attitude of GPs towards community care is familiar in parts of the country. GPs are likely to find the support of older people in the community more demanding when they have a level of need which makes them eligible for residential care. The presence of risk factors such as frequent falling, wandering outside by day or night or fire hazards are situations which many GPs are reluctant to encourage, particularly if they have large caseloads and feel overworked. In contrast, when users live in a care home, the residential staff take on a greater share of responsibility and general levels of risk are reduced. Some GPs are reluctant to accept that a user has a right to live on at home even if this is at the price of substantially increased risk. In Sheppey, where there were practically no private residential care homes, large numbers of older people, with a high proportion living alone, were living in the community. Although the care manager was previously the superintendent of a care home, so familiar at dealing with GPs, the tensions which could arise in this situation are understandable. Another mitigating factor is that the care manager felt very intimidated by the multidisciplinary group which met regularly when the scheme was getting off the ground, and experienced this as an interrogation. This may have been fair comment, though there might have been more productive ways of dealing with the situation than just giving up attending, which was the option which the care manager chose. It is understandable that GPs should feel wary about a scheme which allows very vulnerable older people to live in their own homes, particularly in the absence of an out of office hours standby duty system, when often the only support available was from relatively untrained helpers. Perhaps the care manager for Sheppey did not sufficiently talk through such issues with GPs in the early stages of the scheme. Such problems could then have been balanced against some of the benefits to GPs of the scheme, such as the provision of an early warning of health problems when they first arise and in supporting older people at

home when they are ill. Hospital staff were more supportive, though often resisted a return of patients to the community, preferring residential care, and expressed anxiety over some of the cases supported by the scheme. In contrast, the geriatrician, who had a bad relationship with the social services department and was under pressure to off-load patients from hospital, often discharged cases while still in need of intensive nursing care.

However there were ways of ameliorating these problems. The care manager arranged to regularly receive a list of patients to be discussed at the geriatrician's case conferences, and attended if a Community Care case was included. If an immediate discharge were being contemplated, the care manager could refer to any problems at home which this might cause: frequently discharges were then postponed. Also, by building up good relationships with ward sisters and staff nurses and by working through them, the care manager could often postpone discharges by a few days. During the first five years of the scheme, six new cases entering the scheme were discharged directly from acute or long-stay geriatric hospital care. It is therefore hardly surprising that Community Care resulted in a sharp reduction of health service costs at the expense of the social service department, as shown in Chapter 8. Through willingness to take on these prematurely discharged cases, the care manager obtained a measure of cooperation from the geriatrician in accepting Community Care cases into hospital, though progress was slow. Eventually the care manager obtained regular access to a short-stay hospital bed. In practice this was only used by the scheme in emergencies since users tended to end up in a worse condition after a two week period. This might take the form of the development of bed sores or a deteriorating capacity to perform activities of daily living (adls). This stark contrast in the way the health and disability of older people requiring nursing care changed depending on whether they received Community Care or were admitted to geriatric hospital care illustrates one possible reason why Community Care cases can improve in general health or adl score in comparison with a matched group of control cases, a findings of this study to be discussed later.

The police were cooperative when asked to help with individual cases; for example they would assist in picking up an older person after a fall. When cognitively impaired cases in the scheme wandered and became lost, they would sometimes report in at the local police station. The police would then inform the care manager what action they were taking. An officer for special cases was very helpful in explaining how to obtain the maximum assistance from the police force.

Tonbridge

In setting up the scheme, the care manager made a big investment of time explaining Community Care to others involved both within the social services department and in other statutory and voluntary agencies. This was particularly important with the National Health Service, referrals from GPs or community nurses outnumbering those from the social services teams. In particular, letters explaining the scheme were circulated to primary care teams. Two cases were discharged into the scheme from long-term institutional care. One, in her 60s, had been in long-term geriatric hospital for 30 years. She had originally been admitted as a result of having given birth to an illegitimate child, and entered the scheme when the hospital was closed down. Through receiving daily support and reassurance she was gradually able to overcome some of the effects of institutionalisation such as worries over using and managing money. Another case was discharged to a council flat and supported by Community Care after spending 3 years in long-term residential care. This positive relationship with GPs contrasts with the negative one found in Sheppey. The care manager's background in health services presumably

assisted. A greater proportion of users with informal carers and a good supply of private residential care beds in Tonbridge would be factors expected to reduce numbers of older people living at risk in the community.

11 Responding to particular areas of need

Sheppey

The care manager had to respond to some particular areas of need in Sheppey. The problems of poor housing could sometimes be adequately met without having to rehouse the older person. When there was no bathroom, a regular bath could be arranged at a day centre, and when there was no indoor lavatory, a commode could be provided. Cold and dampness could be reduced by the loan of a convector heater. In other instances, rehousing was the favoured option, normally to sheltered housing or other purpose-built housing for older people. This was facilitated through the building up of close links with the housing department and wardens of sheltered accommodation.

One half of the evaluated Community Care cases living on Sheppey did not move to the island till after their retirement. Consequently a high proportion had no relatives living locally to care for them, and were lonely and isolated. Helpers were therefore encouraged to spend time with the older people they visited in order to provide companionship.

Tonbridge

There was a general consensus amongst agencies in the area that the older cognitively impaired were a particularly problematic group. The original care manager quickly realised the strength of the scheme in being able to support such cases at home whether or not they were living with others or received help from a principal informal carer. Consequently a high proportion of such cases were taken on by the scheme. Visits by helpers generally formed a major part of the support, with the advantages of their flexibility. In the rural areas, particularly the villages around East Malling, frail older people were frequently isolated, lacking access to such services as day care, day hospital and luncheon clubs. In such circumstances visits by helpers could relieve much isolation and loneliness.

12 Building around existing provision

After the benefits of a full initial assessment, care managers might have felt tempted to draw up a care plan from scratch and ignore existing service inputs which may not always have met users' needs ideally. However, the policy adopted aimed to build around services already in place. Their withdrawal could have antagonised these providers who would then be reluctant to refer new cases. Moreover, users who had built up good relationships with their staff, such as home helps, would lose out if they were discontinued.

Much care was taken by the care manager to avoid giving a helper tasks which could equally well be carried out at the same time by a home help or the meals on wheels service. Thus a helper would not be given meals to prepare unless they could be provided in circumstances which were not possible under standard provision. Thus, for an older person who tended to avoid a balanced diet, meals on wheels might be left uneaten. In such circumstances a helper who could prepare a meal at the older person's home and then sit with them while encouraging them to eat it was clearly offering a quality of service which would otherwise not be available. Through preventing the traditional tasks of the home help service from being taken over, the care manager was gradually able to provide some reassurance to the home help organiser and staff who initially felt very threatened that their service would be taken over by the new scheme.

13 Task substitution by Community Care following a withdrawal by other agencies
Despite their aim to build around existing provision, care managers could not always prevent other agencies from withdrawing when it was felt that CCS could equally well perform these tasks, leaving the agency better able to concentrate resources on more appropriate cases.

Sheppey
The community nursing service responded to the scheme in a quite different way from that of the home help service. Because of the demands placed on them, they were eager to unload some of their work onto the scheme. Some tasks, such as dressing or undressing, toileting, the fitting of incontinence pads, managing medication (apart from injections) and bathing under normal circumstances could clearly be undertaken by helpers with a minimum of training. The helpers would have more time at their disposal to manage such tasks and were more likely to respond at a time when the older person most needed help, leaving the community nurses to undertake the more skilled nursing tasks. This policy of allowing tasks to be transferred from community nursing to Community Care would also contribute to the shift in expenditure on this user group from the health service to the social services department.

Tonbridge
Many of the tasks of community nurses were taken over by Community Care helpers. Thus in Sevenoaks and Tonbridge, helpers tended to take over from the community SEN or nursing auxiliary in bathing a user. However, in Maidstone and Malling the care manager never excluded the bath nurse, but regarded that as their role, though might supplement their contribution by arranging for helpers to bath the user on other days of the week as well.

Helpers tended to take over from community nurses or home helps in managing medication, though community nurses continued to administer injections and cope with bandages. Helpers also tended to take over from the community nurses much of the work involved in emptying commodes, clearing up after spells of incontinence and assistance with getting up or going to bed and dressing. Many helpers already had experience in nursing.

14 Qualifications, experience and training of care managers and their line managers
It is clear from Chapter 2 that a care manager should have a good grasp of social work skills, such as the ability to build a good working relationship with the older person and their informal network, make a broad assessment, draw up plans and goals, negotiate with other agencies and apply counselling skills. An ability to manage resources efficiently and effectively in meeting those plans and goals is also desirable.

To meet these skills, qualifications and experience in social work would have been ideal. Unfortunately divisional office line managers did not normally grasp the requirements needed for good care management, but instead saw Community Care as another service running in parallel with the home help service, with a pool of quasi-informal paid helpers undertaking personal care tasks. These line managers saw the work as being largely that of an organiser, just as a home help organiser would recruit, train and deploy a pool of home helps. Consequently job advertisements prepared by county divisional offices frequently alluded to the organisational nature of the work. The result was that the first appointment made in Tonbridge was of a person experienced in administering a voluntary agency with no hands on social work skills. Unsurprisingly, this newly appointed care manager, on

learning the true nature of the job, felt they had been misled and left after a few months with no users served and little having been achieved. Subsequent advertisements frequently failed to refer to the social work skills required and many of those appointed came from other disciplines.

Such problems illustrate how easily a scheme could degenerate in the absence of adequate guidance from management. In the Thanet Project problems like this were avoided through the appointment of a management team meeting at fortnightly intervals and including a senior representative from the PSSRU. The evaluator, by scrutinising the implementation team, could then feed back details of poor practice at grass roots or management levels to the management team (Davies and Challis 1986). It was only after the evaluation period in Sheppey and Tonbridge that a working group of experienced care managers eventually drew up good practice guidelines which included job descriptions for use in job advertising. These are described further in section 16.

Fortunately most of the care managers involved with this evaluation in Sheppey and Tonbridge had to an extent some training and experience in social work related areas, though this was usually insufficient. Qualifications included a degree in the social sciences, a CSS or qualification as a home help organiser. Experience included work as a social work assistant, home help organiser or as superintendent of a care home and most had worked with older people. Only one was a qualified and experienced social worker, though this care manager had little experience with older people. Assistant care managers sometimes had a social sciences qualification and generally had experience in working with older people.

One cause of the inadequate qualifications and experience of some care managers arose through the method by which some staff could obtain internal promotion. Assistant care managers were often appointed with few or no qualifications though normally with some caring experience with older people. These would often be promoted to home help organisers and subsequently to care managers, usually without having obtained any additional qualification.

Since the appointments made did not have all the skills needed, it was therefore desirable that a thorough induction be offered to new staff, and that they receive appropriate supervision and peer support. Induction programmes were arranged for recently appointed care managers in the county. A course, based at the PSSRU, lasting one day per week for some five weeks, covered policy, practice and research issues. Talks, followed by discussion, were given by selected experienced care managers and research staff from the PSSRU. Topics covered included assessment of the needs of older people, innovations and constraints in Community Care, relationships with other agencies, working with the cognitively impaired, recruitment and support of helpers and research findings from the Thanet Community Care Project. During their first few weeks, newly appointed care managers obtained fieldwork experience by spending a day with a number of selected experienced care managers and accompanying them on visits to users, their informal carers and helpers.

Unfortunately, the principal social workers who supervised the care managers were given no training over the period of the Sheppey and Tonbridge evaluations. Only later did it become clear that many line managers had a poor grasp of the principles and operation of the scheme. At countywide six-monthly meetings between care managers and management some Principal Social Workers explained that they had been required to

undertake a management role in relation to a new scheme without adequate briefing. In response to these shortcomings managers were eventually included in more recent induction programmes.

It is therefore unsurprising that much of the supervision offered lacked an understanding of the aims of the scheme, as well as being totally inadequate in quantity. However, in those instances where the supervisor had a good understanding of the aims of the scheme, this fed through to the care manager. The supervision offered in Sheppey and Tonbridge is discussed in section 17.

In the original Community Care Project the PSSRU research team had been heavily involved in frequent meetings with care managers, line managers and senior managers in helping to shape Community Care policy and practice. In addition members of the evaluation team had discussions with the care management team and the divisional director on an almost daily basis and provided constant support and guidance on practice issues. By contrast, the care managers and their line managers in Sheppey and Tonbridge had to rely much more on their own judgement.

Because of the inadequacies of the recruitment and supervision of care managers, it is fortunate that an effective system of peer support was offered through monthly countywide meetings of care managers which built on the introductory induction programme, together with six-monthly meetings between care managers, line managers and senior managers to discuss issues of policy and practice.

These two forms of ongoing support are considered in more detail in the following two sections (15 and 16).

15 The development of collegial support systems

During the evaluation period, monthly meetings were attended by care managers throughout the county. The object of these meetings was firstly to ensure that as the scheme extended into different parts of the county, care managers shared a common understanding of the aims of the scheme. Secondly it allowed these workers to discuss problems they encountered in implementing the scheme. Sometimes this took the form of a case presentation. This group could then benefit from seeing how a colleague approached the management of a particular case, such as an older person suffering from alcoholism, while the presenter could derive ideas from the group over how to cope with particular difficulties encountered. All the case studies described later in Appendix 3 had been used in such presentations. At other meetings outside speakers would be invited to talk about their work with older people; for example, a community geriatrician spoke about medical diagnosis and treatment of certain illnesses and disabilities affecting older people, and how best to secure effective cooperation between the health and social services. Another, a psychologist, talked about reality orientation techniques with cognitively impaired older people. This enabled care managers to instruct helpers in methods for easing disorientation in time, place or person with this user group.

16 The development of policy and practice in Community Care

Six monthly meetings took place attended by all care managers in Kent together with their line managers and senior managers from the county headquarters. Among other things, these heard a presentation by the evaluator on trends and comparison between schemes in different parts of Kent revealed by analysis of the information system from the PSSRU based on the monitoring data already alluded to. Also the implications of the experience of

the Community Care care managers for broader policy being developed by headquarters were discussed, together with the implications for Community Care of changes in county policies and developments. One very capable senior manager acted as co-ordinator of Community Care across Kent and, by keeping in close touch with grass roots care managers, was able to respond effectively to its needs. An assistant director was also very committed to the successful expansion of the scheme across the county and regularly chaired the six-monthly meetings.

The status of helpers

One subject under regular review was the employment status of helpers. During the period of the evaluation this was a quasi-informal status. Because helpers were paid according to the tasks performed rather than by the hour, they were able to adjust the length of their visit according to the needs of the user on each particular occasion. The procedures laid down for helpers stated that they were 'not considered to be a regular workforce providing a general service to all social services department users'. This ambiguity of the job status offered clear advantages of increased flexibility. However, in order to maintain this informal status, a number of obstacles had to be overcome. Thus in 1984 with the introduction of statutory sick pay, helpers of below retirement age with average earnings of at least £35.50 per week during the previous eight weeks and not receiving social security payments were seen as eligible. After discussions between senior management and the County Personnel and Treasurers departments, it was agreed that although helpers would now be considered as employees in respect of tax, national insurance and statutory sick pay, in other respects they could still enjoy the advantages of an informal status.

It was only after the end of this evaluation with the change over to home care, in which the care managed Community Care scheme and the home help service were merged and with home help organisers becoming part of the care management hierarchy, that it was no longer possible to resist the pressure for helpers to be treated in the same way as home helps with full employee status. In contrast, the Gateshead care managed scheme for older people, run by a Labour authority and starting at about the same time as the schemes in Sheppey and Tonbridge, paid its helpers by the hour and offered full employee status with sickness and holiday pay from soon after the start of the scheme. This arrangement was less flexible and more expensive, though provided better conditions of service for helpers.

'Out of hours' support for helpers

Helpers, unlike home helps, frequently visit their users outside office hours. Helpers sometimes expressed fears of being left out 'in the cold' and had no clearly defined procedure when the care manager was not available. Therefore it was necessary to review whether current arrangements were adequate. The matter was discussed at six-monthly meetings. There was a feeling that the department might be expecting helpers to take on an unreasonable amount of responsibility. Care managers had responded in different ways. While some made their private telephone numbers available, others arranged 'support groups' made up of helpers connected with a particular user. One scheme circulated information sheets on each user amongst that user's helpers with telephone numbers of helpers, the user's GP and others involved. None of these arrangements constituted a full back up service.

It was decided that care managers keep a record of their helpers' involvement with out of hours problems and report back at the following six-monthly meeting, in order to gauge the scale of the problem. These reports suggested that the situation was not serious; helpers want assurance and advice, not necessarily practical help. They often obtained

support from each other, sometimes on a network basis. In many cases care managers had given helpers their telephone numbers but even so no really major issues had ensued, and calls became less frequent as a scheme and its helpers became more established. Thus, while care managers were encouraged to continue to provide support in the ways they had individually developed in their separate patches, it was not felt that there were serious shortcomings in the out-of-hours support obtained by helpers.

The working group

A working group with a care manager representing each of the six areas into which Kent was administratively divided, a competent development officer from Kent headquarters and a representative from the PSSRU at the University of Kent met at six-weekly intervals to draw up guidelines for good practice across the county. It was assigned tasks at the six-monthly meetings and reported back to them. This helped care managers in different parts of the county to approach their work in essentially the same way, while still maintaining flexibility. A procedures manual was compiled which included a summary of the aims and principles of the scheme, job descriptions, methods for recruiting and paying helpers and drawing up helper-user contracts, and instructions as to how to complete monitoring forms on individual users. A number of other policy issues were discussed by the working group, such as the setting up of payment bands for helpers for different types of task. This provided a degree of uniformity of practice to be maintained across the county while still allowing some flexibility over the level of payment made.

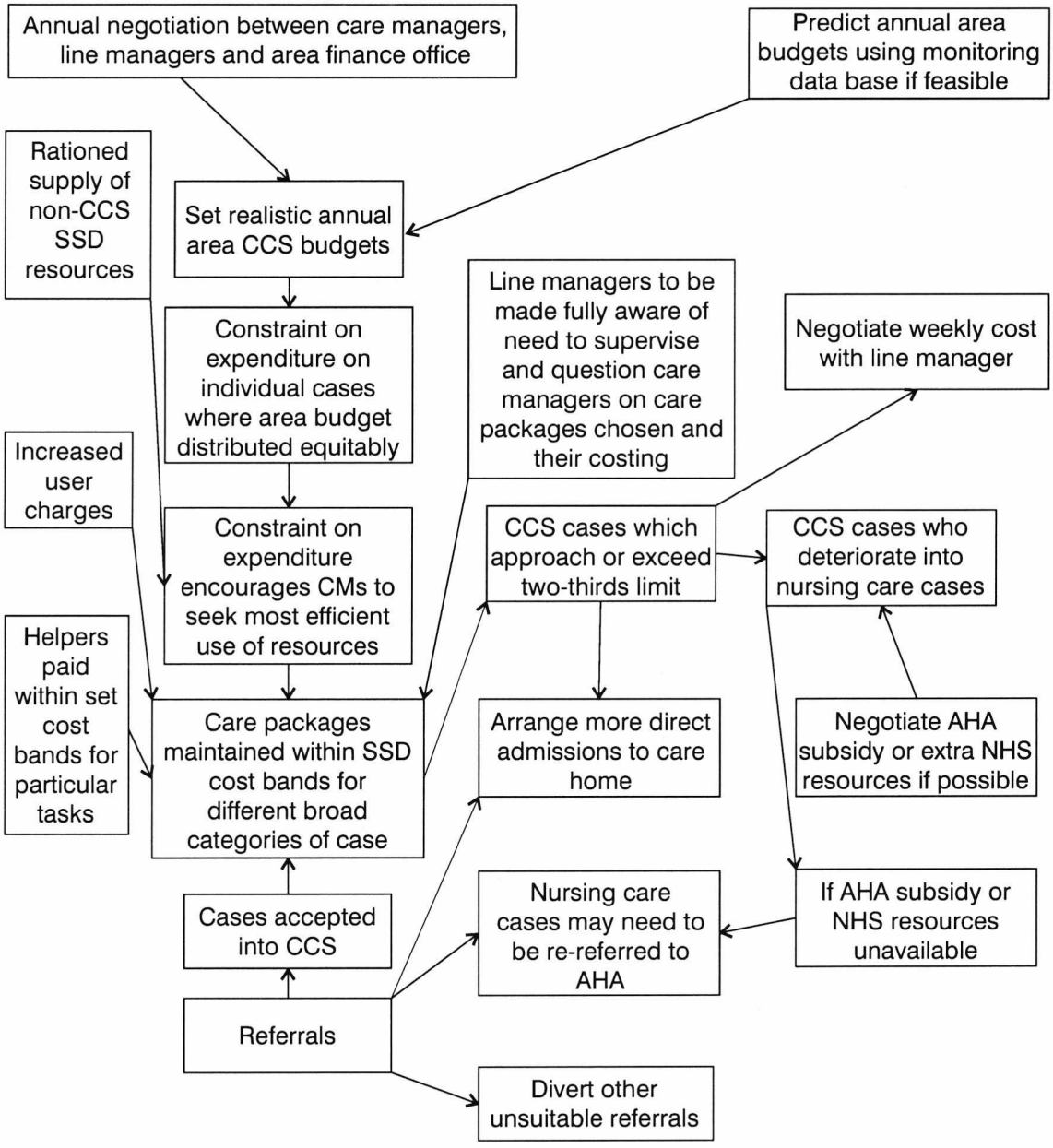
Among the tasks included in the job description were the selection into the scheme of frail older people who would otherwise be at risk of admission to institutional care, assessment of care needs and construction of a care package, mobilisation and coordination of resources and recruiting, training and supporting a pool of helpers. In addition to undertaking normal social work tasks, the care manager would make use of a budget to respond flexibly to the individual needs of users, using innovative means where appropriate. The care manager would adopt overall case responsibility, liaising with other appropriate agencies and arranging the admission of users to institutional care where appropriate. Clearly this description provided a valuable summary for care managers and their line managers which was also available as a guide to drawing up job advertisements. With the reorganisation of the county into six semi-autonomous areas came the need for the Community Care concept to penetrate into strategic thinking at the area level, and the procedures manual was aimed at area directors too.

Managing the escalating costs of Community Care

The subject which probably drew most attention at both the six-monthly and working group meetings was the escalating average costs of Community Care cases at some 18 per cent per annum, far above the rate of inflation. Costs could easily be monitored through the circulation of feedback forms at six-monthly intervals at county, area and scheme levels, as described in Chapter 6. In this way changes in real costs both to the Community Care budget and overall to the social services department could readily be detected, and the proportions of cases approaching or above the 'two-thirds' cost limit identified. These feedback forms also showed that the physical and mental frailty of users entering the scheme increased with time. Moreover, as a caseload matures its needs are likely to increase. Hence one reason for the escalating costs was the expanding needs of caseloads. However cost increases appeared to be too great to be accounted for solely through rising need. The issue then to be faced was how, in a world of limited resources, to cope with these ever increasing demands of care managers. This task was referred to the working group for investigation.

They came up with a strategy for coping with the need to ration overall expenditure on CCS, while applying the principles of equity and efficiency, illustrated in Figure 5.1. Its main features were as follows:-

Figure 5.1 A county-wide system proposed by the working group for maintaining equity and efficiency in the Community Care scheme within a manageable overall budget



(1) Targeting

CCS is not a hospital at home and eligibility criteria need to be made more specific.

(a) Nursing care referrals - namely those at the level of eligibility for admission to a long-term geriatric hospital - should be diverted to the area health authority.

(b) Cases taken on by the scheme with a suitable level of need may deteriorate into nursing care cases. In order to offer continuity to such cases, it would be desirable for the local authority to negotiate an agreement with the area health authority whereby a health subsidy contributes towards the package cost. This would reflect the fact that Community Care would be preventing admission to a nursing care bed. Such subsidies would also have

been appropriate for cognitively impaired cases with costs above the 'two-thirds' limit, since the scheme would frequently be preventing an admission to long-term psychiatric hospital. Because CCS had been so successful in supporting such cases at home, hospital admissions solely on grounds of SSD expenditure would be made with great reluctance. In practice the county were unable to persuade the health authority to make such subsidies, though they agreed to joint financing the care manager and assistant care manager posts in Sevenoaks and Tonbridge. Also it was sometimes possible to negotiate additional NHS resources for these cases such as community nursing.
(c) The effect of growth of CCS and the supply of private sector homes had been to reduce the uptake of cases into care homes, leading to vacancies. Therefore the marginal cost of admitting some potential high need CCS cases into care homes could be less than supporting them in the community. Consequently, if the user's attitude to residential care allowed, suitable cases could be admitted to a care home either at the point of referral or after a period of deterioration and escalating costs in the scheme.

(2) Setting package costs at appropriate levels in relation to need
Countywide weekly cost bands were drawn up for a few broad categories of case as a guide to care managers and their line managers. The cost band widths allowed some flexibility and took account of the variation of package costs between areas due to the differing availability of local resources. Line managers were to be made fully aware of the need to supervise and question care managers on the care packages they set up and their costs.

If weekly SSD costs approached or exceeded the 'two-thirds' limit, care managers should negotiate with their line managers as to whether to continue such expenditure or refer to institutional care.

(3) Expenditure on helpers
(a) Guidelines had already been drawn up at a monthly meeting of care managers specifying index linked payment bands to helpers for different types of task. These guidelines were revised by the working group.
(b) In matching helpers to users, the benefits of matching according to the skills and personality of the helper had to be balanced against the cost savings of selecting users living close to helpers.

(4) User charges
Users were to be charged more for Community Care helpers. This helped to reduce the large discrepancy between the maximum weekly charge to the user for Community Care of £4.25 per week and the maximum for local authority residential care of £105 per week.

(5) Negotiating the following year's budget
(a) Care managers and their line managers should negotiate with their area finance office well in advance to set the Community Care budget for the next financial year. The office should inform them once the level has been confirmed so that care managers can plan their allocation of resources in an equitable and efficient manner.
(b) To facilitate the process of budget setting and to make it equitable between areas, the possibility was explored of using the monitoring data base to predict future expenditure on individual cases in terms of the levels of need of cases entering the schemes, the period cases had been in the scheme and the local availability of non-Community Care resources both within the SSD and in other statutory and voluntary agencies. This particular strategy could not be put into practice since the error bars associated with the predicted cost of

individual cases were too great; only about half the variation in cost could be accounted for. The exclusion of non-SSD costs from the costing contributed to this error. Moreover, in offering care managers a monitoring system which did not over-burden them with paperwork, they were not required to update the initial need assessment made at the point of referral. Uncertainty in cost prediction therefore also arose out of the differing rates at which users deteriorated and required additional resources.

Because the implementation of these new features to promote rationing in community care expenditure was brought about largely as a result of feedback of monitoring data by the evaluation team, the research process was influencing practice. This would have been evident from such new features as targeting which excludes nursing care cases, a more clearly defined relationship between need and package cost, helpers living closer to their users and higher user charges. However, since these cost-cutting measures were not introduced until after the evaluation period, they did not effect the results of the evaluation. The issue of feedback of research information is taken up again in section 3 of Chapter 11.

17 Fieldwork supervision

Sheppey

The care manager received very little supervision from the principal social worker. Monthly sessions of one hour during the early phases of the scheme were discontinued. These were replaced by brief discussions dealing with complex situations and crises which the care manager could request at any time while the line manager was in the office, though there were frequent absences.

The care manager in turn provided the assistant with weekly sessions of informal supervision lasting some 45 minutes. The assistant found these informal sessions more helpful than formal supervision. The care manager also found it helpful having the assistant available to discuss matters. If one worker was failing to make progress or becoming over-involved in a case, they would sometimes make a joint assessment visit to help facilitate a fresh approach.

Tonbridge

Although the original care manager for Tonbridge and Malling received some supervision from the principal social worker, this ceased soon after the area had been administratively split, the care manager being left with no principal social worker. Following the death of the initial care manager, the two assistant care managers remaining made use of the Community Care procedures manual for guidance and discussed cases together. One had some social work training while the other had a practical approach to problems, so they complemented each other. When the former left, the other, who was made acting care manager, felt very isolated. Although the monthly meetings of care managers at the University of Kent were helpful, it was clearly difficult for a care manager under these circumstances to be sure that an orthodox Community Care approach was always adopted.

This care manager particularly felt the need for guidance in working with the depressed and cognitively impaired. Training would have been helpful in recognising the symptoms of these two need areas and distinguishing between them; understanding how cognitive impairment can cause depression and how the symptoms of depression can sometimes be mistaken for cognitive impairment; a knowledge of how life events and difficulties can trigger depression (Brown and Harris 1978, Murphy 1982); understanding the stages gone through in experiencing bereavement and other forms of loss; recognising when a user had failed to progress successfully through these stages and knowing how to assist this

process; a knowledge of the different types of cognitive impairment, its causes and how it progresses (Pitt 1974); offering ways of managing some of the behaviour problems caused by cognitive impairment; and in showing how techniques allied to reality orientation can be used in helping cognitively impaired users to cope more effectively in their environment. In practice, the only help on these issues which the care manager received was from the series of monthly talks by invited speakers and peer reviews, such as case studies 1.3, 2.3 and 2.4 of Appendix 4.

In contrast, the care manager based in the Sevenoaks and Tonbridge office received regular monthly supervision of at least one hour's duration from the principal social worker. This involved discussing the individual cases in the caseload, reporting back on how the budget was being spent and resources being allocated, and considering future planning. The case review forms, quarterly cost sheets and six-monthly feedback forms provided useful summaries of material to assist in these discussions. In addition to these more formal supervision sessions, the principal social worker was available at most times for discussing a particular case. This care manager found the supervision received to be adequate.

18 Clerical support

Sheppey

The Community Care clerk had an important role to play in the running of the scheme. Firstly she acted as a receptionist for users (generally by telephone) and their relatives and friends, and helpers. She co-ordinated the processing of helper claims for payment of fees and expenses, completed the weekly updates on the quarterly cost sheets for each user, and co-ordinated the collecting of other monitoring data. As well as this, she was responsible for the typing of letters and user records and telephoning and also took minutes at case conferences. If this post had been maintained as half-time it would have been sufficient to cover all aspects of the job adequately. In practice, some of the time was taken up in non-CCS duties. The result was that messages were sometimes not recorded and a number of small but important tasks remained undone; for example, not all the users were sent birthday cards. This activity was important to keep going since for some users it would be their only card.

Tonbridge

The schemes in Tonbridge and Malling had good clerical support, with one full-time equivalent clerk attached to a care manager and one or two full-time assistants. This meant there was more time to adequately carry out duties than was the case in Sheppey, where the care manager and half-time assistant had only a half-time equivalent clerk. The clerks carried out a similar range of tasks to the one based in Sheppey.

19 Recording

Sheppey

Although a file was kept on each user, individual visits were not recorded. During most of the evaluation period assessment forms and review forms were completed as the only record of the ongoing process of care management. However, as a result of continued pressure from the area team to increase the caseload, the care manager eventually gave up monitoring as this released some 2½ - 3 hours per week. This left no regular recording, though each case received a brief mini-review weekly while helper claim forms were completed.

Tonbridge
A file was kept on each user and every visit was written up. In addition, copies of the assessment form and review forms were kept on the file to provide an overview of progress and problems.

Clearly, a balance should be struck between the need to provide satisfactory support to as many cases as possible while keeping adequate records to facilitate both carrying out effectively the tasks of care management and being accountable to the local authority. It would appear that while in Tonbridge the care manager established a reasonable balance, those in Sheppey were undermining their ability to practice effectively or be accountable by eventually ceasing to maintain case records following pressure from social workers to take on more cases. In this respect, the location of the Sheppey care managers in the generic team which referred the cases may have been a disadvantage. Nevertheless, even in Tonbridge the original care manager had to withstand pressure from home help organisers who, like area team social workers in Sheppey, carried heavy caseloads. The ability of the care manager to be able to both listen to their team's views and yet maintain a balance between the various demands of care management is clearly advantageous.

20 Gender, and the delivery and receipt of community care

The key actors in the delivery and receipt of community care are usually women, so it is important to consider why this is so, and any implications. This subject can be treated with regard to four groups:

- Care managers;
- Community care helpers;
- Informal carers;
- Users.

Care managers
Over Kent generally, some eighty per cent of care managers were female, a rather higher percentage than in most social work teams. This may partly reflect the appointment of a large proportion of care managers from the home help service and care home staff, predominantly female occupations. In Sheppey and Tonbridge, both original care managers and their assistant care managers were female. However, after the reorganisation of boundaries in Tonbridge and Malling, the new Maidstone team was headed by a male care manager who was a qualified social worker. Gender itself should not have affected the capacity to perform effectively as a care manager, though professional background was important. It is arguable that a social work background is more pertinent to good care management practice than experience as a home help organiser. Indeed most male care managers came from a social work background. The experience of the original care managers in Sheppey and Tonbridge as officer in charge of a care home and in supervising work for older people in the health service respectively turned out to be very suitable for community care.

Community care helpers
In Sheppey, where helpers were evaluated, all were female, since there were no suitable male applicants. In Tonbridge, all but a few helpers were female. This is hardly surprising, since, in view of the absence of guaranteed hours, the low rates of pay, and the very part-time nature of most of the work, the wages would be much too low for a main wage earner. Nevertheless, it is regrettable that there were not more male helpers, as these are regularly needed in making a suitable match to a user, particularly in providing companionship to another man.

Informal carers

The proportion of male principal informal carers was just twenty-five per cent in Sheppey and twenty-one per cent in Tonbridge unmatched experimental groups. Land (1978) has argued that social policy assumes that men are not as capable of looking after older infirm relatives and therefore require more support than women. Several writers note that male carers are favoured with a greater level of domiciliary support, such as Finch (1984), Finch and Groves (1982), and Walker (1983). Bebbington and Davies (1983) observe that over twice as many disabled older married women received a home help (27 per cent) as disabled older married men (11 per cent). The higher provision to men caring for disabled wives is explained in terms of culturally defined gender roles, that men are not expected to perform domestic tasks such as washing, cooking and cleaning.

Users

The proportion of male users amongst experimental unmatched groups in Sheppey and Tonbridge was 17 per cent in Sheppey and 18 per cent in Tonbridge, less than one in five. This reflects the greater longevity of women and that the male partner of a married couple is generally older, and is not a result of selection effects in obtaining referrals to the scheme. As well as being disadvantaged as carers, women also miss out as users, receiving less domiciliary support services than men (Arber *et al.* 1988). Thus older men living alone receive more meals-on-wheels.

One general consequence of these figures is that users are likely to be surrounded by a much greater proportion of females than males in their formal and informal caring networks. This may frequently be detrimental to the user's quality of life.

CHAPTER 6

THE CARE MANAGEMENT PROCESS

Following the approach of Davies and Challis (1986), the activities of care managers in the support of their users could conveniently be covered under raising referrals, assessment, care planning and service arranging, maintenance, monitoring and feedback and terminating care. These activities will now be discussed in detail, with particular regard to differences between Sheppey and Tonbridge, and the reasons for these differences.

1 Raising referrals

This has already been considered in Chapter 5 so only needs summarising here.

1.1 Methods of obtaining referrals

In Sheppey all referrals came through the area team, normally following a visit by the social worker, who subsequently discussed it with the care manager as to its suitability. Particularly in the early stages of the scheme the care manager also actively took part in case finding, through, for example, attending ward rounds in the local acute hospital. Such activity helps to increase the proportion of suitable cases in the population offered the service, the *horizontal target efficiency* (Davies 1978, 1981; Davies and Challis 1986). These cases were still channelled though the area team before being allocated to the care manager. Unfortunately, due to the increasing pressure of suitable referrals from the area team the care manager decided to cut down on actively seeking out referrals. Hence, some categories of suitable cases may have been lost to the scheme. In contrast, referrals to the Tonbridge scheme were made directly to the care manager, who had to sift through a large number of possible cases. Although those referred by team social workers would already have undergone some screening, many inappropriate referrals were assessed by the care manager, particularly in the early stages of the scheme, and this was time consuming. Moreover, once the care manager had seen an inappropriate case, they would sometimes spend more time attending to immediate problems before re-referring or closing the case. This led to a high turnover of inappropriate short-term cases and a consequent lowering of the proportion of cases receiving Community Care who were suitable, the *vertical target efficiency* (Davies 1978, 1981; Davies and Challis 1986). As the scheme became established and referring agencies obtained a clearer picture of which cases were suitable, inappropriate referrals became less frequent.

1.2 Educating referring agencies

In the early phase of each scheme, both care managers invested a substantial amount of time in explaining the scheme to key personnel in different statutory and voluntary agencies involved with frail older people including those from within the social services department.

In Sheppey, regular meetings of the care manager with representatives of other agencies in liaison groups have already been described in Chapter 5, section10, while in Tonbridge the circulation of letters explaining the scheme to other agencies, such as primary care teams, has already been referred to in the same section.

1.3 Screening

It is desirable that, of those cases referred to the scheme, as high a proportion as possible should be suitably targeted. The initial process of raising referrals described in detail for each area in section 1.1 constituted the first stage in the screening process.

Sheppey

The initial shortlist of potentially suitable cases was normally assessed by the care manager and the vast majority of these were subsequently taken on, provided they were willing to accept the help provided. This acceptance sometimes only came later, after a period of monitoring by the care manager. In other cases users in institutional care were offered the option of being discharged into the community with scheme support, and they sometimes decided to remain where they were. This screening process was extremely efficient. The area team social workers, under the direction of their principal social worker, had a clear understanding of the types of older person to be targeted and what constituted eligibility for residential care and hence for the scheme. The care manager was hence involved in only a minimum of activity in the selection process, though was more subject to pressure from the team to take on new cases.

Tonbridge

Because cases were referred directly to the care manager, the initial list needed much more sifting than in Sheppey, though referrals became more suitable as the process of educating outside agencies progressed. Those rejected by the care manager as unsuitable, either before or after an initial assessment, were often re-referred to a different section of the social services department or an outside agency. These rejected cases included those older people unwilling to accept help. Thus the Tonbridge process of screening was less efficient and involved the care manager in much more activity.

2 Assessment

Before visiting, the care manager contacted others involved with the case such as community nurses and day centre staff and would also enquire about medical problems, usually through the GP, to obtain a general picture. The initial detailed assessment by the care manager was frequently spread over several interviews, and would include discussions with any friends, relatives and neighbours who were providing support. The initial visit could be fairly brief, say 45 minutes, to obtain a general impression, without confusing the user by offering various types of support. The user could then take the opportunity to chat about anything of concern. At the same time the care manager could make observations; for example regarding access to the bath and the difficulties caused by steps.

During the second assessment visit, problems and experiences were uncovered, together with the user's hopes, anxieties and expectations. The care manager then spelt out to the older person how they perceived the user's needs to check that the user's requirements had been correctly identified. The assessment was kept very general and wide-ranging. To facilitate this, the care manager used a very practical mental check list to cover the user's ability to perform activities of daily living, the facilities of the home and the help which the older person already received, including the user's perception of this. The structured format of the user assessment form and case review form, including checklists, were helpful in ensuring that a comprehensive assessment was being made. The information could be compared with the description given by others involved, including the referring agency. It was useful to see how the two accounts differed. Sometimes the user was interviewed jointly with other family members. In this way both positive and negative

feelings could be identified, suggesting possible methods of change each with their own implications. The aims of intervention and the risks involved could also be discussed.

An important element of the initial assessment was identifying and interviewing any principal informal carer to gather information about the tasks which they performed and how this affected them, and about their own needs as a result of caring. The initial user assessment form prompted for the carer's physical health and their need for relief. Additionally, frequency of visits to the user from relatives, friends and neighbours was recorded. Care managers also enquired about the effect of caring on the carer's social life and on other family members. Effects on mental health and stress levels were also examined. Peer reviews were a helpful means of exploring the needs of carers and how these might be met, as illustrated in case studies 1.1, 1.2, 1.4, 2.1 and 2.4 of Appendix 4.

This substantial assessment of carer need was unusual at the time of the evaluation. Parker (1985) reports that welfare services at that time paid little attention to carers:

- Few dependent people with informal carers appeared to receive services.
- Such services were usually only crisis orientated and not a part of long-term support.
- The criteria by which services were allocated were often irrational and discriminatory, not being provided where female carers were available.

Parker points out that services were withheld from users with carers in order to save money. However, with some groups of dependent people resources might better be directed towards supporting informal carers.

Also the failure to help carers can partly be attributed to the fragmented organisation of health and welfare services, making it difficult for care packages to meet the needs of both dependent people and their carers.

More recent research (Levin *et al.* 1994) demonstrates the importance of assessing informal carer need as part of setting up a care package. Indeed carer support is now seen as a means of saving money, a view which led to the passing of the Carers Recognition and Services Act in 1995, which formalised the right of carers to ask for a separate assessment. Since then, evidence from the Social Services Inspectorate and the Kings Fund Carers Impact programme suggests that the number of carer assessments is increasing.

In certain circumstances the care manager would need further information in particular problem areas to supplement the assessment. Firstly, although Community Care was generally successful in cases of cognitive impairment or mental illness, intervention was easier if a psychiatric assessment had already been carried out. The user might be too cognitively impaired, or inhibited by feelings of paranoia to trust the care manager and give the information needed. Further discussions with others involved such as the geriatrician or CPN could then be valuable. Secondly, in the case of physical problems, discussions with an Occupational Therapist or physiotherapist about the performance of tasks could be helpful. For cases requiring discharge from institutional care, an assessment by the OT of the user at home was useful. The user may then be able to manage more tasks than was possible in hospital, where they may have been rather disorientated. Also at home there is the opportunity to move furniture around to improve access. Thirdly, it is helpful to know details of the medication taken by all users, and although this information can often be obtained directly from users, who usually let the care manager check through the various pills taken, details can otherwise be obtained from

the GP or community nurse. The scheme could assist both in administering medication and in monitoring whether it was taken.

Sometimes other agencies could offer accurate financial details, when a user was too guarded or cognitively impaired to disclose them. The housing department could supply useful information, particularly regarding housing conditions, and the family could often also provide much valuable background information.

Although full case histories were never taken, it was useful to build up some historical details. Background information could be obtained from others working with the case. Thus GPs could help in providing a background of health and social problems. In one case, the GP explained that an older male user had a history of very bad relationships with his wife, and he had grounds for physical and mental cruelty. The care manager took this information into consideration in dealing with the case. Much background information might be revealed in stages during the following months as the care manager gained the user's confidence. However, some users would never give much away about themselves.

As well as assessment being very involved, it was an ongoing process with user and network, on an almost daily basis, through maintaining contact with all contributing to the package of care, including other agencies and informal support.

3 Care planning and service arranging

The next stage was to look for ways in which the scheme could satisfy needs and wishes of user and informal carers, and to decide on whether anything could be achieved through collaboration between user and care manager. The care manager would explain that Community Care was to assist the user while encouraging independence, and was not prepared to assist with tasks which the user could perform unaided. Sometimes a compromise was made between what the user wanted and what the care manager felt was in the user's best interests; e.g. for a user refusing day care, helper visits to the home might be used as a compromise.

The care manager, working in close co-operation with the user, would next draw up a package of care to best help meet the needs of the user and any informal carers. Users were frequently initially rather reluctant to accept help, and an initial period of enabling by the care manager might be needed before help would be accepted, so as to make that help palatable. Sometimes the relatives, friends or neighbours were already very involved and felt threatened that the scheme would take over. Often they would have been visiting for a long time. The care manager would then take pains to enable them to accept the scheme and to fit them into the package of care and value their contribution. Sometimes they became helpers, but usually remained informal. Neighbours sometimes wanted the older person to be removed from home and felt that the care manager was being unreasonable in encouraging the user to stay. Such neighbours were probably disturbed at night and could become quite aggressive towards the care manager. They would need enabling by the care manager to accept the scheme's intervention.

The Community Care budget at the disposal of the care manager facilitated the mobilisation of resources, through allowing the payment of fees and expenses to Community Care helpers, or providing equipment, such as a convector heater, on loan to a user, or the purchase of any other gap-filling service which the care manager wished to devise. In addition, the care manager could negotiate with other resource providers in the social services department such as home help organisers, and officers in charge of day

centres and residential homes for services such as home help, meals on wheels, day care and short-term residential care. Of these resources, all were normally available in adequate quantities except for home help hours. Through a knowledge of the unit costs of different services to the social services department, the total weekly cost of the package to this department could be determined. This was not normally to exceed two-thirds of the cost of a place in a local authority residential home save with the prior agreement of the divisional director. In practice, one case in three cost more than the two-thirds limit, though, as already mentioned, requests for this additional expenditure were never turned down. Nevertheless, the average weekly cost of all cases to the social services department during the evaluation period was maintained at about only half this limit, namely one-third of the cost of a place in a local authority residential home.

The care manager might also negotiate with other agencies outside the social services department for resources such as community nursing visits. The care manager could take part in the process of deciding how other resource providers both within and outside the social services department allocated their resources between Community Care cases. For example, at a care home panel meeting the care manager decided to allow the assistant's user a long-term bed in preference to their own. Sometimes the care manager would bargain with community nurses about the transfer of nursing services between two Community Care cases. In difficult cases a case conference was sometimes arranged at which the key people from the statutory, voluntary and informal sectors would attend, to assist in the process of assessment and drawing up a package of care. However, these normally took place in the social work office and excluded the user.

Once the older person was willing to accept help, the care manager would frequently arrange for the most basic requirements of the user to be tackled first, such as the needs for nourishment, warmth and companionship. Other types of help such as social stimulation outside the house could follow once these initial tasks had become established and the older person had developed confidence in the scheme. This minimised the risk of the user feeling overwhelmed by too rapid a change in lifestyle.

3.1 The recruitment and maintenance of a pool of helpers

The reasons for using helpers in supporting users have already been discussed in section 3.2 of Chapter 2. Initially, advertising in the local press, shop windows and doctors' surgeries was a successful means of recruiting helpers, together with talks presented by the care manager at Women's Institute meetings. However, as the scheme became established further helpers often came forward through word of mouth, making other means of recruitment less important.

The high level of unemployment on Sheppey affected the recruitment of helpers to the scheme. Many applicants were either unemployed themselves or had an unemployed spouse, and were not particularly suitable for Community Care work, but seeking any paid employment available. Advertising in the local job centre had therefore to be avoided as a means of attracting suitable helpers. Indeed, many of those helpers recruited by other means had a strong primary need for financial reward. A core of helpers was to put pressure on the care manager to increase the general level of payments. This all tended to distract from the task of providing a user-centred service, and made the process of individual and group training of helpers all the more important.

In Tonbridge, helpers were sometimes recruited from the user's informal network: neighbours or relatives. Also in this area, a milkman was sometimes recruited for check up visiting or making a cup of tea.

Helpers were selected according to certain specified criteria. The care manager maintained a pool of helpers recruited from the local community involved to different extents depending on their availability and suitability for the work required. The pool was built up to a size which was sufficiently small for helpers to be offered enough work for most of the time to prevent their losing interest and withdrawing. At the same time, the pool was kept sufficiently large to allow an adequate selection when matching them to users. The care manager could monitor what helpers were doing by maintaining frequent contact with user, helper and the user's formal and informal network.

Although no separate study was made of the Tonbridge helpers like that in Sheppey, some differences were clearly apparent. Helpers in Tonbridge were being recruited from an area with relatively low unemployment, and fees were less frequently an essential part of the weekly income. Indeed, the superior means of many of the helpers meant that both tax and insurance contributions would be deducted from any additional income. This led to some helpers preferring to waive a fee and accept expense payments only. A minority of helpers received no fee or no expenses or neither; for example, members of the user's informal network who had been friends for years. This contrasted with Sheppey, where some helpers became quite militant in demanding higher fees. Initially, payment levels to helpers increased above inflation over time, and in return the scheme looked for increasing skills in the helpers it recruited. From 1st December 1981 onwards county-wide criteria for deciding payment levels for different broad types of task were introduced to achieve a degree of overall equity. These criteria were decided upon at a monthly meeting of care managers. The suggested fee for each category of task was expressed as a band with an upper and lower limit to accommodate a degree of flexibility, and the levels were index linked to prevent further real increases. In 1982 the banding was as follows:-
(a) Less demanding visits £1.25 - £2.50 per visit.
(b) More demanding visits £1.50 - £4.00 per visit.
(c) Whole day support £5.00 - £7.00 per day.
(d) Whole night sitting £10.00 - £15.00 per night.
(e) Short-term family placement £40.00 - £60.00 per week.
Brief guidelines explained and illustrated which tasks were to be included within each of these five categories.

Because of the remoteness of the office at West Malling, and subsequently at Sevenoaks, from cases living in the Tonbridge area, the helpers could not benefit from the regular pop-in visits which were later possible in Sheppey, and had to rely more on telephone calls in communicating with the Community Care team.

Continuing support would be offered to the helper, both individually and through regular coffee mornings in both Sheppey and Tonbridge at which an outside speaker was invited. These meetings brought helpers together, facilitating peer support, and also assisted in training. This peer support frequently continued outside office hours and was particularly valuable in the absence of a standby duty system, since care managers could not always be contacted. Although these meetings continued in Sheppey, they became less frequent in Tonbridge and Malling following the administrative separation of Tonbridge and Malling, ceasing altogether in Tonbridge. Training and supervision then took place mainly on a one to one basis between care manager and helper. Although this change occurred as the result

of a policy decision in Tonbridge, the reduced frequency of training meetings in Malling occurred through understaffing, and the care manager felt the need to restore these on a regular basis. Helpers also received support from the Community Care clerk.

Helpers did not qualify for sickness or holiday payments from the county council. However they were eligible for statutory sick pay if they had been paying National Insurance contributions for at least the previous eight weeks. They were also covered by the local authority in respect of injuries incurred in the course of the provision of Community Care service.

The fact that the local authority did not have to make sickness or holiday payments to helpers would have made the scheme a little cheaper relative to the comparison group. Thus, in providing residential care, an important feature of control group support, care assistants are fully entitled to both sickness and holiday pay. The issue of employment conditions is taken up again when considering the subsequent development of Kent Home Care Service in section 4 of Chapter 11.

4 Maintenance of cases

4.1 Enabling the older person and informal carer to accept help

The first step in the enabling process was to ensure that the referring agency explained to the user what the scheme involved. This was reinforced by the care manager during the initial interviews. It avoided the user feeling duped and rejecting any further help outright.

An unnecessary invasion of privacy into the user's life was also avoided. Thus, users sometimes out of politeness answered questions and later regretted having done so. Moreover, caution was exercised in presenting to the user any interpretation concerning his behaviour. Rather than trying to impose his own views on the user, it was more fruitful to attempt to understand the user's views on life, his beliefs and his needs, and find ways of helping him which were acceptable to him. Nearly all frail older people preferred to be able to stay on in their own homes, but many were very unsure or frightened as to whether they could cope and were making the right decision, and required much initial counselling, to clarify what staying on at home involved.

Good communication between the care manager and user was an essential part of building up mutual understanding and trust and developing in the user a feeling of confidence in the care manager. This included the care manager being a good listener. Communication occurred both verbally and non-verbally. If the user were deaf, blind or cognitively impaired, elements of these types of communication were sometimes lost. In such circumstances, the user could still build up confidence in the worker who persisted in trying to communicate even if this involved cutting back on more subtle forms of communication in order to get across the main points. Enabling the user to accept practical aids to communication such as spectacles, a hearing aid or false teeth which fit, could also be important.

The user was sometimes in a crisis situation making him feel helpless, and the care manager had to be willing for the user to make demands on him. The response of the care manager could be beneficial in tiding the user through a crisis and enabling him to gain confidence in the care manager.

The process of building up trust and mutual understanding took time, particularly since older people operate more slowly and many have poor concentration. This required the

care manager to speak clearly and slowly. Hence, it could take a number of interviews for the user to build up sufficient confidence in the worker to accept any help. Often help needed to be introduced in stages which allowed the user time to accept this help bit by bit, and accustom himself to new people and situations. Indeed, the main problem posed to many users was in accepting strangers into the home. The care manager learned to discern when the user was ready to receive more help. A sudden influx of help could overwhelm him and shatter his feelings of independence and privacy.

Users were frequently having to adjust to deteriorating faculties, both mental and physical, at a time of life when the personality lacks flexibility. If the user were striving to prove his independence, offers of help particularly in the early stages could have been regarded as condescending and sympathy as patronising, if the person were achieving his goals in the best way they could. Praise was sometimes inappropriate, giving the user either a bloated ego or a feeling of being different. If the user could not function as well as others, even with considerable effort, this could lead to considerable frustration and anger, particularly about the feeling of dependency this might have caused. Enabling could therefore be part of the process of helping the older person to accept a loss of mobility or ability.

Sometimes there were ways of making the help offered more palatable. One user in Sheppey did not want the Social Services Department to be involved, but was asking for a friend who could spend time with her, so the care manager arranged for a 'friend' to visit without saying she was a Community Care helper. Subsequently the care manager became accepted, and the fact that the care manager was from the Social Services Department.

Milloy (1964) has suggested using the following criteria for the use of practical resources:

1. How far will the use of the resource increase or help to maintain the user's capacity for mastery?
2. How far will the use of the resource tend to reduce his sense of isolation and increase his feelings of being needed?
3. How far will the resource contribute to the user's protection?

Even in the long-term, users were unlikely to be willing to accept as much help as they actually needed. One reason for this was that the social services had their roots in the charities and National Assistance provision of previous generations, with all the stigma associated with receiving their help. The worker therefore often had to content himself with a situation where a user in the long-term only accepted a proportion of the resources available to help meet his needs.

When the user was unable to reconcile in himself the contrary needs firstly to accept help and secondly to feel in control of his own life, he could become very ambivalent in his attitude towards any kind of help, being highly demanding one moment and very critical the next moment. Moreover, some users appeared to derive some satisfaction over initially asking for a network of help to be set up, and then continually criticising it once it was in operation. This could have been for them yet one more example of a pattern of behaviour they had adopted throughout their lives. Nevertheless, such users could still have been suitable for Community Care, provided the people involved in the support network were able, at least for restricted periods, to withstand the user's criticism.

In addition to the user, it is often the family, friends or neighbours providing support who could be the stumbling block for accepting help from the scheme. They were usually desperate and as a consequence, some were no longer as possessive and more willing to

accept help. Nevertheless, although informal carers often asked for relief, it could be very difficult to get them to accept it once offered, and to take more of a 'back seat'. They were frequently over-involved, and this required much working through with the informal carer. As an example, in a recently referred case, the wife of the user initially said she was pleased that a helper was visiting but later changed her mind, through a combination of a little jealousy and being very protective towards her husband. This refusal of help was made in spite of the wife being physically utterly worn out in trying to cope. She then became the person the care manager had principally to work with, and much enabling and working through was required. Her husband, in contrast, was not a problem and was quite ready to accept help.

The care manager's approach to the informal carer in the enabling process was crucial. Reassurance was needed from the care manager that their caring role would not be taken over. Hence they were kept well informed, were included as part of the package and their contribution valued. Occasionally this was achieved by their becoming a paid Community Care scheme helper. Informal carers could be the care manager's best resource, and given a good working relationship with them, they could offer so much back to the user.

In other situations the reluctance to accept help arose because the informal carer felt that the user should have been in institutional care. As one neighbour put it, who had become quite aggressive towards the care manager, 'This should not be allowed. You are encouraging her to stay at home. She ought to be put away somewhere'. Clearly the care manager had to assist the informal carer to accept the user's living at a certain amount of risk, if this were in the user's best interests. At the same time the care manager took action to minimise the risks involved which also sometimes posed a real hazard to the informal carers concerned. Thus, a neighbour in an adjoining house might legitimately have felt threatened by a fire risk from next door.

The enabling process took anything from a single visit to over one year. Indeed, with more independently-minded users it was sometimes needed on an ongoing basis particularly in instances where their ability to carry out activities of daily living was progressively diminishing. In the next section the mobilisation of resources which the older person had agreed to receive is considered. Because the enabling process was sometimes protracted, this activity often overlapped with that of mobilisation.

4.2 The introduction of Community Care helpers and any other local resources

After making an initial assessment a care manager, in consultation with the user and any informal carer, decided how to adapt and build on the informal and formal support already provided.

Care was taken not to displace the informal care currently provided. It was also important for existing services, such as the Home Help Service, not to be made to feel threatened or taken over. Instead, the care manager sought to fill the gaps in provision and negotiate with the various parties regarding the best times to visit, so as to offer the best overall cover. Helpers were not normally instructed to take over tasks already carried out by the Home Help Service or indeed to carry out tasks regarded as appropriate for a home help. However, there was some overlap in the types of task performed by home helps and helpers, such as in meal preparation. Helpers could provide support at weekends and evenings when others, such as home helps, could not visit.

The care managers could not purchase services provided by the social services department such as home help, meals on wheels and day care directly, but had to negotiate with the service organiser.

Contacts with health personnel such as GPs and community nurses enabled unmet medical needs to be identified. This was facilitated in Sheppey by encouraging the frequent visits by community nurses to the team office once this had moved to Sheerness, while in Tonbridge strong links were maintained with primary care teams. Often hospitals tended to initially resist users suitable for Community Care being discharged into the scheme rather than into long-term residential care. Nevertheless short-term residential care was sometimes a valuable half-way house. The willingness of the care manager to take on users following their early discharge from hospital assisted the care manager to obtain a degree of improvement in health care for other users. Thus in Sheppey, the willingness of the care manager to take back a blind and deaf lady with other problems enabled the geriatrician to admit one day later a terminally ill user, reducing the stress on the family.

Once the geriatrician for Sheppey had gained confidence in the level of service provided by the scheme, the care manager was able to negotiate access to a short-stay bed for Community Care service cases. Building up good relationships with ward staff also assisted in obtaining the goodwill of hospital personnel. In Sheppey the care manager was sent a list of patients to be discussed at the hospital case conferences and was welcome to attend if a Community Care user was included. Problems at home could then be referred to if an imminent discharge were being suggested, and frequently discharges were then postponed.

Despite the care taken for helpers not to take over tasks previously carried out by health workers, a degree of substitution was sometimes inevitable; for example, when the community nursing service adopted the policy of withdrawing some of their support in cases where the tasks were seen as not requiring specialist nursing expertise. The nursing service saw the introduction of the scheme as an opportunity to pass on some of their less skilled personal care tasks to helpers in order that their staff could concentrate on specifically nursing tasks. This sometimes involved community nurses training helpers in tasks such as lifting and bathing in order that they might concentrate on more skilled activities such as dressing sores and giving injections.

Contact with the housing department was maintained via the wardens of sheltered housing. In addition to 22 per cent of cases in sheltered housing at the initial evaluation in Sheppey and 6 per cent in Tonbridge, a further 8 per cent of cases in Sheppey, though none in Tonbridge, moved to sheltered housing after this had been arranged by the care manager.

Liaison with voluntary organisations allowed valuable additional resources to be made available to users in both areas. Thus in Sheppey, Age Concern provided a day centre used by 22 per cent of users. Churches were a valuable source of volunteers, particularly in Tonbridge and Malling, and tended to provide help through companionship, escort duties, or light tasks rather than personal care or housework. The probation service provided useful assistance with gardening in the Tonbridge area.

Private residential care was used for both short-term care and permanent care in Tonbridge.

The Community Care budget available to care managers could be used in any way that the care managers chose to provide support to the older person and any informal carer, and these devolved funds could be drawn on without having to negotiate with others in the social service department. Thus, various types of equipment were purchased such as convector heaters for use in cold weather, electric kettles which automatically switched off for users suffering from memory loss, and a washing machine for incontinent laundry when no laundry service was available.

However, nearly all the budget was used to pay fees and expenses to the Community Care helpers. Although occasionally recruited through the user's informal network, the vast majority of helpers were not previously known to the user and were recruited through the local community. Their aim was to provide types of support not offered by other services; for example, by offering help with personal care tasks or companionship. Assistance was provided flexibly, wherever possible, at times that the user needed it; for example, a helper could visit early in the morning to toilet a user avoiding a long wait before a community nurse could call.

Suitable helpers could generally be found within easy reach of the users they catered for though clearly location was a more dominant factor in rural areas. Helpers were also matched to users according to personality, shared interests and availability both at times of the day or night when the users most needed them and at weekends and bank holidays. Advantage was taken of a helper's existing skills and further training provided as required. After drawing up a contract listing the tasks the helper was to perform, the care manager would personally introduce the helper to the user.

Alternatively, helpers could be paid for less orthodox types of activity. In Sheppey, one helper was paid to be available on call when needed. This was extremely helpful for a particular user with fragile bones who needed special attention, especially when getting up or going to bed. Various ways in which helpers were used in providing innovatory forms of day care are described later in section 6. Community Care users were often particularly in need at bank holidays, when services such as home help or day care were unavailable.

4.3 Methods of supporting users and their informal carers

The care manager used a wide variety of methods for supporting users, and this sometimes involved spending time with them or their families.

Much initial counselling was often required to persuade the older person to accept help (section 4.1), and accept strangers into the home or to make a decision about what the user sees as their future. All users wanted if possible to stay at home and many were very unsure or frightened as to whether they were making the right decision. The aims of the scheme needed explanation, and the user needed to be made aware of the current situation. The care manager needed to draw out from the user how they saw things.

The options open to a user would need clarifying when a decision had to be made. The care manager would assist in obtaining welfare benefits for the older person and might provide help in the payment of bills.

The need for assistance in managing money became a growing problem. Although care managers typically had several cases in which the scheme was handling money, this was against official county policy, since it put Community Care into a very vulnerable position and was also seen as a 'temptation' for helpers and care managers. The care manager was

concerned over whether the county would provide support if they were accused, and so safeguarded themselves as much as possible. In addition, the management of finance was very time-consuming. Sometimes a user wanted financial management to be carried out solely by Community Care staff. For example, one older lady of nearly 100 had Community Care do all financial transactions - paying rent and bills and holding her cash which was kept downstairs. Difficulties arose when the care manager was on leave and the user accused other people of taking money.

The care manager would frequently take part in problem shooting. Crisis intervention by the care manager was occasionally required. For example, following the sudden death of a spouse, bereavement counselling by the care manager combined with intensive support from Community Care helpers could allow a user to remain at home instead of the frequent traditional response of social services departments admitting them to residential care.

Indeed, the care managers and their assistants spent much time in ongoing counselling, mainly regarding different types of loss; as well as bereavement, loss of use of limbs (such as with stroke victims), loss of ability and freedom to choose and loss of home. The effects of such loss require older people to make major emotional adjustments and take on new roles at a stage in their lives when such changes can be difficult to achieve. Where appropriate, a care manager can facilitate this process of adjustment by allowing the user to express the frustration and sadness brought about by such circumstances. Possible new coping strategies for the user can also be discussed. In time, this can help the user to adapt to the current situation and accept its limitations.

The dying could sometimes be supported by listening and sharing feelings. Loss of mental function could respond to counselling in certain cases, though most of the cognitively impaired users were too confused to have this insight. Users suffering from depression or anxiety were supported by helping a user accept their situation.

It was found that children could sometimes provide valuable stimulation for the older person. This was sometimes arranged through a single user's attending day care in the helper's home, in order that the user could integrate with the helper's family. This was successfully achieved with one very cognitively impaired lady who normally felt threatened in the presence of strangers and she attended every Saturday and Sunday. In another case a severely physically handicapped user sometimes spent the day with a helper with four young children, and got on excellently with them.

Through a chance encounter, it was found that a child of six living locally was able to help an older stroke victim to regain his powers of speech. The user could not communicate with adults but could with the child. The boy would point to a word in a book and the user would make an effort to pronounce it. In this way the user's speech improved while at the same time the boy learnt to read new words. The care manager recognised the value of these encounters and encouraged them to continue. The child visited for over an hour each week over a period of several months.

Care managers also spent time in co-ordinating family help. Families were frequently brought together to chat about problems and future care. It was sometimes necessary to smooth out conflicts between family members over who was responsible for providing care. Often, once the care manager, seen as taking overall responsibility, was available to

relate to, family members who had opted out would re-involve themselves in providing support, thus reducing the burden of care on any one member.

The care manager needed to include the informal carers in the ongoing package of care and not allow Community Care to take over the user. The care manager would explain that the scheme needed to work with the informal carer in order to keep the user where they wanted to be.

Informal carers were sometimes given counselling support. For instance they might have needed encouragement to 'let go' of the user, in order to accept relief from caring. When an informal carer is overworked, there is a need for sharing of responsibility, particularly with the cognitively impaired. For example, a cognitively impaired user, an ex-district nurse, used to wander, imagining she was doing her old rounds, and her daughter had become extremely overworked in providing support. Although not living with her mother, the daughter was plagued day and night by her over-dependent mother, who used to telephone her. Eventually the daughter's husband decided to take his wife away for a fortnight's holiday abroad. He insisted that the care manager was not informed about where they were going, and this became a crisis point in the marriage. It meant that even in the case of death the care manager would have been unable to contact her. The care manager therefore provided total care during this period which was possible with the assistance of excellent helpers. The care manager had to work with and alleviate the strong feelings of guilt of the daughter before and after the holiday and tried to be understanding and share her feelings. Having had the holiday, the daughter was able to cope for a little longer. However the user deteriorated further mentally and became a severe danger to herself. Refusing residential care, she was admitted to long-term geriatric hospital care. The care manager kept in touch with the daughter who still felt guilty two years after her hospital admission. At the same time the daughter did not regret what happened and accepted that without Community Care she (the daughter) would not have been able to cope and that her mother would have been admitted to hospital much earlier. Although the demands on those involved were considerable, no one regretted what had happened, and the mother was certainly much happier at being able to stay on longer at home, albeit at a risk to herself.

The care managers were nearly always eventually successful in enabling informal carers to accept the involvement of the scheme, once their initial feelings of guilt had been worked through. It required the care manager's working closely with the helper, who could otherwise aggravate the situation. Much tact was required and sometimes only limited progress could be made. In one case a cognitively impaired older lady, with difficult behaviour, was being supported by a lady who was almost as old with whom she shared the house. Although the informal carer allowed the helper to visit just twice a week to provide some relief, she was unable to let go of the situation and needed to feel fully in control, so scheme involvement had to remain minimal. In a number of other cases Community Care operated through providing relief to the informal carer rather than by arranging a total package of care.

Periodic relief would normally be provided through arranging for a helper to substitute tasks over a block period and hence enabling the older person to remain at home, rather than by providing short-term institutional care. Relief could also be provided on a regular basis through the helper carrying out the tasks of an informal carer on a particular day each week. For example, a daughter living with an older couple needed the respite of having a

regular day out away from them. Indeed, relief was more often provided during the week than as a holiday for the informal carer.

Through a close liaison with the helper, changes in the user's state were immediately brought to the attention of the care manager who also provided help and support to the helper when needed. This was particularly necessary when the user was very demanding, when the helper had become emotionally over-involved, when the community were exerting pressure or following a stressful experience, such as a helper finding a user on the floor or dead. Counselling was also needed for helpers who may have felt that they had failed. For example, one very difficult user was cognitively impaired and suffered from hypothermia, as she would turn off the heat when the helpers left, who were visiting very frequently. The helpers felt awful when the user was eventually admitted to long-term hospital care. The care manager saw their role as one of backing up the helpers and reassuring them that they had done all they could.

These methods of supporting users and their carers described in this section formed a vital part of the care provided, yet could be quite time consuming for care managers. With the much greater caseloads carried by care managers following the community care reforms, the opportunity to perform these tasks adequately must have been severely restricted.

4.3.1 The range of a care manager's activities

Since the three-monthly case reviews completed by care managers indicated which activities had been carried out during the preceding quarter, it was possible to gauge the frequency of occurrence of these activities by selecting the first five case reviews for each user. These covered the first twelve months in which Community Care was received, corresponding to the evaluation period. In Tonbridge it was possible to select a much larger group by including the four cases out of every five which were not sampled for evaluation.

Table 6.1 Range of care manager activities from case reviews in Sheppey and Tonbridge, compared with values for an area team in a different study

	Sheppey	Tonbridge	Area team study[3]
	%	%	%
Exploratory/(re-) assessment	92	65	20
Information/advice	26	29	17
Mobilising resources	34	47	23
Co-ordinating resources	63	47	
Check-up/review visits	91	72	78
Social skills education	4	2	
Facilitating problem solving/decision making	43	12	8
Sustaining/nurturing user	90	74	8
Sustaining/nurturing informal carers	21	55	
Sustaining/nurturing CCS helpers	86	64	
Advocacy	6	7	5
Sample size[1,2]	160	513	

Notes:

1. A maximum of the first 5 reviews was selected for each case, corresponding to the first year of being supported by the scheme.
2. All such case reviews were selected during the evaluation period, including those cases in Tonbridge and Malling which were not selected for evaluation.
3. Results drawn from the case reviews completed for the physically disabled (65+ years) and older people (Goldberg and Warburton 1979).

The results for both schemes are shown in Table 6.1, from which a striking range of activities is evident; far greater than would normally be the case for an area team social worker. To illustrate this, a third column shows the percentages for case review forms of a fairly similar format completed for the physically disabled (65+ years) and older people in the study described by Goldberg and Warburton (1979) for an area team. Although these reviews were not completed at precisely three-monthly intervals, the average time between reviews was fairly comparable.

4.3.2 Complexity and variety of care packages

Instead of care managers providing a very limited range of standard responses to user problems, they had a wide variety of resources at their disposal, and could vary both the nature and the quantity of resources used depending on the needs of the user. Table 6.2 shows how the proportion of cases receiving the main types of community resource provision changed between referral (time 1) and after one year in the scheme (time 2). Almost two-thirds of cases survived in the community until time 2. The last two pairs of columns each refer to this same sample of cases which had survived, so that direct comparisons can be made between them.

Overall, cases received a greater number of services after having spent one year in the scheme. Whereas only a small minority had been in receipt of social work support at the point of referral, all benefited from having a care manager with overall case responsibility by time 2. Home help provision was rather less frequent in Tonbridge than Sheppey, due to the larger proportion of cases with a principal informal carer in Tonbridge who were less likely to need the service. The proportions receiving home help showed little change over the year, which is consistent with helpers not taking over home help tasks. However, the percentage receiving private help dropped sharply in both areas, suggesting that home helps or helpers may have been taking over some of these tasks. Moreover, the proportion receiving community nursing fell in Sheppey, reflecting the care manager's experience of the withdrawal of nursing support for some cases. At the same time all cases were receiving visits from helpers at time 2 except for one Tonbridge user where the scheme had withdrawn.

Changes in meals-on-wheels provision were quite different in each area. While the proportion in Sheppey almost halved, due partly to CCS taking over some meal preparation, that in Tonbridge increased slightly. This area difference may have been due to the Sheppey service being less useful, since only available on a limited number of days each week and the meals not always being sufficiently appetising. Visits from GPs were more frequently received in Tonbridge than Sheppey, reflecting the negative attitudes of GPs in Sheppey towards the frail older people remaining at home, as expressed by the care manager and also, perhaps, their bigger workloads. However, the proportion of cases visited did not change over the year. The percentage of cases in receipt of chiropody increased in each area as a result of referral by the care manager via the GP. This is a resource which is frequently not received by those older people needing the service, and the scheme was able to facilitate its provision where appropriate.

Table 6.2 Main types of community resource received at time 1 and time 2 in Sheppey and Tonbridge

Resource type	All cases at time 1		Cases in community at time 2			
			time 1		time 2	
	Sheppey %	Tonbridge %	Sheppey %	Tonbridge %	Sheppey %	Tonbridge %
Home help	68.3	60.6	76.0	57.1	72.0	61.9
Private help	14.6	15.2	8.0	14.3	4.0	4.8
Community nurse	70.7	51.5	60.0	38.1	44.0	42.9
CCS helper	-	-	-	-	100.0	95.0
Meals-on-wheels	29.3	36.4	40.0	47.6	24.0	57.1
Social worker/care manager	12.2	9.1	12.0	14.3	100.0	100.0
GP	26.8	33.3	28.0	42.9	24.0	42.9
Chiropody clinic	29.3	45.5	32.0	38.1	40.0	61.9
Day hospital[1]	0.0	15.2	0.0	15.0	0.0	20.0
Local authority day centre[1]	19.5	27.3	20.8	15.0	29.2	35.0
Voluntary club/day centre	7.3	6.1	4.2	5.0	8.3	0.0
Lunch club	9.8	6.1	16.7	5.0	25.0	5.0
Sheltered housing warden	22.0	6.1	24.0	4.8	32.0	4.8
Valid cases	41	33	25	21	25	21

Notes:

1. Day centres and day hospitals could also provide chiropody, in addition to chiropody clinics.

Day hospital was only available in Tonbridge where the proportion in receipt had increased slightly by time 2. However, the percentage attending day care increased substantially, particularly in Tonbridge, where the larger proportion of cases with a principal informal carer led to a greater need for day relief. Lunch clubs at time 1 were used for a greater proportion of cases in Sheppey, where the scheme had also introduced them to additional cases by time 2. Thus, through the provision of day care, day hospital and lunch clubs, care managers in both areas had enabled over half their users to have a change of scene and meet people by time 2. In addition to this social opportunity, the combined effect of day care, day hospital and attendances at chiropody clinics appeared to arrest or reduce any deterioration in physical performance, particularly the ability to transfer to and from bed and chair. This effect was strongest in Tonbridge, where the overall use of these three services was greater. Day centres and day hospitals offered opportunities for physiotherapy and chiropody as well as general exercise. Moreover, other studies have shown a possible link between the provision of services such as day hospital or chiropody and improved physical functioning (Bergmann and Jacoby 1983; Davies and Challis 1986).

Sheltered housing wardens were more frequently in evidence in Sheppey, demonstrating the greater use of sheltered accommodation amongst cases in this area, where the proportion being visited increased slightly over the year due to a few more cases entering this type of housing.

Involvement of occupational therapists (OTs) was too infrequent to be included. OT assessments by the SSD were uncommon in both areas, reflecting both staff shortages and long delays between the referral date and the visit date, particularly in Tonbridge. While community based OTs were concerned primarily with the provision of aids and adaptations, the main focus of hospital OTs was towards assessing and rehabilitating users, which was much more relevant to the needs of the Community Care scheme. Consequently, when CCS users entered hospital, discussion between the care manager and the hospital OT was much more relevant and useful and led to a much quicker response.

While Table 6.2 shows the proportion of cases receiving different types of community resource at the point of referral and a year later, Table 6.3 gives the average number of units of different types of resource consumed each week while cases were in the community, including periods in short-term residential care and acute hospital care. Although this represents an average weekly package, it must be remembered that packages show much variation between cases. Nevertheless, means for Sheppey and Tonbridge were fairly similar as regards the main ingredients. Thus, the average package in each area included roughly one day's day care/day hospital, 2.5 hours home help, CCS helper fees of £10 and expenses of £3 and 0.5 hours community nursing. There were however some important differences. The greater use of meals-on-wheels in Tonbridge and of sheltered housing in Sheppey has already been commented upon. While Sheppey cases benefited from about double the care management time (1.4 hours per week) per case than was offered in Tonbridge, part of this difference was made up for by a greater use in Tonbridge of assistant care manager time (0.40 hours per week). The remainder of the shortfall in Tonbridge arose from the larger caseloads, resulting in care managers having less time to spend on each case.

Table 6.3 Average number of units of different services consumed per week while in the community for all experimental cases in Sheppey and Tonbridge

	Average number of units of resource consumed per week	
	Sheppey	Tonbridge
(1) SSD Resources		
Average weekly net SSD revenue cost of care in community[1] (£[2])		
- mean	40.84	37.07
- lower quartile[3]	26.56	20.58
- median[4]	39.20	31.47
- upper quartile[5]	52.20	44.12
Short-term care days in care home	0.06	0.15
Days day care in an old people's home	0.59	0.37
Day centre attendances	0.30	0.41
Days in Age Concern day centre	0.27	0.00
Hours of home help	2.52	2.28
Meals on wheels	0.43	1.06
Lunch club attendance	0.14	0.08
Care manager hours	1.44	0.70
Assistant care manager hours	0.05	0.40
Community Care helper fees (£[2])	10.24	9.04
Community Care helper expenses	3.00	2.87
SSD telephone rental weeks	0.11	0.07
Sheltered housing subsidy weeks	0.31	0.07
SSD aids and adaptations (£[2])	0.08	0.07
(2) NHS resources		
Average weekly NHS cost of care in community (£[2])		
- mean	21.38	12.13
- lower quartile[3]	1.47	0.81
- median[4]	4.35	5.67
- upper quartile[5]	20.77	16.89
Days in acute hospital	0.40	0.17
Geriatric day hospital attendances	0.00	0.24
Community nursing hours	0.59	0.40
Chiropody appointments[6]	0.04	0.02
NHS aids and adaptations (£[2])	0.30	0.10
Combined cost to SSD and NHS in community (£[2])	62.22	49.20
Average number of weeks at home	42.57	45.06
Sample size	41	33

Notes:

1. The period in the community includes all short-term care in a care home and acute hospital care.
2. 1982 prices.
3. Lower quartile: the case for which one quarter of all cases had lower costs.
4. Median: the case for which one half of all cases had lower costs.
5. Upper quartile: the case for which one quarter of all cases had higher costs.
6. Chiropody appointments excluded treatment at day centres or day hospital.

Regarding consumption of health service resources, more than twice as many days were spent in acute hospital care in Sheppey as in Tonbridge. This was probably in part a result of the greater proportion of Sheppey cases living on their own or without a principal informal carer and so lacking the informal support which can sometimes prevent cases from deteriorating in health to a state in which they need hospital treatment or sometimes allow illness to be treated at home. Despite the withdrawal of some community nursing in Sheppey, the mean provision over the first year at 0.59 hours per week was roughly 50 per cent higher than in Tonbridge (0.40 hours per week). Again, the greater opportunities for informal support in Tonbridge probably reduced the need for community nursing. NHS

chiropody appointments were twice as frequent in Sheppey since greater use was made of private chiropodists and facilities at day centres in Tonbridge. Finally, NHS aids and adaptations cost three times as much in Sheppey, due to a few relatively high cost items, though the mean cost in each area was still extremely low. Differences in the overall need of cases in Sheppey and Tonbridge and in the availability of resources in the two areas could also have contributed to some of these differences in consumption of services.

In order to place these results in a more recent context, the levels of resource consumption given in Table 6.3 have been compared with 1995 figures from the study 'Evaluating Community Care for Elderly People' – ECCEP (Bauld *et al.* 2000) for a few key resources. This study was based on data drawn from ten local authorities in England and Wales. Although these users had levels of cognitive impairment comparable to those in the Sheppey and Tonbridge schemes, their levels of physical disability and illness were less severe; thus mean ADL score was only 1.3, compared to 1.9 (Sheppey) and 2.4 (Tonbridge). The ECCEP users received far less care management time: only 0.22 hours per week compared to 1.44 (Sheppey) and 0.70 (Tonbridge). They also received less day care: only 0.47 days per week, compared to 1.16 (Sheppey) and 0.78 (Tonbridge). Community nursing was also much less: 0.15 hours compared to 0.59 (Sheppey) and 0.40 (Tonbridge). Nevertheless, ECCEP users received more home help, which included personal care, not provided in Sheppey and Tonbridge. In ECCEP, 5.73 hours per week home help compared to 2.52 (Sheppey) and 2.28 (Tonbridge). However, if expenditure on helper fees had instead been used to purchase additional home help, these levels would rise to 6.16 (Sheppey) and 5.50 (Tonbridge), comparable to that for ECCEP. Although provision of delivered meals for ECCEP users at 1.33 meals per week was greater than for Sheppey (0.43) and Tonbridge (1.06), Community Care helpers frequently prepared meals, which users generally found more appetising than meals-on-wheels. In ECCEP, sitting services were deployed for only 5 per cent of users and a laundry service for only 3 per cent. When these two services were unavailable in Sheppey and Tonbridge, they were sometimes undertaken by helpers. The only slight resource advantage for ECCEP users was that while SSD and NHS OT visits were at negligibly low levels in Sheppey and Tonbridge, they occurred at a frequency of 1.5 visits per year (SSD OTs) and 0.9 visits per year (NHS OTs) in ECCEP, still very low levels. Also respite care amounted to 0.15 days per week, greater than for Sheppey (0.06 days per week) but equal to that for Tonbridge. Thus, in comparison with ECCEP, the Sheppey and Tonbridge schemes were characterised by much greater targeting on users with higher physical disability, a much more intensive use of care manager time through low caseloads and a greater use of day care and community nursing. The use of Community Care helpers in addition to home helps provided more flexible support and better value for money.

Davies and Challis (1986) reported some relationships which emerged between costs and user needs in the Thanet Community Care Project, and these relationships have been tested on the Sheppey and Tonbridge data. The first relationship to test was that in Thanet, the group of users whose average weekly SSD cost lay in the top twenty-five per cent of cases (the *upper quartile*) were extremely frail and chronically sick and so at high risk of entry to institutional care. They therefore required substantial domiciliary services which frequently enabled them to survive the full year at home, since the longer a person stayed at home the greater the tendency for average costs to increase. In Sheppey these cases, with a cost of at least £52.20 per week, had general health problem index scores and Isaacs and Neville disability scores which were both only slightly above average. However, they also had cognitive impairment ratings which were well above average, unlike Thanet. The proportion remaining at home was also a little above average. Thus, in Sheppey, cases

with a high weekly SSD cost were a little above average in need and substantially more cognitively impaired. Despite this, the expenditure appeared to have reduced the number having to leave the community during the evaluation year.

In Tonbridge the result was different. The lower cost limit of the upper quartile was only slightly lower at £44.12 per week. Although health problem index scores were greater, disability was average and cognitive impairment below average. Moreover, these cases were slightly less likely to remain at home, perhaps a result of their above average health problems.

Thus while Sheppey CCS was successfully targeting social services resources at cases which had a greater likelihood of cognitive impairment and reducing the risk of leaving home during the evaluation year, Tonbridge CCS was targeting these resources at cases with slightly more health problems, but these cases survived for less long than average in the community. These results suggest that the Sheppey policy of targeting most SSD resources at cases of greater cognitive impairment may have led to a greater proportion of cases overall having survived at home, though the sample sizes are too small for this finding to be statistically significant. Since a greater proportion of cognitively impaired older people had been taken on in Tonbridge, budget constraints led to less scope for targeting more resources at this group. Moreover the targeting criteria which were applied in Thanet appeared to differ from those used in both Sheppey and Tonbridge.

Another finding from the Thanet Community Care Project was of a contrast between cases for which the costs of Community Care helpers were a low proportion (less than 10 per cent) of the costs and those for which they constituted a high proportion (greater than 50 per cent). The first group tended to enter institutional care and to need much domiciliary support, such as meals and home help at times when these could be readily provided. These characteristics were also found in Sheppey but not in Tonbridge. The second Thanet group tended to suffer from mental disorder and need both out of hours care and care tasks not normally provided by standard services, such as check-up visits, companionship and support for families. The corresponding Sheppey and Tonbridge groups showed above average cognitive impairment, the Tonbridge cases also being mostly clinically depressed and with a high proportion of principal informal carers. In other words, in Thanet, Sheppey and Tonbridge, cases whose SSD costs were mainly due to helper payments tended to suffer from mental disorder and require a more flexible response to need.

Effective care management of frail older people with multiple problems frequently involved co-ordinating a large number of resources to meet these needs. The task required negotiation with the different parties in order that services could be interwoven to provide consistent support at times when the user needed it. A count of the number of services consumed over the evaluation year provided one measure of case complexity. The way this number of services is distributed across cases is shown in Table 6.4. The mean for Sheppey of 6.2 was similar to that found for the Thanet Project and only slightly greater than in Tonbridge (5.5). Moreover, cases with the top 25 per cent of scores (upper quartile) consumed at least eight services in Sheppey and seven in Tonbridge and the proportion of cases consuming just one or two services was less than ten per cent in each area. The minimum was for just a helper to visit.

Table 6.4 The distribution of cases according to their complexity as measured by the number of services consumed during the evaluation year[1]

Number of services consumed	Sheppey	Tonbridge
Mean	6.17	5.49
Minimum	1	1
Lower decile[2]	3	2.4
Lower quartile[3]	4.5	4.5
Median[4]	7	6
Upper quartile[5]	8	7
Upper decile[6]	9	7.6
Maximum	11	8
Sample size	41	33

Notes:

1. The services included were short-term residential care, day care in an old people's home, day care centre, Age Concern day care, home help, meals on wheels, lunch club, SSD telephone, sheltered housing, CCS helper, SSD aids, geriatric day hospital, community nursing, chiropody, acute in-patient care, NHS aids.
2. Lower decile: the case for which one tenth of all cases had lower scores.
3. Lower quartile: the case for which one quarter of all cases had lower scores.
4. Median: the case for which one half of all cases had lower scores.
5. Upper quartile: the case for which one quarter of all cases had higher scores.
6. Upper decile: the case for which one tenth of all cases had higher scores.

In order to obtain a picture of how resources were distributed quantitatively between cases, the average weekly cost to the social services department and National Health Service for each user while at home was determined for matched Community Care and comparison groups in each area. Table 6.5 shows the frequency distributions.

The large spread in weekly package costs to the SSD and NHS in both areas and for both Community Care and comparison groups is clear. It can be seen that the average weekly cost while at home for both schemes was much greater in the experimental group, particularly in Sheppey. However, because control group cases spent a greater proportion of the evaluation year in residential care, which is normally much more expensive than community care, the annual cost in each group becomes comparable. The mean values will be further commented on in Chapter 8. Taking into consideration the Community Care weekly SSD expenditure ceiling of £71.80 (the 'two-thirds' limit) it was found that while 9 per cent of Sheppey cases were above the limit, all Tonbridge cases were below it.

After having discussed how the care manager spends time with users and deploys resources, the approaches to coping with different types of user problem are now considered in turn.

Table 6.5 Distributions of average weekly cost to the social services department and National Health Service while at home[1] by matched groups in Sheppey and Tonbridge, £ at 1982 prices

Average weekly cost[2]	Sheppey		Tonbridge	
£	Matched community care group %	Matched comparison group %	Matched community care group %	Matched comparison group %
(a) SSD cost				
Less than 5		16	4	13
At least 5 and less than 10	6	28	9	22
At least 10 and less than 20	9	38	22	26
At least 20 and less than 30	19	3	22	13
At least 30 and less than 40	16	3	17	17
At least 40 and less than 50	9	3	17	9
At least 50 and less than 60	16	9	4	
At least 60 and less than 70	16		4	
At least 70 and less than 80	3			
At least 80 and less than 90	3			
At least 90 and less than 100	3			
Median[3]	42.09	10.91	23.43	17.22
Mean	40.68	11.99	28.29	20.73
Standard deviation[4]	21.46	16.07	16.17	13.30
(b) NHS cost				
Less than 1	37	53	35	39
At least 1 and less than 2	22	13	9	13
At least 2 and less than 3	3	3	13	4
At least 3 and less than 4	6	6	9	5
At least 4 and less than 5	16			
At least 5 and less than 10	13	9	13	9
At least 10 and less than 15		10	9	22
At least 15 and less than 20			4	4
At least 20 and less than 25		3	4	4
At least 25 and less than 30				
At least 30 and less than 35			4	
At least 35 and less than 40		3		
At least 40 and less than 45	3			
Median[3]	1.66	0.77	2.06	1.91
Mean	2.71	4.56	5.53	4.32
Standard deviation[4]	7.38	7.91	8.49	7.09
Sample size	32	32	23	23

Notes:

1. Periods spent in short-term residential care or acute hospital care are excluded.
2. These costs may be compared with the individual budget cap for 1982 of £58.71.
3. Median: the case for which one half of all cases had lower scores.
4. Standard deviation: a statistical measure of degree of spread of individual values about the mean.

4.4 The management of different kinds of specific problem

Care managers developed particular techniques for coping with older people in different types of problem category:

4.4.1 The bedbound

In dealing with the bedbound, a close liaison was maintained with the community nurses. When helpers were undertaking some of the personal care tasks they would frequently be given training and guidance by the nurses. Sometimes community nurses might attend some mornings and helpers other mornings to make an interwoven package. The care

manager would also ensure that all the appropriate SSD and NHS aids available had been provided.

The scheme was able to cope successfully with a few such cases at any one time, though they could sometimes be demanding for both care manager and helpers. One older lady was being supported by a highly anxious daughter, so the care manager assisted the daughter as well as the user. The Community Care package consisted of the daughter visiting mornings to see her mother, with the support of a home help and a Community Care helper. Also a helper visited some afternoons to chat or read to her and a district nurse called some days. In all, the user was visited four times daily which covered meals and getting up and going to bed. Very practical caring was provided, and because the user was partially sighted she was provided with a talking book and enjoyed listening to the radio. A technical officer for the blind also visited.

In another case, a totally bedbound user had been living with her sister who had provided care until the death of the mobile sister. The user was then supported daily by a community nurse visit, two home help visits and an evening helper visit. Arrangements were made with the vicar for the user to take communion - she had always been a church-goer.

4.4.2 The incontinent

Sheppey

In dealing with problems of incontinence, all helpers were provided with training through a film on incontinence and talks from the community nurse on prevention and treatment. Incontinence sheets, pads and aids were ordered when necessary for delivery to the home. If the user suddenly became incontinent, the care manager would look for a reason, and make use of acquired medical knowledge. Sometimes a urinary infection would be the cause. Helpers were made aware that 'padding up' is not the only answer, and could make things worse. Sometimes the regulation of fluid intake could be of assistance. Where there was doubt, the community nurse or local incontinence adviser was consulted. In cases of persistent, unavoidable incontinence, the care manager would work with the user to help cope with the shame experienced and coming to terms with the condition.

In the absence of an incontinent laundry service, washing was sometimes dealt with by the home help or helper. Alternatively, if transport was available, washing machines at the day centres and at a county home for older people could be used.

Tonbridge

In Tonbridge, there was fortunately an incontinent laundry service. The care manager would work closely with the community nurses and the nurses in the Cottage Hospital. The nurses frequently trained the helpers in coping with nursing tasks involving incontinence, such as dealing with catheters. This is one illustration of how helpers took on traditionally nursing tasks and became far more involved and knowledgeable in the nursing field. The helpers were not provided with general training, but only for specific tasks with a particular user and this arrangement worked out well.

In Malling, which came under a different area health authority, there was no laundry service. Community nurses supplied pads, but a bath nurse could visit only once weekly. Consequently helpers or home helps had to cope with incontinent laundry, including some due to double incontinence. When there was a risk of infection, disposable sheets were used. They managed this very well, but needed support. For example, a helper rang the

care manager to say that the user, a double amputee, had been doubly incontinent and needed someone strong to lift him. The care manager and home help organiser immediately made a joint visit to assist the helper in cleaning him up. By providing this type of support, the user could be maintained at home for a long time, despite resistance from the GP.

4.4.3 Cognitive impairment

The scheme was highly successful in supporting cognitively impaired users at home, particularly since traditional methods of coping with this user group had often failed. Nevertheless, the scheme was unable to cope with the most demented users. Because brain failure is normally a progressive condition, it was not always possible to maintain these cases at home until their death. Although the scheme could normally cope during the day and evening, night-time could be a big problem for the demented living alone, particularly when nocturnal wandering occurred. Management was sometimes easier for a user living with family, as Community Care relief could then be arranged. However, families often did not want to be very involved. They were frequently older people themselves and unable to cope with the situation. A study of demented older people living in the community (Bergmann *et al.* 1978) showed that living group was an important predictor of survival at home. Those living alone were least likely to stay at home, those living with a spouse were more likely, and those with younger relatives were most likely to do so. The author stressed the importance of supporting these relatives to reduce the risk of breakdown, particularly through the provision of domiciliary help.

One older cognitively impaired lady, living alone, became increasingly noisy by night, disturbing the neighbours and wandering. It was therefore necessary to keep day clothes on the user, but there was still a risk of a road traffic accident or suffering exposure. Moreover, the care manager felt very pressurised by neighbours to have her removed from home. However, the user was sufficiently lucid to express a wish to stay at home. The care manager tried to respect this wish, but found this type of user most stressful.

The assistance of helpers in administering medication could be very helpful, and this could assist in stabilising sleep patterns and reduce nocturnal wandering.

Providing support for cognitively impaired users was one of the most difficult areas for Community Care. Helpers tended to find them the most trying and stressful. The users were usually very active physically and did not need as much practical help in the home. Helpers would often visit around meal times and stay while the user was eating as the user might otherwise forget to eat. The cases were monitored closely, and visits would tend to be short but frequent, with helpers receiving extra support from the care manager. Although some helpers tended to go along with a user's fantasies (for example, of her dead mother sitting in the armchair), the care manager encouraged helpers to bring the user back to reality. The care manager in Maidstone and Malling felt the need for helpers to receive a general training on the problems of brain failure, as well as the individual information they received on the condition of particular users. In Sheppey, this need was addressed through talks on cognitive impairment given at some of the monthly coffee mornings. Helpers were informed as to why a user was suffering and the behaviour patterns gone through, to allow a deeper understanding of their needs and how to respond.

There were occasional instances of *acute confusional state*, in which a sudden change in condition was observed. The care manager would then contact the GP. The user would then sometimes be admitted to hospital. In one instance, a relief GP had prescribed

antibiotics for a toe infection and this had reacted adversely with the tranquillisers she was taking. The helpers observed the reaction and alerted the care manager, who contacted the GP to have the medication changed.

4.4.4 Alcoholism

Coping with alcoholic users was always problematic. The user had a right to drink, and the care manager would be infringing on this right by forcibly preventing this. Often some kind of compromise was reached. In one instance, a severely cognitively impaired older lady had been purchasing large quantities of liquor locally. After a discussion with the user, it was agreed that her consumption be limited to one bottle of whisky per day. The helper collected this, and it was arranged with the shop that if the user also called, they would inform her that the helper had already collected the bottle. The user accepted this arrangement.

In another case, the user was not cognitively impaired but was housebound. A nearby off-licence delivered the drink. She tended to conceal the problem. Indeed alcoholism can be quite difficult to detect, particularly if the user is taking medication. On being confronted with her alcoholism by the care manager, the user at first perceived this as a crisis, but subsequently was able to accept that there was a problem and agreed to be admitted to hospital to be 'dried out'.

In a further case of alcoholism, drinking led to frequent falls causing periodic hospital admissions. The user had a secret supply of drink, though admitted to drinking. She said she had always had a drink and was not going to stop now. The helpers and home help were able to moderate the purchase of alcohol. However, this was a difficult case to manage and only limited achievement was possible. The helpers monitored the situation and made sure she was fed and clean. They tried to give her a good diet which would help to 'absorb' the alcohol. However she would still drink late at night when alone, and would frequently end up on the floor by the morning.

In another instance, the care manager had been able to restrict the money available to an alcoholic user for spending and her condition had improved considerably as a result. However she later started asking customers at the local public house to buy her drinks, which was a cause of annoyance to them as well as causing her to deteriorate. In view of the improvement in her health since her money was restricted, it would have been counter-productive to have increased her weekly allowance. The care manager therefore encouraged the staff at the public house to take any action which they might normally take to protect their customers from harassment, even if this involved barring her from entry.

4.4.5 Boredom

Users did not often admit to boredom directly, but might say 'I'm worn out', 'I'm finished' or 'I'm ready'. Day centre attendance may relieve boredom, though this might not have been feasible if the user were a recluse. Providing motivation to older people can be difficult, though the care manager would sometimes attempt to gently introduce some stimulation through the helper. It was no use going in and saying 'Right, I think we should do so and so today'. The care manager needed a good relationship with the helper, who could then be sounded out about the viability of different possible approaches.

One older male user, depressed and tearful following a stroke, became bored despite some physical improvement. All his visitors were women. He had been a train driver, and it emerged by chance that the husband of a prospective helper was a steam train enthusiast. It

was therefore arranged that he visit, and this proved highly successful, with an immediate transformation in the user, as well as the visitor deriving considerable satisfaction. Visits then followed at fortnightly intervals. This illustrates the importance of providing suitable stimulation.

4.4.6 Independence and the need to offer something back to society

As older people lose their capacity to perform tasks and become increasingly dependent, it is important that they should be given the opportunity to improve their feeling of autonomy. This was achieved by deploying resources in a way which increased or helped to maintain the user's capacity for mastery, as discussed in section 4.1 (Milloy 1964).

There were many little ways in which users could give back, giving them satisfaction and self-confidence. For example, a user with arthritis in the hands could be motivated to relearn knitting and make squares for the Red Cross. Some users were encouraged to bake cakes to be donated to the church. By assisting a handicapped user to relearn how to make a cup of tea, he could make himself a cup and offer one to a neighbour at the same time.

Quite frequently a user would share a helper's problems and provide support. The helper would be allowed to talk things through with the user, and might seek advice from the user, drawing on their experience of life.

A significant aspect of caring for older people at home is in allowing them to keep their dignity and making them feel whole. They should still be the kingpin within their home. Helpers were made aware of the importance of respecting the user's standards, home and privacy.

4.4.7 Depression

The scheme was successful in coping with depressed users, usually through a helper providing companionship. Nevertheless, these visits were frequently wearing, though following them with ones in less emotionally draining situations could assist in revitalising helpers. It was frequently difficult to increase the user's self-esteem.

In cases of depression, it was helpful to have a case history to be aware of whether the condition was one of long-term *endogenous* depression or a shorter-term *reaction* to events. If the user had a long history of depression then it was unlikely to have been caused by the present environment. For example, a user might be demanding re-housing when the real problem was the underlying depression. The care manager would alleviate problems where feasible and then re-examine their plan of action. In the case of endogenous depression, the care manager, through accepting the user's condition, helped them to accept their situation and become less depressed. The care manager sought advice if progress could not be achieved.

Suicidal users were monitored closely, and the GP and others involved were kept fully aware of the situation, in particular threats of suicide. In Sheppey, GPs tended to think only in terms of treatment via medication, and drugs did not take effect during the first eight days. Moreover, one suicidal user in Sheppey with an alcohol problem could not be given anti-depressants as these would have reacted adversely with the alcohol. The handling of this case was difficult both for the care manager and for the helper.

In one Tonbridge case the user was very agitated as well as being suicidal and would sometimes head-bang. The workers involved, including the helpers, met informally every

week so that everyone was aware of the situation and any changes. The GP gave up a lot of time to discuss the long-term support needed with the helpers, talked over the fears of the helpers and ways in which they could provide assistance. The CPN was also very supportive.

In both areas, psychiatric advice was sought where appropriate; for example, if the state of depression did not improve. Despite the successful outcome of a majority of suicidal cases receiving CCS intervention there was always an element of risk in supporting this user group, and occasionally they did take their own lives.

4.4.8 Dying

It was normally the aim to keep a dying person at home right up to death, and the scheme was successful in allowing many users to die at home. If the doctor agreed to Community Care support, intensive care would be provided to enable the user to die at home. For example, one user who had already had two strokes suffered another severe stroke. She then said she wanted to die. She only lived another two days but was able to stay on in the familiar surroundings of her home with the presence and support of helpers whom she knew well, rather than in the strange surroundings of a hospital.

Leading up to a death, the care manager supported the helpers and saw that they knew exactly what the situation was. The care manager made sure that the user and family were getting all the support they needed through regular monitoring, but stayed on the sidelines and did not become over-involved, this being in the best interests of the user and family. While withdrawing to a degree, the care manager would liaise more closely with the helpers so they could feed back the information needed. Users differed in their approach to death, and the care manager responded differently as appropriate. Some users talked about death, perhaps saying 'I want to die; I'm ready to die'. Sometimes the care manager would say little but provide support simply by listening to the user. There was nothing the care manager could do, and they could not change what was happening. With other users, the care manager might appeal to their sense of humour, perhaps answering 'Oh well, not while I'm here please!' For other users, the care manager felt they could almost weep with them.

In Sevenoaks and Tonbridge, a substantial amount of terminal care was arranged, sometimes through new referrals. It was found that very strong relationships developed with the helpers. In one very successful case, Community Care provided 24 hour care for one and a half weeks, though this level of intensity was not normally possible. The care manager worked closely with the hospice. The helpers found this a very educating experience because of the involvement with the hospice and the support they obtained from both hospice staff and GP.

In another case a son, providing support for his terminally ill mother, became over-stressed and no longer able to cope. He received much support from the care manager and helpers, who volunteered to help in these difficult circumstances. They found the work gruelling but learnt a lot about terminal care.

Most of the users who died were ready to die and many of that generation held quite strong religious beliefs. It was in situations like this that the flexibility of the Community Care scheme and the reduced caseload were particularly helpful; for example, by allowing the care manager, where appropriate, to spend perhaps two hours with the user.

There was always work to be done after death. The family and helpers would need support. The care manager normally attended the funeral, as by that stage they were usually regarded as 'part of the family'. This also helped the care manager to come to terms with the death through the process of sharing.

4.5 Care managers' use of authority

There were several compulsory admissions to psychiatric hospital of Community Care cases. However, the social worker forms were completed by an approved social worker, not the care manager. Also, a few users were admitted to hospital under section 47 of the National Assistance Act, following an assessment visit by the Community Physician.

5 Monitoring and feedback

The need for a monitoring scheme has already been discussed in section 3.2 of Chapter 2. One early example of a large scale monitoring system was the collection of the American minimum data set for long-term care (Shanas 1979). It was applied to all cases entering institutional care or receiving certain community services and provided information on people in the health care system, their problems and their use of services. This allowed users to be compared with non-users and service consumption to be related to user characteristics.

The monitoring system set up in Kent bore some resemblance to that adopted by Goldberg and Warburton (1979) and was eventually adopted county-wide (Davies and Challis 1986; Challis and Chesterman 1985, 1986, 1987). It took the form of an initial assessment form completed on each new user that entered the scheme, three-monthly case review forms describing the problem areas and activities undertaken with each user, and quarterly cost sheets which provided a continuous record of the social services department resources deployed on them. These were processed centrally by the evaluator and feedback forms were circulated at six-monthly intervals analysing the data at the different levels of aggregation appropriate for workers and managers in various positions in the hierarchy. The monitoring forms are presented by Challis and Davies (1986) in their Appendix B and a sample feedback form is included in Appendix 2. At the same time the forms completed on individual users provided a structure for some of the user records and helped to encourage the definition of goals, the practice of regular reviews and reassessment and the revision of user care plans. The layout of the assessment form required the care manager to take a wide view and be fully aware of the contributions made by other agencies.

The case reviews acted as memory joggers; for example, in identifying where contacts which should have been made with other agencies had been missed. Also the section on social worker activities tended to trigger questions about how care management time was being distributed between cases and whether this was being done equitably. In Tonbridge, the information summarised on case reviews was of value as a supervision tool. The feedback forms were helpful in allowing the workload to be seen in aggregate and this contributed to an overall direction for policy. For instance, it gave an overview of the relative importance of different problem areas. By comparing the Sheppey feedback form with that for all Kent, differences in the level of need of cases being accepted into the scheme could be identified, and in the frequency by which different types of social worker activity were performed, as well as differences in the resources consumed.

In Tonbridge and Malling, because of the contrast which has already been described between the more urban character of Tonbridge and the more rural nature of Malling,

separate feedback forms were provided for each area. This assisted in understanding and responding to the different needs of the two regions.

Although the monitoring system placed extra administrative demands on care managers, most Kent workers felt that the advantages, particularly through the feedback system, outweighed any difficulties (Saunders 1987). This was certainly the view in Tonbridge. However in Sheppey the pressure from the social work team for the care manager to take on more cases eventually led to the care manager withdrawing from the production of assessment and review data, to release more time for implementation, though the completion of quarterly cost returns continued.

Some care managers in Kent felt that the monitoring system might expose them to criticism that their caseloads were too small or not sufficiently needy. However, the majority became aware that this caseload information could be used productively as a lever to bid for support staff. Moreover, once care managers had become accustomed to the monitoring system they did not in general feel that it interfered with their autonomy. This finding is confirmed by Sung (1982) in regard to an American monitoring system of social services. He found that social workers' fears about their autonomy can be allayed as they come to realise how their own effectiveness is enhanced and opportunities to obtain resources are improved.

The immediate availability of information on such indicators as caseload size, average cost and quarterly expenditure to the social services department from the feedback forms put the Community Care team at a distinct advantage compared to other team members when budgets were being allocated. It allowed projections of future expenditure to be readily estimated.

6 Innovations

Various types of innovation in Community Care were set up, particularly in the Sevenoaks and Tonbridge scheme, where the care manager was encouraged to spend time in implementing such arrangements. Most related to day care. Sometimes a user would visit a helper's home for part of the day. Thus, in one instance a cognitively impaired older lady in Sheppey was successfully integrated into a family with children. In another instance in Tonbridge two care managers arranged for three of their users to meet together for one day each week in the home of one of the users. Great care was taken in selecting them and they became good friends. These day care arrangements had been set up following discussions at a monthly meeting of care managers about family placement schemes of the type set up in North Yorkshire for long-term care (Martin 1981) and in Leeds for short-term placements (Leeds City Council 1979).

In another extremely successful innovation, the Tonbridge scheme provided its own day care over the Christmas six day bank holiday period while the regular staff were on leave. This facility was used particularly for users who were depressed, lonely or not seeing their family over Christmas. Up to 12 users were present each day and a few visited daily. It required a substantial commitment from the scheme: the care manager or assistant had to be present every day, supported by a rota of helpers. A friendly family atmosphere was created and activities such as carol singing were arranged, meals being provided by the adjacent care home. One user who had been depressed and suicidal said that it was the best Christmas she had had for a long time. The outcome was that the value of extending the period over which the day centre operated was appreciated, and it was decided to open the

day centre on a regular basis on Saturdays, though this was implemented independently of the scheme.

Such innovations were frequently time-consuming for the care manager to set up and implement. In the context of post-reform community care, with high caseloads, opportunities for such activity seldom arise.

7 Terminating care

In the early stages of the Tonbridge scheme, when a proportion of inappropriate cases were taken on, these were normally closed once the immediate aims had been achieved, or through the withdrawal of the user. Apart from these cases, a substantial number remained in the scheme for many years. Often the same helpers would continue to visit throughout this time. They became very committed, and as the user deteriorated the care provided by the helpers was stepped up.

Death, either at home or after a brief hospital admission, was the most frequent cause of closure during the evaluation year. Thus in Sheppey 38 per cent of matched cases were closed during the first year of which 42 per cent died, while in Tonbridge 25 per cent of matched cases were closed of which 52 per cent died. This confirmed that the principle of the scheme of allowing users to stay on for longer at home and, where possible, to die at home was being substantially upheld. However, it was found that a level of dependency could be reached beyond which the scheme could not cope, and that case closure might then become inevitable. This sometimes occurred if the user became in need of constant or very frequent attention requiring extensive nursing care. This was particularly the case when long-term night sitting by helpers was required since it could not usually be provided. Acute illness sometimes required a hospital admission, though in such instances a case was normally kept open to await the user's discharge home. However, there were other physical illnesses for which a hospital admission was not essential, and Community Care could cope by providing support at home. In extreme cases of mental illness or dementia, where there was a severe risk to the user or others, an admission to hospital was sometimes appropriate, even if this required a compulsory admission under the Mental Health Act. Indeed apart from death, dementia was one of the most frequent causes of termination of care, at a stage when the risks became too great. For all cases, a severe risk due to falling, burns or scalds might lead to case closure. Frequent aggressive or demanding behaviour towards helpers could be another reason for closure. Providing support in such cases could result in a rapid turnover of helpers due to the emotional demands placed on them. There was therefore a strong argument for terminating care and using these resources to support other cases less wastefully.

Closure was often precipitated as the result of a crisis and was more often unplanned than planned. For example, a user might have been admitted to hospital due to physical or mental illness or injury. Subsequently, a case conference held at the hospital might have recommended long-term hospital care. Central in the decision to terminate a case would be the user and any family, together with the GP and any community nurse, geriatrician or other agency involved, as well as the care manager and helper.

For cases which could no longer be maintained at home, the alternative was admission to long-term residential or hospital care, which would usually be viewed as a crisis measure by the older person. However, the admission rate to residential care was low, this amounting to 16 per cent of all matched cases during the evaluation year in Sheppey, and 8 per cent in Tonbridge. When residential care was envisaged, careful planning minimised

the disruption to the user. A lot of work was done in gradually easing in the user in the transition to admission. At the same time, the older person was assisted in coming to terms with their inability to cope at home. The user's feelings about residential care were explored to see whether it was a feasible option, and any difficulties talked through. The user was shown the establishment or placed there for short-term care or a trial period to assist in coming to a decision. The care manager liaised with the care home and provided the older person with information about it. If private homes were being considered, the user was provided with a list of registered homes. The care manager then showed the user around a few homes, but only made use of homes which were already known to be satisfactory at first hand. Finally, after admission, the care manager continued to visit to talk to the older person about their experience of having moved, help them come to terms with their loss of home and see whether they settled. The helper, who was by now often regarded as a good friend, frequently continued to visit, easing the transition to residential care. Paid visits were gradually phased out, though some helpers continued visiting on a voluntary basis. Only when the user was ready to accept a permanent place was the tenancy/ownership of their home given up and the case closed: typically some six weeks after entering long-term care, but later if appropriate.

8 Problematic cases

To illustrate a few of the most problematic cases which were provided with Community Care, to clarify both their level of need and the techniques employed by the care manager in responding to those needs, some case studies are included in Appendix 3.

9 Comparison with post-reform community care

Levels of weekly consumption of some key ingredients of care packages in Sheppey and Tonbridge have already been compared with nationally representative figures for 1995 drawn from the ECCEP study in section 4.3.2. The cases in this study were less disabled than in Sheppey and Tonbridge and received less day care, community nursing and care manager time, being a part of much bigger caseloads. While in Sheppey and Tonbridge detailed assessments could be justified by the flexible and wide-ranging response to need provided, the limited range and levels of resources found in the ECCEP study reduced the scope for responding to need. Perhaps the most critical difference is the much greater caseload size typical of the ECCEP study, preventing care managers from having the time to respond flexibly to need and provide sufficient direct help through such activities as enabling and counselling. The relatively small cost savings these larger caseloads allow can hardly justify this inferior response to need.

With the high caseloads typical of post-reform community care, assessment activity must be much more restricted. Indeed, in view of the rather limited range of services currently available, a wide-ranging assessment could hardly be justified. Re-assessment activity is also much more limited: in the ECCEP study, only 60 per cent of cases had received a formal review within a year of referral.

Care managers in Sheppey and Tonbridge also had much greater autonomy in spending their devolved budgets, allowing greater scope for innovation, than was normally the case in the ECCEP study, for which only 56 per cent had full authority to spend. In particular, when there were gaps in services available, care managers frequently had time to use their budgets creatively to fill these gaps, such as by training helpers to perform a task.

Another important difference is the absence of helpers from the ECCEP study. These helpers provided the Sheppey and Tonbridge schemes with a more flexible service and

better value for money. Thus, helpers could be available early morning or late evening to assist with rising and retiring, and visit at weekends. In contrast, post-reform home help visiting is normally restricted to office hours Monday to Friday, though independent sector provided home help can be available to a limited extent at other times. Helpers were normally matched to users, though the scope for this with home helps was very restricted. Helpers' contracts allowed them to adjust the length of visits according to the user's needs on a particular day, while home help visits were restricted to specified times. Nevertheless, home helps were better paid and had better conditions of service than Community Care helpers, although helpers had greater flexibility with regard to arranging user visits around other commitments of the helper during the day.

It is a matter of concern that post-reform community care is characterised by care managers with high caseloads who are frequently unable to respond flexibly to the needs of their users at the times that they most need help. Unlike the intensive care management schemes, services are normally not able to respond outside normal office hours, frequently leaving early mornings, late evenings, weekends and bank holidays uncovered (Bauld *et al* 2000). This is even the case for post-reform community care in Kent, suggesting that problems arose in the subsequent development of care-managed schemes. This issue is discussed further in section 4 of Chapter 11, though it is worth making a few observations at this stage regarding the Kent scheme:

- Following the transition from community care to home care, involving the merging of the community care scheme and home help service, senior management became much less involved, handing over responsibility to team managers with backgrounds mainly in the home help service. These team managers saw community care as being simply a service provided by helpers, and could not grasp the care management aspect of the work. The fact that the recently appointed Director of Social Services was not particularly sympathetic to social work values probably played a part in this.
- As a consequence vital aspects of the scheme were lost. These included the importance of maintaining low caseloads in order that the core tasks of care management could be achieved, the need to target resources at those users with greatest disability in order to maximise cost-effectiveness, the importance of spending direct time with users and carers in troubleshooting, counselling and reviewing need and with helpers in providing support and advice and the importance of responding flexibly at times when the user or carer most need help.
- The criterion for selecting a service should not just be that it is the cheapest available. By aiming instead to enhance the quality of life of user and carer, survival time in the community can be increased, with consequent cost savings.
- The small working group was so disenchanted when leadership of the group was handed over from a senior Kent manager to a team manager with a home help organiser perspective, that the group decided unanimously to disband, since it was found that any attempt to improve practice fell on deaf ears and was thwarted. In this way, an important means of maintaining good practice was lost.

Three important conclusions can be drawn from this:

- In order to maintain standards, it is vital that senior managers should be committed to the aims of care management and maintain involvement in running the scheme.
- Line managers should receive training in the principles of care management. They can then provide guidance where necessary to care managers.
- Senior management should encourage methods of maintaining good practice such as the activities of the small working group.

PART III: STATISTICAL OUTCOMES ANALYSIS

CHAPTER 7

OUTCOMES: THE WELFARE OF USERS AND CARERS

1 Outcomes in the context of production of welfare

The term *outcome* is a measure of improvement in some aspect of the subject's life, such as quality of care, depression or loneliness, due to the intervention. In this study these improvements were determined as the difference between the values obtained at time 1 and time 2, with deteriorations being treated as negative outcomes. The interpretation of outcomes can be achieved in different ways. A simple but limited approach is to make separate comparisons of the cost and welfare outcomes for the group of cases receiving Community Care with the corresponding values for the comparable ('matched') group receiving standard provision. This is the approach most frequently made not only in this country but in the international literature and is the first method adopted here.

A more subtle technique is to determine the costs to particular agencies of combinations of outcomes for persons in different circumstances in each of the two forms of provision, and to compare these results for the two groups of matched users.

The first approach was limited in that the outcomes achieved and costs incurred for each matched group were overall means for a particular mix of needs related circumstances[1]. This mix was assumed to be the same for each group as a result of the matching process. It is to be expected that the relative values of group means for costs and outcomes would be likely to vary depending on the overall level of need of the cases on which the scheme had been targeted. Both the needs related circumstances of populations and the resource levels and policies about targeting and service content vary both within different countries and between them. For instance, gross differences in the provision of institutional beds exist between Australia, Denmark, the Netherlands and some US states (to name a few high providers whose systems have been studied at first hand) and the UK (Davies and Challis 1986; Kraan *et al.* 1990). Also there is much international variation in community resource provision, such as between France, Scandinavian countries and England and Wales (Davies *et al.* 1990).

This in turn causes big differences in the range of disabilities and other dependency-generating characteristics of persons who are at high risk of being admitted to institutions for long-term care. Moreover, some of the variability within the UK of the needs related circumstances of cases acceptable for Community Care schemes may reflect differences in the supply of new cases rather than differences in targeting criteria.

The logic of the PSSRU argument on which the experiments were based made welfare outcomes and resource levels inseparable. The PSSRU's 'production of welfare' approach makes the assumption that, other things being equal and over some ranges of variation but not all, a larger deployment of resources permits an improvement in some welfare outcomes (Davies 1985). In the initial Thanet Community Care Project the aim was to support a group of cases at a lower average cost to the social services department than

[1] Needs related circumstances refer to the characteristics of users and their informal carers which were measured at time 1. These include items of the type included in Table 5.1 and were sometimes measured using a multi-point scale.

would have been the case under standard provision, when many would have been admitted to institutional care. In this way a greater number of cases were supported at the same overall cost than would have otherwise been possible. In subsequent replications of this project in different parts of Kent, aimed at the same broad clientele, both the average cost, the expenditure limit and the caseload size were based on what had worked in Thanet, just as Thanet became the place to which appointee care managers elsewhere went to see how things were done.

So the most powerful evaluative criterion is not that there is a cost advantage, or that there is an advantage in the welfare outcomes. It is that the costs of acceptable or desirable combinations of outcomes would be less. That criterion itself hides a multitude of complications beyond the scope of this study. Here the main results are reported.

To start with, a comparison of group means is presented in this chapter for 'destinational outcomes' (the location of users) after one year in section 2, for 'utilisation days outcomes' (the time spent over one year in these different types of location) in section 3, for welfare changes of various kinds during the period in section 4 and in Chapter 8 for costs to various agencies. Finally the relationships between costs and outcomes for each group were described in Chapter 9 for both the full evaluation year and for just the period spent at home.

2 Destinational outcomes

Sheppey

One of the aims of the Community Care Scheme was to prevent or delay an admission to institutional care when this was in the older person's best interests. The permanent locations of matched Community Care and comparison group cases after six months and one year are shown in Table 7.1. It can be seen that the scheme was successful in enabling a greater proportion of older people to remain at home. After one year 62 per cent of Community Care cases were still at home, compared to only 44 per cent of the comparison group, for whom more had ended up in residential care or hospital care, or had died. Nevertheless, this difference was insignificant at the 10 per cent level due to the rather small sample sizes and was rather less than that found for Thanet (Challis and Davies 1986; Davies and Challis 1986) and by Challis *et al.* (1990) in the Gateshead Social Care Scheme (Table 7.2). However the proportion admitted overall to institutional care in Sheppey was significantly smaller for Community Care cases. In both the Community Care and comparison groups almost twice as many cases died during the second half of the year as during the first half, though the death rate in Sheppey over the full year was only 57 per cent of that in the control area. This lowering of the death rate for Community Care cases was almost as big as in the Thanet Community Care Project (42 per cent) and the matter is pursued further later in this section.

Permanent locations at four-weekly intervals over the evaluation year are shown for Community Care and comparison cases in Figure 7.1. Destinations have been aggregated into four types: home, long-term residential care, long-term hospital care and death. A consistently greater proportion of Community Care cases remained at home over the year, although the difference was statistically insignificant except at the sixteen week stage, when it was significant at the 5 per cent level.

Table 7.1 Location of matched Sheppey cases after 6 months and 1 year

Location	After six months				After one year			
	Community care group		Comparison group		Community care group		Comparison group	
	N	%	N	%	N	%	N	%
Own home	26	81	23	72	20	62	14	44
Local authority residentl. care	4	13	2	6	5	16	4	13
Private residential care			2	6			3	9
Hospital care			2	6	1	3	2	6
Died	2	6	3	10	5	16	9	28
Moved away					1	3		
Total	32	100	32	100	32	100	32	100

Note:

1. Group differences at 6 months and 1 year for each locational outcome were insignificant at the ten per cent level, using a chi-squared test with continuity correction.

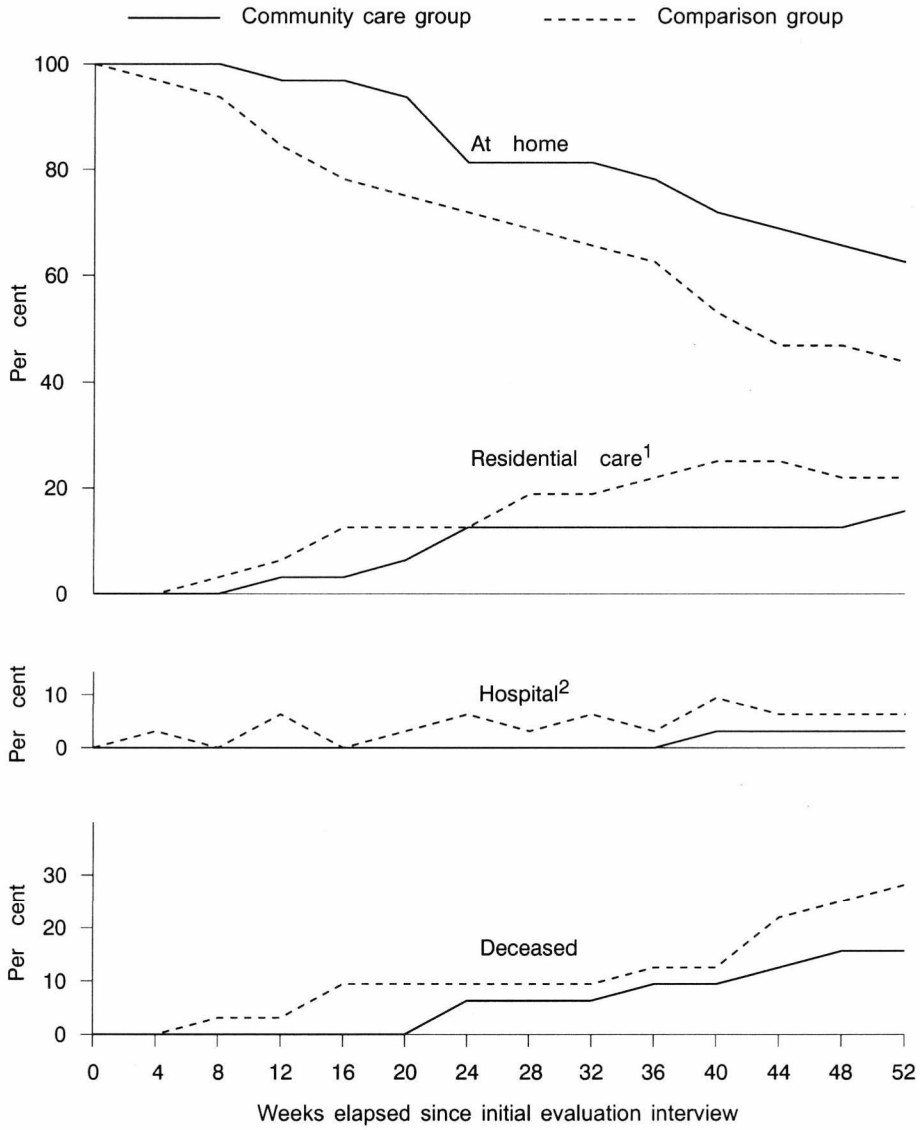
Table 7.2 A comparison of locational outcomes by matched group after one year for Sheppey, Tonbridge, Thanet and Gateshead Social Care

Location	Sheppey		Tonbridge		Thanet		Gateshead Social Care	
	CCS %	Control group %	CCS %	Control group %	CCS %	Control group %	CCS %	Control group %
Own home	62	44	75	60	69	34	63	36
Local authority residential care	16	13	4	9	4	22	1	37
Private residential care		9	4	9	8	5		2
Hospital care	3	6	4	9	4	5	7	4
Died	16	28	13	13	14	33	28	20
Moved away	3				1	1	1	1
	100	100	100	100	100	100	100	100
Sample size	32	32	23	23	74	74	90	90

It is clear that over practically the whole year there was a greater proportion of comparison cases both in long-term residential care and in long-term hospital care. Although the saving in consumer weeks for the scheme appears to be greater for residential care than for hospital care, the cost savings are more comparable in size, because of the higher cost of hospital beds relative to residential care beds.

At all times after the first eight weeks a greater proportion of deaths occurred amongst the comparison group. Indeed, during the first twenty weeks there were no deaths at all amongst Community Care cases. However, the difference in death rates never became statistically significant. This lowering of the death rate for Community Care cases adds some weight to the argument proposed regarding the Thanet Project that Community Care intervention can enable older people to live longer (Challis and Davies 1986; Davies and Challis 1986). Even so, some caution should be exercised in attributing the difference in attrition rates in Sheppey to the benefits of the Community Care approach.

Figure 7.1 'Permanent' residence for matched groups in Sheppey, at four-weekly intervals



Notes:

1. Local authority or private/voluntary long-term residential care
2. Long-term hospital care

Although it can be seen from Table A1.3 in Appendix 1 that there are no significant group differences in health characteristics at the time of the initial assessment, it is possible that some more subtle factors leading to death remained unmeasured. Nevertheless, there is evidence that admissions to institutional care may increase the likelihood of death (Yawney and Slover 1973). It has already been observed that the intervention of the Community Care Project in Thanet appeared to result in fewer deaths than would otherwise have been the case (Challis and Davies 1986; Davies and Challis 1986). However, amongst the matched Sheppey comparison cases entering long-term institutional care four out of thirteen (31 per cent) died, whilst of those remaining at home five out of nineteen (26 per cent) died at home or in acute hospital care. Thus, death did not appear to

be a significantly more likely outcome for cases admitted to long-term institutional care. The four deaths in institutional care occurred 6 weeks, 12 weeks, 14 weeks and 25 weeks after admission. Although the admission could have contributed to the early death, it is also likely that the admissions were in part a result of deteriorating health.

Another way in which Community Care may have reduced the number of deaths was in allowing some health problems to be detected at an early stage, followed by negotiations between the Care Manager and the health service to help mobilise the resources required. Of the six cases in the Sheppey group admitted to long-term institutional care, none died. Out of the remaining 26 cases who stayed at home, three died at home and two died in acute hospital shortly after admission. Thus all the matched Sheppey cases who died were enabled to do so at home or after a brief spell in hospital. This result was also evident both in the Thanet and in the Gateshead Social Care Schemes (Challis and Davies 1986; Davies and Challis 1986; Challis *et al.* 1990). In contrast, only one comparison case died at home, and all four cases who died in acute hospital care did so at least two weeks after admission, with a further four cases dying in long-term institutional care.

Seen in the context of existing health authority support for older people in Sheppey, the low death rate amongst Sheppey Community Care cases was a considerable achievement. The care manager found that, out of nineteen GPs in the area, she could only talk to five of these and only two were really understanding. Their general view was that Community Care cases should be in residential care, and 'how dare anyone contradict me'. This attitude can partly be attributed to their high workloads. When a Community Care case was ill it was sometimes difficult to get the GP to visit and in extreme cases the care manager would have to take matters into her own hands by telephoning for an ambulance.

The local geriatrician had a history of poor cooperation with social services and was under pressure to off-load hospital in-patients to the social services department. At the same time, he tended to resist severely disabled users returning to the community but encouraged a move to residential care. The care manager gradually built up some cooperation with the geriatrician and by sometimes being willing to accept home cases prematurely when beds were in particularly short supply, the geriatrician in return was more willing to accept Community Care cases into hospital when necessary.

There was evidence that cases of non-severe illness were often better coped with at home with extra support from the scheme. Although the care manager successfully negotiated for a bed in the local hospital to be earmarked for use by Community Care cases, this was only used for emergencies. It was found that its use for respite care in providing relief for informal carers could be counter-productive, through users becoming more dependent. It could then take several weeks to retrain the user.

Relationships with community nurses became very good, particularly after the team had moved to an office on Sheppey which allowed more frequent informal chats about cases, though this move would have been too late to have influenced these results. Although there was pressure from the nurses to unload some tasks to the scheme, they were willing to become involved with the more difficult nursing cases.

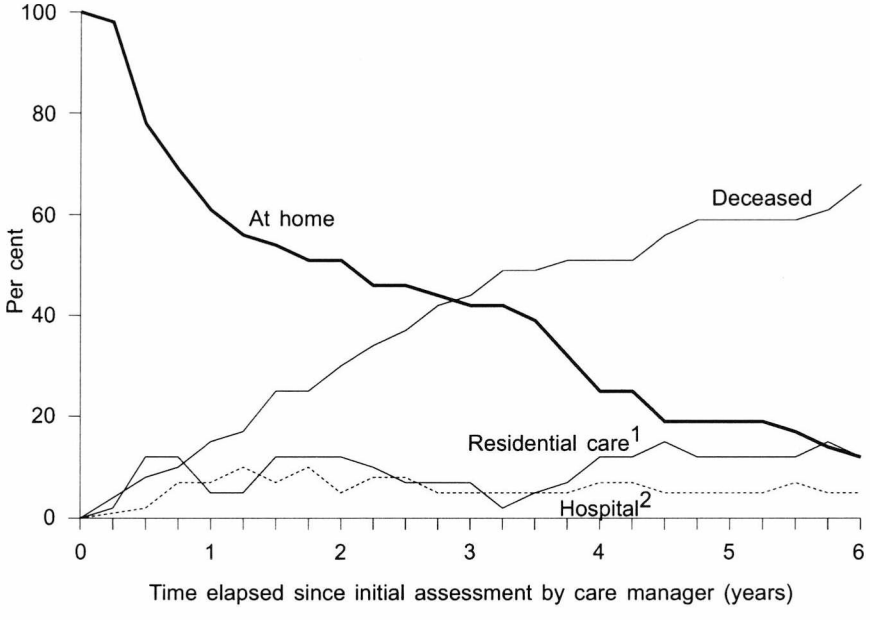
A third factor which could have reduced the mortality rate of the Community Care group was the enhanced feeling of security and well-being experienced. Thus the older person's felt capacity to cope increased significantly more over the evaluation year than in the

comparison group, as shown in Section 4.1. Moreover, just one person, the care manager, was in overall charge of co-ordinating care and users were encouraged to play a central role in decision-making. Consequently they were less likely to 'give up' or lose their will to live.

This evidence, backed up by the results from Thanet, makes it likely that at least some, if not all, of the difference in mortality rates could be attributed to Community Care intervention.

The location of all 41 Community Care cases evaluated is shown over a six year period in Figure 7.2. It can be seen that the first year only represented 'the tip of the iceberg' with respect to the overall input of the scheme, involvement in terms of user years being represented by the area under the graph of those remaining at home. Corresponding figures are given in Table 7.3. Over 50 per cent of the cases were still in the scheme after two years. Indeed, almost 40 per cent of cases were still being supported after three and a half years. Even after six years, 12 per cent still remained.

Figure 7.2 Locational outcomes for Sheppey Community Care cases over six years



Notes:
1. Local authority or private/voluntary long-term residential care
2. Long-term hospital care

The proportion of cases in long-term residential care remained fairly steady at between 8 per cent and 15 per cent after building up during the first six months, though with a dip to 2 per cent after three years. Although this may be a spurious effect due to the small sample size, it may alternatively suggest the presence of two groups of cases, those admitted to residential care during the first year of the scheme, and those admitted during the fourth and subsequent years. Long-term geriatric hospital care shows a similar pattern, but with a lower ambient level of between 5 per cent and 10 per cent. On comparing the initial group characteristics of those cases admitted to long-term institutional care during the first three

years (13 cases) with those admitted in the fourth, fifth and sixth years (6 cases) it was found that the second group were significantly less needy in a number of respects. The main differences were in connection with rising and retiring: getting into bed ($p = .06$), getting out of bed ($p = .04$), dressing ($p = .05$), and the need for extra help at time of rising and retiring ($p = .06$). Thus, of those cases entering institutional care, those who could manage better at the initial assessment at times of rising and retiring were more likely to be admitted during the fourth, fifth and sixth years. In this latter group of six cases, the initial assessment showed that two were deteriorating mentally and at risk. One suffered from painful arthritis, tinnitus and extreme loneliness. Another two lonely users had poor sight which, coupled with a proneness to dizzy spells, rendered them at risk of falling. The remaining case had recently broken her hip. This generally at risk group were able to benefit from Community Care for at least three years before being admitted to institutional care.

The proportion of cases having died increased fairly smoothly with time. After six years it can be seen that, out of the 29 per cent of cases that were still alive, and had not moved away, 12 per cent were at home in the scheme, 12 per cent were in a local authority residential home, and 5 per cent were in long-term geriatric hospital; i.e. 42 per cent of those surviving in the area were still in the scheme.

The first permanent location after closure of the Sheppey Community Care scheme cases is shown in Table 7.4, taken over the six year period. It can be seen that one quarter were admitted to local authority residential care, and half this proportion to long stay geriatric hospital. Over one quarter were enabled to die at home, with a further 10 per cent dying following a short period in acute hospital. The scheme therefore went some way towards allowing its users, wherever possible, to die at home or after a brief period in hospital. However, this still left quite a high proportion (46 per cent) who ended up in permanent institutional care.

Table 7.3 Survival rate at home in the scheme over six years for Sheppey and Tonbridge community care cases

Period elapsed	Proportion of cases remaining in scheme (%)				
	Sheppey		Tonbridge		
	Evaluated cases		Evaluated cases		All monitored cases
	Matched	Unmatched	Matched	Unmatched	
6 months	81	78	83[1]	82[1]	75
1 year	63	61	70[1]	61[1]	52
2 years	50	51	52	45	31
3 years	38	41	17	15	14
4 years	19	24	13	12	10
5 years	16	19	13	12	7
6 years	6	12	9	9	4
Sample size	32	41	23	33	110

Note:

1. Figure smaller than that for locational outcome of home after 6months and 1 year, since cases still at home who had withdrawn from the scheme were excluded.

Table 7.4 Permanent location after closure of Sheppey and Tonbridge evaluated cases and monitored Tonbridge cases over a period of 6 years after the initial assessment

	Sheppey All evaluated cases %	Tonbridge All evaluated cases %	Tonbridge All monitored cases %
At home without community care		9	15
Local authority care home			
category 2	25	12	9
category 3 (emi)[1]		3	6
Private/voluntary care home		9	7
Private nursing home	2	9	6
Long-stay geriatric hospital	12		7
Long-stay psychiatric hospital	7	6	6
Died[2]			
at home	27	27	20
local authority care home, category 3 (emi)			1
local authority nursing home			2
acute hospital	10	9	10
geriatric hospital		6	6
psychiatric hospital			1
Moved away from area	5		
Still in scheme after six years	12	9	4
Total	100	100	100
Sample size	41	33	110

Notes:

1. emi: elderly mentally infirm
2. To be classed as having died, death occurred within 3 months of closure

In order to shed light on whether mortality amongst the Sheppey programme group had been reduced as a consequence of the improved level of well-being resulting from care managed intervention, tests were carried out to see whether cases with higher improvements in morale or felt capacity to cope were less likely to die at some future time. In what follows, attention was restricted to those cases who were still alive, in the area and at home or in residential care after one year, for whom such improvements had been measured. First, each improvement was predicted in terms of the characteristics of cases at the initial assessment, using multiple regression analysis. Secondly, an attempt was made to predict death during the two and a half years following the second interview in terms of both the initial characteristics and the two improvement measures, using the method of logit analysis (Hosmer and Lemeshow 1989). This attempt was repeated to predict death during the five years following the second interview. It was found that neither improvement in morale nor in felt capacity to cope were significant in predicting a reduction in mortality. This suggests that the greater improvement in morale and felt capacity to cope experienced by the Community Care group as compared with the comparison group did not contribute to the reduced mortality of the former.

The locations of the Sheppey Community Care cases over the first four years were compared with those of the matched Community Care cases for the Thanet Community Care scheme (Chesterman *et al.* 1988). It was found that the cases in each scheme were distributed between locations over time in a very similar manner. In particular, the respective percentages remaining at home in Thanet and Sheppey were 69 and 61 after 1 year, 50 and 51 after 2 years, 35 and 41 after three years and 23 and 24 after 4 years. The

main difference was a greater use of private residential care in Thanet as a substitute for local authority residential care, and a greater use of private nursing homes as a substitute for long-stay hospital care. This difference is to be expected in view of the extensive supply of private sector homes in Thanet, compared with their virtual absence from Sheppey.

Tonbridge

The permanent locations of matched Community Care and comparison cases after six months and one year are shown in Table 7.5. It can be seen that 75 per cent of cases who received Community Care support were still at home after one year compared to only 60 per cent of the comparison group, so the scheme was being successful in allowing more cases to stay at home. However the difference was not quite as great as that found in Sheppey, and was again statistically insignificant. Also, the numbers staying at home in both groups were substantially greater than in Sheppey. By allowing more cases to stay at home than in the comparison group, the scheme had reduced the number of cases entering institutional care. After one year only 12 per cent of Community Care cases had entered long-term institutional care compared with 27 per cent of the comparison group. However the Community Care group was not associated with a reduced death rate as had been the case in Sheppey, the proportion having died after one year amounting to 13 per cent in each group. This was considerably less than the proportion of Sheppey comparison cases having died (28 per cent).

Table 7.5 Location of matched Tonbridge cases after 6 months and 1 year

Location	After six months				After one year			
	Community care group		Comparison group		Community care group		Comparison group	
	N	%	N	%	N	%	N	%
Own home	22	96	19	83	17	75	14	60
Local authority residentl. care					1	4	2	9
Private residential care			1	4	1	4	2	9
Hospital care			1	4	1	4	2	9
Died	1	4	2	9	3	13	3	13
Total	23	100	23	100	23	100	23	100

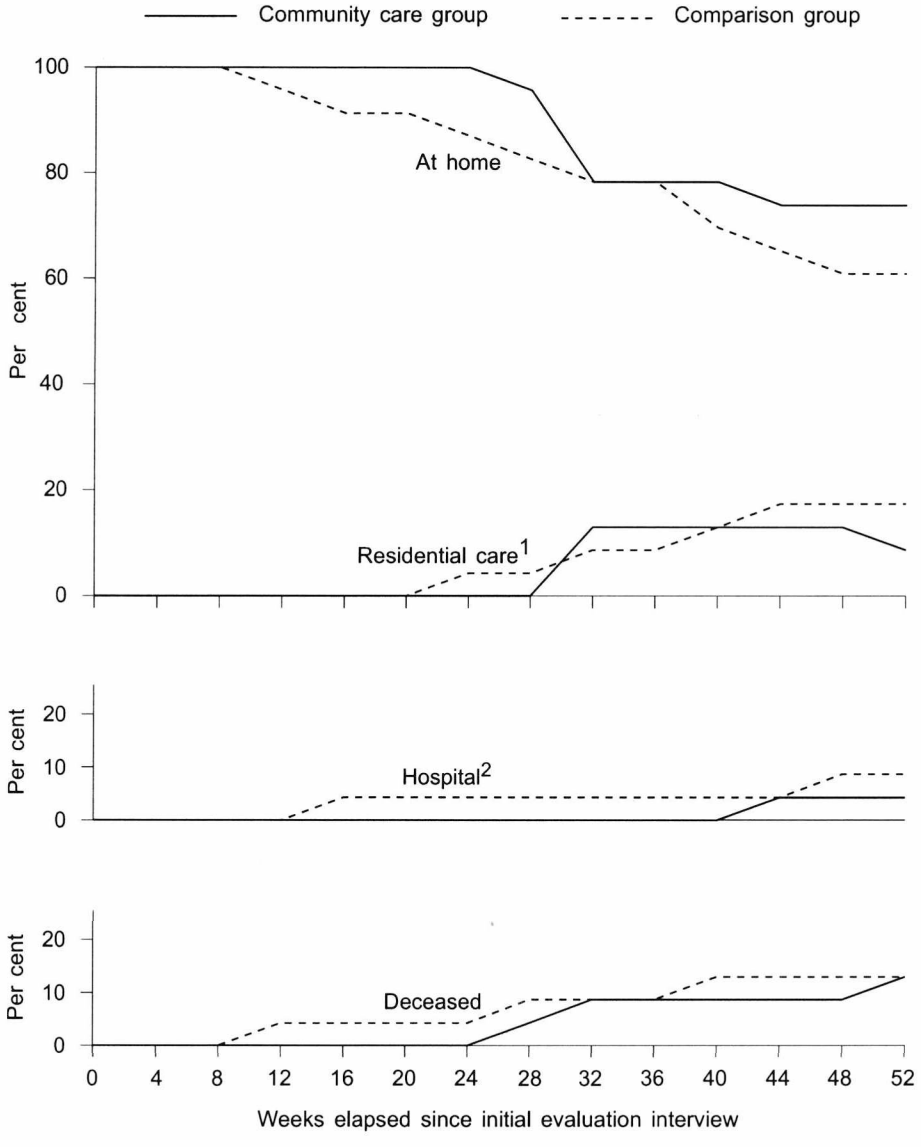
Note:

1. Group differences at 6 months and 1 year for each locational outcome were insignificant at the ten per cent level, using a chi-squared test with continuity correction.

There was no evidence from the initial characteristics of cases to suggest that the Tonbridge control cases were significantly less needy than the Sheppey control cases. Moreover Table A1.4 in Appendix 1 provides no evidence that the availability of health resources was significantly less amongst comparison cases in Tonbridge than in Faversham. The greater proportion of matched control cases with a principal informal carer in Tonbridge (48 per cent) than in Faversham (28 per cent) could have reduced the numbers that died. Thus Anderson *et al.* (1998) have shown that living with others, which is highly correlated with having a principal informal carer, can reduce mortality amongst older people. Also, Tonbridge control cases could have been less prone to death as a result of their greater consumption of day care. Thus over half of the matched Tonbridge control cases received day care. About one third received an average of at least one day of day

care per week, and about one fifth an average of at least two days day care per week. As well as providing warmth and a nutritious meal, any deterioration which might require intervention would normally be identified by staff and a referral made to a suitable agency when appropriate. All these features could reduce the death rate.

Figure 7.3 'Permanent residence for matched groups in Tonbridge, at four-weekly intervals



Notes:

1. Local authority or private/voluntary long-term residential care
2. Long-term hospital care

The locational outcomes for matched groups at four-weekly intervals during the evaluation year are shown in Figure 7.3. For most of the time the Community Care group had a greater proportion of cases remaining at home. Indeed, during the first 24 weeks all Community Care cases were maintained at home. However, the difference was not as great as that found in Sheppey. Moreover, the proportions of cases entering long-term

residential care and long-term hospital care were for most of the time greater for the comparison group but the difference was again smaller than in Sheppey. Although death rates by the end of the evaluation year were equal, the graphs suggest that Community Care was successful in delaying admissions to long-term institutional care and perhaps even death until later in the evaluation year. Of the three Community Care cases who died within the year, one died at home and another on the same day that he was admitted to acute hospital from home. The third had died in a long-term private nursing home. This admission had been necessary after the relatives living with and supporting the older person had moved with him to an area with no Community Care and had no longer been able to cope. Thus, when Community Care was available, the experimental cases who died were enabled to do so at home.

Although GPs in Tonbridge were sometimes uncooperative, they were generally much easier to work with than in Sheppey. If the care manager felt that a geriatric assessment was appropriate but the GP resisted the idea, a supportive local community physician could sometimes visit ostensibly to assess for an admission to hospital under the National Assistance Act but in practice to provide a geriatric assessment, hence bypassing the need for the GP's cooperation.

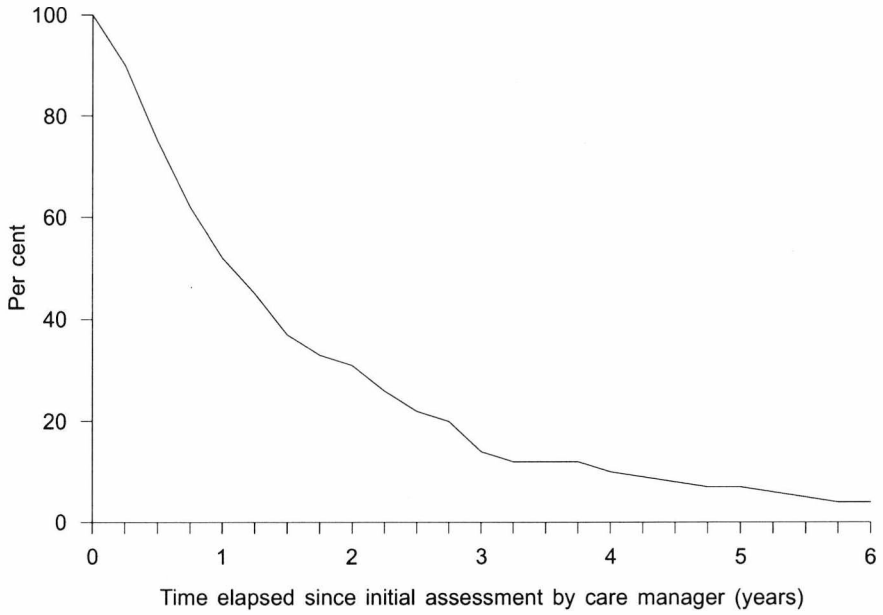
In the case of Mrs E (subject of a case study in Appendix 3, section 2.4) the user suffered from senile dementia and double incontinence and lived alone. Following a rapid deterioration both physically and mentally, no local authority residential home would take her. The GP felt she had only six weeks to live and the case was referred to CCS. At the initial assessment the care manager found Mrs E to be suffering from a chest infection and had become bedfast. The care manager recognised the importance of having the chest infection treated, as this could have been contributing to her cognitively impaired state. Following her mental deterioration Mrs E had been unable to remember fairly basic tasks like eating. This situation was exacerbated by the son and daughter-in-law, Mr and Mrs F, who lived locally, disagreeing over the type of care required and never leaving sufficient food in the house. Through persuading Mrs E and Mr and Mrs F to accept relief visits from helpers some mornings, her diet could be controlled more readily. During the following three months her chest infection cleared up and later she became less cognitively impaired and started making herself a cup of tea. However, by the time she had been supported by the scheme for eight months, her physical health began to deteriorate through suspected kidney failure. CCS support was stepped up but two months later she was unable to remain at home and since the condition was incurable, she was admitted to long-term geriatric care.

It would appear likely that CCS intervention had allowed Mrs E to live longer and had postponed the need for long-term geriatric hospital.

All Tonbridge cases entering the Community Care scheme during the first three and a half years, including those which were not evaluated, were followed up over a six year period. With the assistance of the initial assessment forms and three monthly case reviews it was possible to determine how long different types of case were served by the scheme and the destination shortly after closure. However, as case reviews were not continued beyond closure, no information was available beyond this point. In this way 143 cases were investigated. Of these 33 were regarded as having received negligible Community Care involvement, leaving 110 cases. The 33 cases (23 per cent) reflected shortcomings both in the understanding of referring agencies as to what constituted a suitable referral and in the

screening process, undertaken directly by the care manager. Initially the assessment form material for evaluated and unevaluated cases was compared. This confirmed that the one in five sample of evaluated cases was essentially representative of the whole group. Although a range of indicators pointed to the evaluated sample being slightly less needy than the remainder, the differences were never significant at the 10 per cent level. It can be seen from Table 7.3 that the evaluated cases spent consistently longer in the scheme over the six year period and this effect was still stronger for those evaluated cases which were matched. This adds weight to the suspicion that evaluated cases may be slightly less needy and supports the finding that matched cases were a little less needy than unmatched.

Figure 7.4 Proportion of 110 Tonbridge cases remaining in the scheme over six years



The variation in the proportion of the total group remaining in the scheme over the six year period is illustrated graphically in Figure 7.4. When this is compared with the corresponding curve in Figure 7.2 for Sheppey, the proportion remaining at home in Sheppey and hence in Thanet appeared much greater. This is partly because some Tonbridge cases continued to live at home after they had left the scheme; Tonbridge care managers were more willing to close cases (and subsequently reopen them if necessary). Also in Tonbridge the cases were rather more needy than in Sheppey. Firstly it has already been remarked that the Tonbridge monitoring system sample of 110 cases was slightly more needy than the unmatched evaluated Tonbridge Community Care group. Secondly this latter group was a little more needy than the unmatched Sheppey Community Care group; although the Tonbridge cases were two years younger, they had a larger ADL score and a much greater proportion were cognitively impaired than in Sheppey, a characteristic associated with a reduced length of stay at home. These differences arose largely through the Tonbridge scheme having taken on a substantial number of highly cognitively impaired referrals from the home help service with high ADL scores, together with a smaller number of referrals from hospital social workers, also with high ADL scores.

The permanent location of cases following closure for both the evaluated and total groups is shown in Table 7.4. Here further changes in permanent location are excluded. It can be

seen for the total group that about one case in seven remained at home without Community Care. Of those cases entering local authority residential care, 40 per cent were being admitted to specialist homes for the cognitively impaired. Just as the use of private or voluntary homes made up nearly one third of residential care consumption, so the use of private nursing homes constituted a similar proportion of the long-term care also found in geriatric and psychiatric hospitals. This reflected an increasing use of the private sector as a substitute for both local authority residential care and long-stay hospital care. In comparing locations for the evaluated group with those for Sheppey, although the total proportions entering long-term residential care for the two areas were similar, the Sheppey scheme did not have access to specialist local authority care homes for the cognitively impaired or significant access to private sector homes. Consequently the residential care offered to Sheppey cases was in ordinary local authority care homes.

The proportion of closed evaluated cases who died at or within three months of case closure was 42 per cent, similar to that for Sheppey (37 per cent). Of these, the proportion dying at home or within a week of admission to acute hospital care was 27 per cent for each scheme. Moreover, there were a further 39 per cent of evaluated cases ending up in long-term institutional care who were unlikely to return home. The success of the scheme in maintaining older people at home and allowing them to die at home was therefore, as in Sheppey, only partial. Nine per cent of Tonbridge cases were still in the scheme after six years, comparable to 12 per cent for Sheppey. Some of the Tonbridge cases who left the scheme but remained at home (9 per cent) may have survived at home for the six years.

Considering further the one case in every seven of the total group who remained at home after leaving the scheme, the reasons for closure are shown in Table 7.6. For nearly half of these cases, the aims of Community Care intervention had been achieved or partially achieved, and these will now be studied in more detail.

Table 7.6 Reason for closure for cases remaining at home without Community Care

	%
Aims achieved	31
Aims partially achieved	13
Aims cannot be effected	13
No longer of sufficient priority for community care	6
User withdrew	31
User left area	6
Total	100
Sample size	
applicable	16
non-applicable	94

Of the seven cases for which aims had been at least partly achieved, three ended up with their helper continuing to provide support but on a private basis. In one of these cases, a stroke victim, the male helper moved in with the user and his wife. In another, an agoraphobic and depressed man, the helper continued to visit informally as a friend. In the third case, a recent amputee, a friend had been paid as a helper to provide support, and this arrangement was later made private. In each case, the care manager had withdrawn once the period of crisis or rapid change was over, but was available to become reinvolved should the need arise. One case had been supported by the scheme during a period of

severe anxiety and depression following the death of her mother who had also been a Community Care user. The case was closed a year after her death, by which time the daughter had come to terms with her bereavement. In another case two separate bouts of confusion rendered an older lady in sheltered accommodation unable to cook her own meals. On each occasion, Community Care intervention, with its emphasis on encouraging independence, had restored the user's confidence and ability to prepare meals in a period of a few weeks and the helper was withdrawn some months later. The care manager continued to monitor the situation and eventually closed the case after one year eight months. The warden was available to alert the care manager should problems recur. The other two cases were an over-protective mother living with her ESN daughter who was also an older person. The mother was just out of hospital at the time of the initial assessment, and was unable to cope. The initial problem was that the daughter had only taken care of her mother under the mother's constant instruction, and was never allowed to touch anything apart from making a cup of tea under instruction. A helper was introduced who encouraged the daughter to become more independent and take on more responsibility for the care of her mother, while encouraging the mother to allow her daughter to become more independent. The mother gained in confidence and ability to care for herself. The scheme was able to reduce its involvement though it increased it again when the users were being rehoused, due to the extra strain which this involved. Finally, the care manager was able to withdraw completely one year after rehousing.

Of the other older people staying at home without Community Care, the case of insufficient priority was of a woman who had been supported during the period following the admission of her husband, who had previously been in the scheme, to long-term psychiatric care, until she was able to cope again on her own. The remaining seven cases appeared to indicate a degree of failure of the scheme's intervention, either because its aims could not be effected, or because the older person decided to withdraw. These 7 cases may be added to the 33 already eliminated from the sample, through having received negligible care management input, to give a total of 40 unsuitable cases out of 143, or 28 per cent. This high failure rate is likely to be largely a result of the care managers undertaking the screening of all new cases entering the scheme without assistance from the area team, at a time when agencies were still learning what types of case made suitable referrals. In Sheppey there were no instances of cases leaving the scheme and remaining at home. The assistance of the area team in the screening of referrals eliminated any which were unsuitable. Also the Tonbridge care managers showed a willingness to occasionally leave helpers to continue supporting cases outside the scheme, though were available to become reinvolved if necessary.

Table 7.7 Location of survivors after one year by group and scheme for users living alone at time 1.

	Number alive and not moved away[1]			
	Sheppey		Tonbridge	
	E	C	E	C
At home	18	10	11	9
Moved into sheltered housing with warden	0	2	0	0
Moved into residential/nursing home	5	7	1	2
Moved into long-term hospital	0	2	1	0
Sample size	23	21	13	11

Note:

1. E: experimental (Community Care) group C: control (comparison) group

2.1. Predicting institutional care

Selecting matched experimental and control groups in combination, the permanent location of each case at the end of the evaluation year was determined, for cases who were initially living alone. This location was represented on a 4 point scale arranged in a hierarchy:

0 Remaining at home or in sheltered accommodation with warden.
1 Moving to sheltered accommodation with warden.
2 Moving to long-term residential care.
3 Moving to hospital care.

Cases who died or moved away were excluded, since these outcomes were likely to have been caused mainly by *exogenous* factors; namely factors which were not affected by quasi-inputs or inputs, but were external influences to the production of welfare model.

The numbers of cases in each location at the end of one year are shown in Table 7.7. Analyses were now undertaken to determine the factors which might predict this location, using polychotomous ordered probit (Finney 1971). The pool of predictor variables used covered health and dependency, social support, personality and attitude to help, initial level of well-being, initial health status, other user factors and effects on the informal carer. Experimental/control group memberships and some interaction terms between this and other selected variables in the pool were also included. The sample of Sheppey cases (44) was sufficiently great for this area to be analysed separately. However, because the Tonbridge sample (24) was small, differences between Sheppey and Tonbridge were determined by combining cases from the two areas and investigating whether locational outcome was dependent upon area.

Sheppey

The results of a polychotomous ordered probit analysis of the factors predicting locational outcome for cases living alone are shown in Table 7.8. It can be seen that both physical and mental functioning could influence moves to institutional care, as represented by arthritis and cognitive impairment. Also, just as attitude to help could influence the degree to which an older person would accept help at home, so also it affected propensity to enter institutional care, with users who were independent, requiring persuasion, being less willing to leave home. Men were more likely to be admitted to institutional care that women. This may reflect the different roles undertaken in the past by married couples, with the wife being more accustomed to dealing with housework. Following the death of a spouse, a woman would then be better able to cope than a man. Finally, care managed Community Care was successful in reducing the likelihood of an admission to institutional care.

Table 7.8 Factors predicting the movement during the first year of older people living alone at home[1] to different types of institution[2] in Sheppey

Variable type	Variable	Coefficient	Significance level, p
Health and dependency	Arthritis	1.05	.07
	Cognitive impairment	.877	.05
Personality and attitude to help	Independent - requires persuasion	-1.30	<.05
Other user factors	Whether female		
	Whether receiving community care	-2.98	.01
	Constant	-1.72	<.01
		1.88	.05

Equation: Chi-squared = 29.9
Significance level <.001
Percentage correct predictions = 80%

The value, z, predicted by this equation corresponded to a locational outcome of

0 for $z \leq \mu_0$
1 for $\mu_0 < z \leq \mu_1$
2 for $\mu_1 < z \leq \mu_2$
3 for $\mu_2 < z \leq \mu_3$

μ_0 was normalised to 0.

The method of maximum likelihood was used with a log-likelihood function.
It was estimated that:

$\mu_1 = .22$ significance level, p = .25
$\mu_2 = 2.62$ significance level, p = .01
μ_3 was not estimable.

Notes:

1 Matched groups were combined in the analysis, though the ten cases who died or moved away during the evaluation year were excluded from the analysis, leaving a sample of 44 cases.

2 Locational outcomes:

0	Remained at home.
1	Moved to sheltered housing with warden.
2	Entered long-term residential care.
3	Entered long-term hospital care.

The probability of each of the 4 categories of locational outcome resulting for different types of case was estimated by polychotomous ordered probit, using the computer package LIMDEP, version 6.0.

Comparing Sheppey and Tonbridge

The results of a similar analysis for Sheppey and Tonbridge cases combined are shown in Table 7.9. This time the pool of predictors included the additional variable 'area' (Sheppey or Tonbridge) and some interaction terms between this and other selected variables in the pool.

Table 7.9 Factors predicting the movement during the first year of older people living alone at home[1] to different types of institution[2] in Sheppey and Tonbridge combined

Variable type	Variable	Coefficient	Significance level, p
Health and dependency	Incontinence of urine	.784	<.05
	Confusion/disorientation	.309	<.05
Personality and attitude to help	Accepting attitude to help	.770	.06
	Feels life run too much by others in Tonbridge	1.216	.06
Other user factors	Whether receiving community care	-.865	<.05
	Constant	1.732	NS[3]

Equation: Chi-squared = 26.3
Significance level <.001
Percentage correct predictions = 81%

The value, z, predicted by this equation corresponded to a locational outcome of
0 for $z \leq \mu_0$
1 for $\mu_0 < z \leq \mu_1$
2 for $\mu_1 < z \leq \mu_2$
3 for $\mu_2 < z \leq \mu_3$
μ_0 was normalised to 0

The method of maximum likelihood was used with a log-likelihood function.
It was estimated that:

$\mu_1 = .12$ significance level, p = .16
$\mu_2 = 1.78$ significance level, p < .001
μ_3 was not estimable.

Notes:

1. Matched groups were combined in the analysis, though the twelve cases who died or moved away during the evaluation year were excluded from the analysis, leaving a sample of 68 cases.
2. Locational outcomes:

0	Remained at home.
1	Moved to sheltered housing with warden.
2	Entered long-term residential care.
3	Entered long-term hospital care.

The probability of each of the 4 categories of locational outcome for different types of case was estimated by polychotomous ordered probit, using the computer package LIMDEP, version 6.0.

3. NS: Not significant.

Table 7.10 Time distribution between different types of location over the evaluation year for matched groups in Sheppey

Location	Days in different types of location utilised over the evaluation year		
	Community Care[1]	Comparison group	Significance level, p[2,3]
Home	291.8	229.5	<.05
Local authority residential home	32.7	46.7	NS
Private residential or nursing home	0.0	20.9	.06
Acute hospital care	10.1	14.1	NS
Long-stay geriatric hospital care	4.0	9.4	NS
Psychiatric hospital care	1.3	12.3	.08
Aggregated time spent in institutional care			
Local authority or private residential/nursing home	32.7	67.6	NS
Hospital care	15.4	35.8	<.05
Residential or hospital care	48.1	103.3	<.05
Sample size	32	32	

Notes:

1. All community care cases were supported by the scheme throughout the period at home.
2. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. An analysis of variance could then be used in determining significance levels.
3. NS: Not significant.

As in Sheppey alone, both a physical and a mental aspect of functioning entered the equation, though for the combined areas it was incontinence of urine and cognitive impairment/disorientation which were predictors of institutionalisation. Also cases with an accepting attitude to help were less likely to resist admission. Once again, Community Care successfully reduced the likelihood of an admission. The only area difference to enter the equation was that older people who felt that their life at home was run too much by others were more likely to enter institutional care in Tonbridge only. This area difference may reflect the more frequent involvement of informal carers in Tonbridge.

Thus the evidence shows that Community Care in both areas significantly reduced the probability of an admission to institutional care.

3 Utilisation days outcomes

While destinational outcomes gave a 'snapshot' of the location of cases at particular stages in the evaluation period, such as one year after the initial interview, utilisation days outcomes provided the overall totals of days spent in different types of location over the evaluation year.

Table 7.11 Time distribution between different types of location over the evaluation year for matched groups in Tonbridge

Location	Days in different types of location utilised over the evaluation year		
	Community Care[1]	Comparison group	Significance level, p[2,3]
Home	315.3	271.6	0.11
Local authority residential home	9.2	13.8	NS
Private residential or nursing home	14.7	13.5	NS
Acute hospital care	2.3	22.1	<0.05
Long-stay geriatric hospital care	3.4	17.4	NS
Psychiatric hospital care	3.7	0.2	NS
Aggregated time spent in institutional care			
Local authority or private residential/nursing home	23.9	27.3	NS
Hospital care	9.4	39.8	0.07
Residential or hospital care	33.3	67.1	NS
Sample size	23	23	

Notes:

1. All community care cases were supported by the scheme throughout the period at home.
2. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. An analysis of variance could then be used in determining significant levels.
3. NS: Not significant.

Sheppey

The results for Sheppey, given in Table 7.10, correspond to the actual temporary locations each day, rather than to their permanent destinations; for example, if three weeks were spent in acute hospital while the permanent address was still the older person's home, then the location was counted as acute hospital, not home, over this period.[2] Older people in the scheme spent significantly longer at home, the difference amounting to 62 days. Most of the rest of the time was spent in residential care in both groups, this amounting to roughly twice as much for comparison cases as for Community Care cases. It included local authority homes together with private residential and nursing homes. The fact that no private residential care was consumed amongst the Community Care group was as much due to the virtual absence of private homes in Sheppey as to any policy differences between Community Care and standard provision. Community Care cases consumed less of all three types of hospital care. The contrast was particularly marked in the case of psychiatric hospital care, the difference of eleven days being almost statistically significant ($p = .08$). When all types of hospital care are included together, the difference of twenty days is significant at the 5 per cent level, as is the overall difference in consumption of residential and hospital care combined of 55 days.

Tonbridge

[2] Significance levels were obtained using an analysis of variance, which assumes independently selected cases. Although the groups consisted of matched pairs which will therefore not be entirely independent, the matching was only carried out using seven criteria, the majority of features being matched, where possible, on a group basis. The reduction in the strength of significance levels which would result from the halving in the number of degree of freedom for perfectly matched pairs (Blalock, 1960, pp 179-180) was therefore assumed not to apply. This assumption is implicit in all analyses of variance by matched group which follow.

Comparison of Table 7.11 for Tonbridge with Table 7.10 for Sheppey confirms the finding that cases in both the Community Care and comparison groups spent more days at home in Tonbridge than in Sheppey. Once again, the Community Care group in Tonbridge spent longer at home than the comparison group, though this time the difference was not statistically significant ($p = .11$). Although the consumption of residential care was almost as much for Community Care as for comparison cases, far less time was spent in hospital by the Community Care group, this difference of 30 days being almost significant at the 5 per cent level ($p = .07$). Overall, Community Care cases spent less than half as long in institutional care as the comparison group, though this difference was not of statistical significance.

Thus, Community Care in both Sheppey and Tonbridge was apparently reducing the number of days spent in both acute and long-term hospital care by some three to four weeks overall during the evaluation year, and this is the main factor in the shift of financial responsibility from the NHS to the SSD for these cases. Considering now the effects of an admission to residential care on the quality of care received, it was unsurprising that the need for extra help was reduced, this effect being statistically significant with regard to help needed at times of rising and retiring and particularly help with weekly household care. The reliability, effectiveness and sufficiency of this help were also significantly improved following admission. However, those in residential care were able to go out or make social visits significantly less frequently than those remaining at home.

4 Quality of life, quality of care and health status outcomes

Because users and their carers had been given an assessment interview both at the beginning of the evaluation period and, where feasible, a year later, it was possible to measure the improvements or deteriorations, referred to as outcomes, on a range of indicators of quality of life, quality of care and health status. This offered a means of comparing the benefits for users receiving the Community Care Scheme with those in the comparison group. Because some of these changes were a consequence of entry to residential care, results were broken down according to final location as well as by experimental/control group.[3]

4.1 Quality of life outcomes

Social and emotional needs outcomes of users are shown in Table 7.12. These are all measures of change in the quality of life of users as indicated by their mental well-being. It can be seen that cases receiving Community Care were significantly better off both in their felt capacity to cope, and through reductions in anxiety, depressed mood and Wakefield

[3] Group differences were measured using a two-way analysis of variance, firstly according to differences in outcomes by group (experimental or control), secondly differences by location after one year (home or institutional care) and thirdly, by interaction effects. The latter were the differences remaining which could not be accounted for when the separate effects of both group and location had been subtracted out. They resulted from the influence of one effect on the other. Where interaction effects were insignificant or of only moderate significance in comparison with the main effects, the approach of Applebaum and Cramer (1974) was adopted in assuming that these interaction effects were entirely absent and that all group differences resulted from main effects. Where interaction effects were highly significant, the individual tests by group and by location were ignored. Instead, the nature of the interaction effect was studied by examining the relative sizes of outputs in the four cells corresponding to the four possible combinations of the two group effects. Because attrition led to the matched groups becoming unmatched when outcomes were measured, it was decided instead to analyse results for unmatched groups. Covariate tests were then applied to determine whether a correction for group differences at time 1 as given by the needs related circumstances listed in Tables A1.3 (Sheppey) and A1.6 (Tonbridge) would affect significance levels.

depression score (Snaith *et al.* 1971). Although there was a greater improvement in morale, as measured by the PGC scale (Lawton 1975), for the experimental group, this was not sufficient to be statistically significant (p = .18, 2-tail test). The other measures of quality of life shown did not indicate a significant improvement for cases receiving Community Care.

Table 7.12 Social and emotional needs outcomes in Sheppey

Variable		Mean change		Tests[1]	
		E	C	EvC	HvR
Felt capacity to cope*	Home	2.33	0.04	0.001	<0.001++
	OPH	6.83	5.00		
Anxiety+	Home	-0.46	0.21	0.001	NS
	OPH	-0.67	0.14		
Depressed mood+	Home	-0.63	0.07	<0.01	NS
	OPH	-0.33	-0.29		
Wakefield depression score+	Home	-3.35	-0.11	<0.05	NS
	OPH	-1.33	0.43		
Morale*	Home	1.48	0.37	0.18	NS
	OPH	1.25	0.29		
Overall dissatisfaction+	Home	-0.33	-0.07	NS	NS
	OPH	-0.33	-0.29		
Dissatisfaction with life development+	Home	-0.31	-0.34	NS	0.08
	OPH	0.33	0.36		
Loneliness+	Home	-0.42	-0.11	NS	NS
	OPH	-0.17	-0.14		
Boredom+	Home	-0.22	0.00	NS	0.06
	OPH	0.33	0.86		
Felt degree of privacy*	Home	-0.04	-0.04	NS	<0.01
	OPH	-0.50	-0.57		
Sample size	Home	24	28		
	OPH	6	7		

E Experimental group
C Control group
H Home
R Residential care

* Positive sign represents improvement
\+ Negative sign represents improvement
++ Cases in residential care improved more than those remaining at home

Note:
1. Significance levels were obtained using a two-way analysis of variance.

Entry to residential care resulted in a still stronger improvement in felt capacity to cope. However this was at the expense of enhanced boredom which was almost statistically significant (p = .06), as was an increase in dissatisfaction with life development (p = .08).

Table 7.13 Social and emotional needs outcomes in Tonbridge

Variable		Mean change		Tests[1,2]	
		E	C	EvC	HvR
Felt capacity to cope*	Home	1.05	-0.05	NS	<0.001++
	OPH	4.75	6.00		
Anxiety+	Home	-0.20	0.00	NS	NS
	OPH	0.00	0.00		
Depressed mood+	Home	-0.50	-0.05	0.06	NS
	OPH	0.00	0.00		
Wakefield depression score+	Home	0.40	-0.33	NS	NS
	OPH	0.00	0.67		
Morale*	Home	1.02	0.07	NS	NS
	OPH	0.33	-0.92		
Overall dissatisfaction+	Home	-0.13	-0.10	NS	<0.05
	OPH	-0.33	1.58		
Dissatisfaction with life development+	Home	-0.13	0.31	0.07	NS
	OPH	-0.33	0.42		
Loneliness+	Home	-0.55	0.00	0.11	<0.01
	OPH	-2.00	-1.17		
Boredom+	Home	-0.16	-0.05	NS	NS
	OPH	-0.50	-0.33		
Felt degree of privacy*	Home	0.00	0.05	NS	NS⊗
	OPH	0.67	-0.50		
Sample size	Home	20	21		
	OPH	4	6		

E Experimental group
C Control group
H Home
R Residential care

* Positive sign represents improvement
\+ Negative sign represents improvement
++ Cases in residential care improved more than those remaining at home
⊗ Strongly significant interaction effect (p<0.01)

Notes:
1. Significance levels were obtained using a two-way analysis of variance.
2. NS: Not significant.

Tonbridge

Social and emotional needs outcomes of the older people are shown in Table 7.13. With the exception of the Wakefield depression score, all the indicators showed the Community Care groups to improve relative to the comparison group, though none gave a significant result, partly a consequence of the relatively small sample sizes. In three cases statistical significance was almost reached: depressed mood ($p = .06$), dissatisfaction with life development ($p = .07$) and loneliness ($p = .11$).

However, admission to residential care did lead to some significant results despite the extremely small sample sizes. Older people in residential care felt much more able to cope given the extra support available. However their feeling of overall dissatisfaction had increased, although this effect was experienced by comparison group cases only. Also, those who had entered residential care were significantly less lonely. Group differences in feelings of privacy were dominated by a strong interaction effect. Although cases remaining at home in either group experienced little or no change in their feelings of privacy, cases entering a care home experienced improved privacy in the Community Care group but reduced privacy in the comparison group. This difference may at least in part result from the longer time spent by care managers in assisting the older person to select an appropriate residential home and in preparing them for the change.

4.2 Quality of care outcomes

Sheppey

Some of the reductions in need shortfall which brought about the quality of life benefits to the Community Care group are shown in Table 7.14. There was a significant reduction in need for extra help at times of rising and retiring, in personal care and in daily household care, and this was almost significant in weekly household care ($p = .08$). Because cases which had entered residential care were normally seen to receive an adequate amount of care in performing activities of daily living, it was unsurprising that their need for extra help at times of rising and retiring and in performing personal care tasks was significantly reduced. The reliability, effectiveness and sufficiency of the help provided and the reduction in need for extra services all improved significantly both for cases receiving Community Care and for those in residential care. It was the comparison group cases living at home that fared the worst in these respects. This result was particularly evident in the Gateshead Social Care Scheme (Challis *et al.* 1990).

The reduction in the number of severe life events within the past year was greater for Community Care cases though the result was not quite statistically significant ($p = .09$). Nevertheless it was probably a contributory factor to the reduction in depression experienced by this group. An association of this type has also been found for middle-aged women (Brown and Harris 1978) and may apply to older people too (Murphy 1982). However cases which had entered residential care suffered a significant increase in severe life events, one of which would have been the admission itself.

Despite the reduction in need for help with certain activities of daily living on entering residential care, the frequency with which residents went out or made social visits was significantly lower. This presumably contributed to the extra boredom which they experienced. The OARS rating of social resource impairment (Pfeiffer 1975), which also took into account the level of support received, showed a significant improvement for cases receiving Community Care.

Table 7.14 Care needs outcomes in Sheppey

Variable		Mean change		Tests[1,2]	
		E	C	EvC	HvR
Need for extra help am/pm+	Home	-0.67	0.29	<0.01⊗	<0.05++
	OPH	-4.33	0.14		
Need for extra help in personal care+	Home	-10.58	3.11	NS(<.05) **	<0.05++
	OPH	-17.83	-29.86		
Need for extra help in daily household care+	Home	-8.08	-0.07	<0.01	NS
	OPH	-12.17	-5.71		
Need for extra help in weekly household care+	Home	-7.04	-1.14	0.08	NS
	OPH	-7.00	-8.29		
Reliability of help*	Home	1.42	-0.54	<0.001	<0.01++
	OPH	4.83	0.86		
Effectiveness of help*	Home	1.50	-0.25	0.001	<0.01++
	OPH	4.00	1.00		
Sufficiency of help*	Home	3.46	-0.43	<0.01	<0.001++
	OPH	10.83	10.43		
Need of extra services+	Home	-1.38	0.18	<0.001	<0.01++
	OPH	-3.83	-1.00		
No. of severe life events within past year+	Home	-0.83	-0.25	0.09	<0.01
	OPH	0.50	0.14		
Going out/social visits per week*	Home	0.67	0.36	NS	<0.05
	OPH	-2.33	-1.00		
Social resource impairment (OARS)+	Home	-1.13	0.00	<0.001	NS
	OPH	-1.17	-0.43		
Sample size	Home	24	28		
	OPH	6	7		

E Experimental group
C Control group
H Home
R Residential care

* Positive sign represents improvement
\+ Negative sign represents improvement
++ Cases in residential care improved more than those remaining at home
⊗ Weakly significant interaction effect (.05>p>.01):ignored.
** The effect of including covariates to allow for group differences at the initial assessment is given in brackets.

Note:
1. Significance levels were obtained using a two-way analysis of variance.
2. NS: Not significant.

Tonbridge

Improvements in quality of care are shown in Table 7.15, and these do include some significant advantages for the Community Care group despite the small sample sizes. The need for extra help at times if rising and retiring and with daily and weekly household chores all became significantly reduced relative to the comparison group. Although the

extra reliability and effectiveness of help received by the Community Care group was no longer significant, the sufficiency of this help was significantly improved. Moreover, Community Care cases needed significantly fewer extra services. Social resources of the Community Care group also improved significantly.

Table 7.15 Care needs outcomes in Tonbridge

Variable		Mean change		Tests[1,2]	
		E	C	EvC	HvR
Need for extra help am/pm+	Home	-2.15	0.86	<0.001⊗	<0.05++
	OPH	-2.00	-2.00		
Need for extra help in personal care+	Home	-14.15	-4.86	0.12	NS
	OPH	-27.50	-8.00		
Need for extra help in daily household care+	Home	-7.30	0.71	<0.001	0.09
	OPH	-10.75	-4.00		
Need for extra help in weekly household care+	Home	-4.05	1.62	<0.05	<0.001⊗
	OPH	-8.25	-11.67		
Reliability of help*	Home	0.80	0.24	NS	<0.001++
	OPH	2.50	2.83		
Effectiveness of help*	Home	1.10	0.19	NS	0.01++
	OPH	2.50	2.50		
Sufficiency of help*	Home	3.65	-0.76	<0.001	<0.001++
	OPH	12.75	9.67		
Need of extra services+	Home	-1.25	-0.78	<0.05	NS
	OPH	-3.50	0.00		
No. of severe life events within past year+	Home	-0.25	0.00	NS	NS
	OPH	0.00	-0.50		
Going out/social visits per week*	Home	0.30	0.19	NS	<0.05
	OPH	-1.50	-1.33		
Social resource impairment (OARS)+	Home	-0.85	0.05	<0.001	0.11++
	OPH	-1.00	-0.50		
Sample size	Home	20	21		
	OPH	4	6		

E	Experimental group	*	Positive sign represents improvement
C	Control group	+	Negative sign represents improvement
H	Home	++	Cases in residential care improved more than those remaining at home
R	Residential care	⊗	Weakly significant interaction effect (.05>p>.01): ignored.

Note:

1. Significance levels were obtained using a two-way analysis of variance.
2. NS: Not significant.

Considering now the effects of an admission to residential care on the quality of care received, it was unsurprising that the need for extra help was reduced, this effect being

statistically significant with regard to help needed at times of rising and retiring and particularly help with weekly household care. The reliability, effectiveness and sufficiency of this help were also significantly improved following admission. However, those in residential care were able to go out or make social visits significantly less frequently than those remaining at home.

Table 7.16 Health needs outcomes in Sheppey

Variable		Mean change		Tests[1,2]	
		E	C	EvC	HvR
Adl score+	Home	0.29	0.57	NS	<.05
	OPH	1.33	1.29		
Adl impairment rating (OARS)+	Home	-0.13	0.18	0.10	.01
	OPH	0.50	0.43		
Isaacs & Neville disability index+	Home	0.13	0.14	NS	.08
	OPH	0.33	0.71		
Self-rated degree of ill-health+	Home	0.04	0.21	.12(.05)**	<.05++
	OPH	-0.67	0.00		
General health problem index+	Home	0.13	0.57	.10(.05)**	NS
	OPH	-0.67	1.00		
Risk of falling+	Home	-0.21	0.11	<.05	NS
	OPH	-0.17	0.00		
Incontinence of urine+	Home	0.13	0.25	.13	NS
	OPH	-0.17	0.43		
Cognitive impairment+	Home	0.08	0.07	NS	.01
	OPH	0.50	0.43		
Sample size	Home	24	28		
	OPH	6	7		

E	Experimental group	+	Negative sign represents improvement
C	Control group	++	Cases in residential care improved more than those remaining at home
H	Home		
R	Residential care	**	The effect of including covariates to allow for group differences at the initial assessment is given in brackets

Note:

1. Significance levels were obtained using a two-way analysis of variance.
2. NS: Not significant.

4.3 Health status outcomes

Sheppey

One of the tasks of a care manager is to assess aspects of a user's health and physical performance and to alert the primary care team to any health difficulties at an early stage. Moreover, older people in the scheme were encouraged to manage tasks for themselves wherever feasible and were facilitated in this through such means as the provision of appropriate aids and adaptations, assistance from helpers in the performance of daily exercises and the provision of a good diet; and perhaps encouragement from the helper to eat in cases of frailty brought about by self-neglect. Consequently, the changes in different aspects of health status over the evaluation period were compared by group, as shown in Table 7.16, to see whether the Community Care group benefited from any net improvements over those receiving standard provision. Many of the indicators showed a smaller deterioration amongst the Community Care group than in the control population, this difference being significant for three of the measures.

The ADL score was calculated as the number of tasks for which the user required help, drawn from six basic activities of daily living. Although the Community Care Scheme did not lead to a significant reduction in the increase of ADL score over the evaluation year, admission to residential care gave rise to a significant increase in score. This was probably due to a selection effect, whereby a decline in ADL capacity precipitated the admission. However, the before-after experimental design did not allow such effects to be investigated. The OARS ADL impairment rating (Pfeiffer 1975) confirmed this effect regarding residential care admissions. Also, this rating showed that cases receiving Community Care experienced an improvement which was almost significant ($p = .10$). The Isaacs and Neville index provided a measure of disability according to the frequency at which an older person needed help (Isaacs and Neville 1976). Like ADL score, the Isaacs and Neville index showed no relative improvement for the Community Care group, though once again those admitted to residential care showed a deterioration, this being almost statistically significant ($p = .08$).

The self-rated degree of ill-health is rather more subjective than the ADL ratings and is influenced by the older person's morale. Those in receipt of Community Care experienced a smaller deterioration, which was statistically significant ($p = .05$). In contrast to the ADL result, cases entering residential care rated themselves as having a significantly smaller degree of ill-health, reflecting the improved security, warmth and medical attention frequently encountered. The general health index was obtained by adding a range of different health indicators for which problems were present. Cases in the Community Care Scheme showed a reduction in this index, which was statistically significant ($p = .05$).

A significant reduction in risk of falling for Community Care cases in comparison with control cases was likely to have been brought about by the care manager through such means as improving nutrition and encouraging users to become more mobile and less shaky on their legs, ensuring that prescribed medication was taken regularly, providing rails for extra support, removing obstacles in the home which could cause tripping and offering more supervision and assistance with tasks involving an undue risk of falling. More frequent check up visits by Community Care helpers reduced the risk of a 'long lie' should a fall have taken place.

Incontinence of urine deteriorated less rapidly for cases in the Community Care Scheme though this result was not quite statistically significant ($p = .13$). This was a result of the

improved management of incontinence in the scheme though such techniques as more frequent toileting and regulation of fluid intake.

Finally, there was no evidence that Community Care could arrest or reduce a state of cognitive impairment/disorientation. However, cases which were admitted to residential care showed a significant increase, which was presumably largely a result of the disorientating effect of this type of relocation, requiring a whole range of activities and routines to be relearnt. This relocation effect was probably superimposed upon a selective effect, whereby cases whose cognitively impaired state had deteriorated most rapidly while at home were more likely to have been admitted to residential care.

Table 7.17 Health needs outcomes in Tonbridge

Variable		Mean change		Tests[1,2]	
		E	C	EvC	HvR
Adl score+	Home	0.00	0.62	0.08	NS
	OPH	0.25	0.50		
Adl impairment rating (OARS)+	Home	-0.05	0.19	0.07	0.07
	OPH	0.25	0.50		
Isaacs & Neville disability index+	Home	0.00	0.14	NS	NS
	OPH	0.00	0.00		
Self-rated degree of ill-health+	Home	-0.10	0.00	NS	NS
	OPH	-0.50	0.00		
General health problem index+	Home	-0.20	0.52	NS	NS
	OPH	-0.25	-0.50		
Risk of falling+	Home	-0.05	0.05	NS	NS
	OPH	-0.25	-0.17		
Incontinence of urine+	Home	-0.10	0.19	NS	NS⊗
	OPH	0.75	-0.17		
Cognitive impairment+	Home	0.15	0.10	NS	NS
	OPH	0.25	0.17		
Sample size	Home	20	21		
	OPH	4	6		

E	Experimental group	+	Negative sign represents improvement
C	Control group	++	Cases in residential care improved more than
H	Home		those remaining at home
R	Residential care	⊗	Strongly significant interaction effect (p<.01)

Notes:

1. Significance levels were obtained using a two-way analysis of variance.
2. NS: Not significant.

Tonbridge

Although the health needs outcomes for Tonbridge given in Table 7.17 show that no indicator provided an improvement for the Community Care group relative to the comparison group which was significant at the 5 per cent level, all except cognitive impairment suggested some benefit to the scheme. Results approached statistical significance for ADL score ($p = .08$) and the ADL impairment ($p = .07$) given on the Old American Rating Scale. Cases being admitted to residential care also showed no significant changes compared to those remaining at home, although the ADL impairment rating increased by an amount almost significant at the 5 per cent level ($p = .07$). As in Sheppey, this effect was likely to result partly from the deterioration in their ability to perform these tasks which had initially led to their admission to residential care, together with the subsequent loss of further personal care and housework skills as a result of the extra help which they received.

4.4 Outcomes to the informal carer

So far, our consideration of outcomes has focused on the benefits to the older person. In cases where an informal carer was providing substantial support, they were also interviewed at the time of the initial assessment and a year later provided the user had not already died. Hence, changes in circumstances of the informal carer could be determined. Since some of the changes experienced by the carer could be a result of a move by the older person into institutional care, a breakdown by location as well as by experimental/control group was again made.

Sheppey

The results are shown in Table 7.18. Unfortunately, since only four of the Community Care cases and only six of the cases entering institutional care had an informal carer who received a follow-up interview, the results are of very limited statistical significance. Carers supporting users in the scheme became less involved in providing help at times of rising and retiring, though the result was not quite statistically significant ($p = .08$). However, changes in the number of hours of help provided overall per week showed no significant difference. There was a significant reduction in support from others within the carer's household as a result of some tasks being taken over by the scheme, together with a reduction in the need for other tasks brought about by day care and respite care in a local authority home. Although the scheme had no overall effect on physical health, the level of psychological strain was reduced for cases in the scheme, though this effect was not quite significant ($p = .09$). There was also some evidence that informal carers of cases in the scheme showed an increase in warmth expressed towards the older person in the interview ($p = .17$).

It can be seen from Table 7.18 that most indicators showed the quality of life of the informal carer to improve after entry of the older person into institutional care, the results being significant or nearly significant at the 5 per cent level. Thus lifestyle problems - covering household routine, employment difficulties, social life, effects on children and physical health - were reduced as were feelings of burden expressed by the carer. An important exception to this trend was provided by examining the proportion of carers with a Malaise score of at least 7. This score was derived from an inventory of 24 stress symptoms originally used on the parents of mentally handicapped children (Rutter *et al.* 1970), for which a score of 7 or over indicated 'critical stress'. A significantly greater proportion of carers whose older person had entered institutional care had become critically stressed. However this effect was brought about entirely by the control

population. Clearly the stressed state of these carers could have been brought about by caring for the older person and could have precipitated the admission to institutional care, if not enough time had elapsed for the carer to recover from the anguish caused by the breakdown of their care. The feelings of failure and guilt which this brought about were likely to be stronger and more long-lasting in the comparison group, due to the absence of a care-managed approach, and could prolong the symptoms of stress, while other more immediate symptoms of the caring process eased.

Table 7.18 Outcomes for informal carers in Sheppey

Variable		Mean change		Tests[1,2]	
		E	C	EvC	HvI
Involvement in getting up/going to bed+	Home	-1.00	0.00	0.08	<0.01
	Institution	-3.00	-1.80		
Change in amount of care given+	Home	-6.00	-22.58	NS	<0.01
	Institution	-98.00	-105.20		
Support from others within household+	Home	-1.00	-0.25	<0.05	NS
	Institution	-3.00	-0.40		
Lifestyle problems+	Home	-1.00	-1.25	NS	<0.05
	Institution	-2.00	-3.00		
Backstrain through lifting+	Home	0.00	0.08	NS	NS
	Institution	0.00	0.00		
Mental health problems+	Home	0.00	-0.42	NS	NS
	Institution	0.00	-0.20		
Malaise score of at least 7+	Home	0.00	-0.08	NS	<0.05⊗
	Institution	0.00	0.40		
Expressed burden+	Home	-0.33	-0.17	NS	<0.01
	Institution	-2.00	-1.20		
Level of strain+	Home	-1.33	-0.42	0.09	0.07
	Institution	-1.00	-1.20		
Warmth expressed towards subject*	Home	0.33	0.00	0.17	0.14⊗
	Institution	1.00	-1.00		
Sample size	Home	3	12		
	Institution	1	5		

E	Experimental group	*	Positive sign represents improvement
C	Control group	+	Negative sign represents improvement to carer/household
H	Home	⊗	Improvement was less for carers whose older person had entered institutional care
I	Institution		

Note:

1. Significance levels were obtained using a two-way analysis of variance.
2. NS: Not significant.

The rather limited degree of improvement in quality of life for carers of Community Care cases can be interpreted as a result of the scheme's enabling the older person to remain longer at home. Thus, although the carer is receiving more support, the period of commitment for the carers is increased. This contrasts with the improvement in quality of life experienced by many of the control group carers once the older person has been admitted to institutional care. Also, as in the case of user outcomes, the before-after experimental design ignored the state of the informal carer at intermediate stages during the evaluation year. An average carer stress or quality of life score over the period taking into account the crisis and anguish preceding and during an admission to institutional care might give a different result from a change score between two points of time separate from the crisis period.

Tonbridge

Outcomes for informal carers in Tonbridge are shown in Table 7.19. Sample sizes, though small, are greater than for Sheppey. As in Sheppey, the scheme was able to reduce the need for carers to be involved at times of rising and retiring, the result being almost significant at the 5 per cent level ($p = .06$). Although the scheme brought about no overall effect on physical health, there was a significant reduction in backstrain through lifting the older person. The increase in expressed burden was less for carers of Community Care cases, though this result was not quite significant ($p = .08$). Although all the other indicators, with the exception of warmth expressed towards the older person, showed some improvement for carers of Community Care cases, the results were not strong enough to be of statistical significance.

As was the case in Sheppey, informal carers experienced a number of improvements when the older person was admitted to institutional care and some of these were sufficiently strong to be statistically significant despite the extremely small numbers involved. However, as there were only four carers in this category, the following results are extremely tentative. As well as the expected reduction in involvement with tasks as illustrated by getting up and going to bed and the overall amount of care given, there was some evidence of reduction in lifestyle problems though this was not quite significant ($p = .08$). The informal carer's mental well-being also showed a recovery as indicated by the improved mental health rating and reductions in expressed burden and level of strain, as well as an increase in warmth expressed towards the older person. However the before-after experimental design does not allow the upheaval to the informal carer during the period leading up to and just after an admission to institutional care to be monitored.

4.5 Further corrections to outcome comparisons in Tonbridge

Tests were made to identify any modifications required to group differences caused by, firstly, the contrasting characteristics of Tonbridge and Malling and, secondly, the effect on cases evaluated during the period of disruption to the Malling scheme. This was brought about by the death of the care manager, the principal social worker's post subsequently becoming vacant and finally one of the assistant care managers resigning her post, leaving the other as acting care manager.

4.5.1 The effect of differences between Tonbridge and Malling

The cases for which follow up interviews were available were split equally between Tonbridge and Malling, with twelve in each area. The proportion of cases in each area remaining at home after one year was not sufficiently different to be statistically significant, being 80 per cent in Tonbridge and 69 per cent in Malling. Although three

cases died in Malling (23 per cent) compared to none in Tonbridge, the result was again insignificant. Two of the indicators of quality of life displayed some area differences in the changes measured. Depressed mood showed a much bigger improvement amongst Community Care cases in Malling than those in Tonbridge, although this difference was not statistically significant (p = .24). Dissatisfaction with life development improved in Malling but became slightly worse in Tonbridge Community Care cases. Again this difference was not significant (p = .22).

Table 7.19 Outcomes for informal carers in Tonbridge

Variable		Mean change		Tests[1,2]	
		E	C	EvC	HvI
Involvement in getting up/going to bed+	Home	-0.71	0.85	.07(<.05)**	<0.01
	Institution	-1.50	-2.50		
Change in amount of care given+	Home	-5.29	10.85	NS	<0.01
	Institution	-81.50	-117.00		
Support from others within household+	Home	-0.29	0.08	NS	NS
	Institution	0.00	-0.50		
Lifestyle problems+	Home	-0.43	0.33	NS	0.08
	Institution	-2.00	-1.50		
Backstrain through lifting+	Home	-0.71	0.62	<0.05	NS
	Institution	-1.00	0.50		
Mental health problems+	Home	0.14	0.23	NS	<0.05
	Institution	-0.50	-0.50		
Malaise score of at least 7+	Home	0.00	0.15	NS	NS
	Institution	0.00	0.00		
Expressed burden+	Home	-0.14	0.54	0.08	<0.01
	Institution	-1.00	-1.00		
Level of strain+	Home	0.00	0.46	NS	<0.01
	Institution	-0.50	-1.00		
Warmth expressed towards subject*	Home	-0.14	-0.08	NS	<0.05
	Institution	1.00	1.00		
Sample size	Home	7	13		
	Institution	2	2		

E	Experimental group	*	Positive sign represents improvement
C	Control group	+	Negative sign represents improvement to carer/household
H	Home		
I	Institution	**	The effect of including covariates to allow for group differences at the initial assessment is given in brackets

Note:
1. Significance levels were obtained using a two-way analysis of variance.
2. NS: Not significant.

Two of the measures of health status also showed area differences, though the effects were in opposite directions. Improvements in ADL score were achieved in the Tonbridge

scheme compared with a deterioration in Malling. The difference was again insignificant ($p = .35$). However, the ADL impairment rating improved in Malling but became worse in Tonbridge. These last two results are hard to reconcile.

It is difficult to see how these differences between Tonbridge and Malling could have been brought about by the relatively small differences in the availability of resources shown in Table A1.5. Following the administrative reorganisation leading to Tonbridge and Malling providing their own separate schemes, it is possible that the differences result from different styles of care management. However, in view of the problems encountered by the Malling scheme, the greater improvements in some aspects of quality of life in Malling were surprising. Alternatively, slight variations in the types of case targeted in Tonbridge and Malling, combined with the unreliability of drawing conclusions from small sample sizes, could account for the difference. Most outcome indicators were not associated with area differences, and the number of outcomes where area differences were identified was no more than would be expected by chance.

4.5.2 The effect on outcomes of the period of disruption to the Malling scheme

Seven of the Malling Community Care cases with follow up interviews had been evaluated during the period of disruption. Since these cases were all from Malling, the effect of disruption would be superimposed on the area differences already considered. For simplicity, the combined effect of these two factors was measured by contrasting these seven cases with the remaining Tonbridge and Malling Community Care cases. The proportions of cases in each group remaining at home after one year were not sufficiently different to be statistically significant, being 83 per cent for the disrupted group and 71 per cent for the remainder. Thus, despite the difficulties in the Community Care team in Malling, a greater proportion of cases survived at home during this period than in Tonbridge.

Regarding quality of life outcomes, the only indicator to be affected was dissatisfaction with life development, though this difference was insignificant. Surprisingly it was the cases being managed during the period of disruption which improved most.

One health status indicator was also affected - ADL score. This time the cases evaluated during the period of disruption did worse while the remaining Community Care cases did slightly better.

All other indicators of user outcome were unaffected and the changes to significance levels were no more than would be expected by chance. It may therefore be concluded that the period of disruption had a negligible effect on the outcomes achieved by the Community Care Scheme.

5 Overview of outcome results

Although a greater proportion of older people in both schemes were enabled to stay at home over the evaluation year, particularly in Sheppey, the effects were not quite as strong as in Thanet and Gateshead, and were statistically insignificant. As in Thanet, the death rate was much smaller in the Sheppey Community Care group, though the effect was not statistically significant and was absent in Tonbridge. The Sheppey result is likely to be due, at least in part, to Community Care intervention.

The aim of allowing users to die at home was partially achieved. Over six years, more than one quarter of users in each group died at home in the scheme, and a further ten per cent of Sheppey cases (fifteen per cent in Tonbridge) died within three months of being admitted to hospital. However, forty-six per cent of Sheppey cases (thirty-nine per cent in Tonbridge) ended up in long-term institutional care. Despite the absence of significant group differences in the individual categories of locational outcome, care management intervention significantly reduced the probability of admission to institutional care overall in Sheppey but not in Tonbridge.

Sheppey Community Care cases spent significantly longer at home and significantly less time in institutional care. In Tonbridge the effects were not quite as strong and were statistically insignificant. However, time spent in hospital in Sheppey by the care managed group was less than one half that in the comparison group ($p<.05$) and in Tonbridge less than one quarter ($p=.07$). This was the main factor responsible for a considerable shift in financial responsibility from the NHS to the SSD.

In Sheppey there were significant improvements in some social and emotional needs outcomes relative to the comparison group: felt capacity to cope, anxiety, depressed mood and Wakefield depression score. Improvements were generally smaller in Tonbridge though approached statistical significance for depressed mood, dissatisfaction with life development and loneliness or social isolation. However, results for quality of care were strikingly good. Significant improvements were found for most indicators in Sheppey and over half in Tonbridge. Some health needs showed significant improvements in Sheppey: self-rated degree of ill-health, general health problem index and risk of falling. Effects in Tonbridge were comparable but all statistically insignificant. Finally, sample sizes in both areas were too small for improvements in quality of life of informal carers to be reliably detected. Nevertheless, in Tonbridge the scheme apparently enabled carers to become significantly less involved with users at times of rising and retiring and problems of backstrain through lifting appeared significantly reduced.

Although improvements in quality of care and health status in Sheppey and Tonbridge were comparable to those found in the Thanet and Gateshead schemes, improvements in the user's and informal carer's quality of life in both schemes were generally smaller. This is likely to reflect the smaller PSSRU involvement in Sheppey and Tonbridge. It was a combination of these smaller improvements and the smaller sample sizes in Sheppey and Tonbridge which led to the generally smaller significance levels for outcomes. Nevertheless, improvements over the whole range of outcomes are still substantial.

This discussion of outcomes is further developed in the concluding chapter. In the next chapter the costs incurred in bringing about these outcomes are examined.

CHAPTER 8

THE COSTS OF CARE

Referring back to the production of welfare model described in Chapter 3, costs result from the prices attached to the resource inputs which help to achieve outputs. In the last chapter the schemes were shown to offer an improvement in a range of outputs in comparison with their control groups. As a further step in this cost-effectiveness study, the present chapter examines the effect of the care-managed approach on costs to the social services department and health service.

1 Unit costs

The first step in working out the costs of care was to determine the unit costs of services, using the method adopted in earlier Community Care evaluations (Challis and Davies 1986, Davies and Challis 1986). The unit costs of services were averaged between Sheppey and Tonbridge and are shown in Table 8.1.

Unit costs to the social services department for which a charge to the older person may be made are expressed both before and after deducting the average charge; that is, both gross and net. The values for residential and day care have been expressed both as revenue costs, calculated assuming capital repayments on average aged buildings, and as opportunity costs, which assume capital repayments on new buildings using two alternative discount rates of 5 per cent and 7 per cent. The opportunity cost takes into account that, at a time when increasing numbers of frail older people require care, the scheme will be preventing the need to build as many new residential homes. Since unit revenue costs to the National Health Service exclude capital repayments altogether, opportunity costs for hospital in-patient care, accident and emergency services and day hospitals have also been calculated at two discount rates, assuming capital expenditure on upgrading of buildings.

2 Annual and weekly costs by matched group

Sheppey

Annual and weekly components of cost to the social services department and National Health Service for matched groups are shown in Tables 8.2 and 8.3. Overall costs both to these two agencies and to the private sector and informal carers are compared by matched group with significance tests in Table 8.4.

It can be seen from Table 8.4 that while the annual opportunity cost to the social services department for Community Care, using a 5 per cent discount rate, is almost double that for comparison cases, the opportunity cost to the National Health Service is almost halved. Moreover, the difference for SSD net revenue cost was significant at the one per cent level and that for NHS revenue cost at the five per cent level, for both annual and weekly costs. As a result, while for comparison cases costs to the National Health Service worked out to be 57 per cent of the combined total, for Community Care cases this was only 26 per cent. The additional cost to the social services department of the Community Care Scheme was due to increased expenditure on community resources, which far outweighed the savings caused by a reduced demand for local authority residential care. The savings to the National Health Service were mainly through reduced usage of psychiatric, geriatric and cottage hospital in-patient beds by Community Care cases. Thus, in an average 12 month period Community Care cases spent, in round figures, 2 weeks less in local authority

residential care, 4 days less in a cottage hospital, 5 days less in a geriatric hospital and 10 days less in a psychiatric hospital, as well as 21 days less in private residential care. The differences in the overall availability of resources between the Community Care and comparison group areas, shown in Table A1.4 of Appendix 1, could only have accounted for a small proportion of these savings.

Table 8.1 Unit cost of resources at 1982 prices in Sheppey and Tonbridge

	Revenue costs[1]		Gross opportunity costs Discount rates	
	Gross £	Net £	5% £	7% £
Social services department resources				
Residential care (per day)	15.39	11.10	16.64	17.55
Day care centre (per day)	16.26	15.61	16.34	16.79
Day care in a residential home (per day)	4.19	3.81		
Age concern day care (per day)	2.28	1.90		
Home help (per hour)	3.36	2.81		
Meals on wheels (per meal)	0.90	0.52		
Lunch club (per attendance)	1.00	0.62		
Area team social worker (per hour)	5.06			
Community Care social worker (per hour)	6.54			
Assistant Community Care social worker (per hour)	5.06			
SSD occupational therapist (per hour)	6.64			
Telephone for disabled person (per week)	1.19			
Sheltered housing subsidy (per week)	3.94			
National Health Service resources				
Hospital in-patient (per day)				
district general	79.32		82.45	83.54
small/mainly/partly acute	43.61		46.74	47.83
long-stay geriatric	28.82		31.95	33.04
psychiatric	29.21		32.34	33.43
Hospital out-patient (per attendance)				
medical	16.30			
physiotherapy	16.30			
Hospital accident and emergency (per attendance)	22.68		25.81	26.90
Geriatric day hospital (per day)	8.12		11.25	12.34
Domiciliary visits				
community nurse (per hour)	6.28			
community psychiatric nurse (per hour)	7.56			
health visitor (per hour)	7.56			
chiropodist (per appointment)	2.04			
NHS occupational therapist (per hour)	6.64			
geriatrician (per hour)	14.20			
Private residential care (per day)	12.18			
Community Care budget ceiling (two-thirds of the gross weekly cost of a place in a local authority home)	71.80			

Note:

1. Revenue costs are given both before and after deduction of an average user contribution.

Table 8.2 Costs of matched groups[1], annually and per week of survival to the social services department in Sheppey, £ at 1982 prices

	Annual Cost			Cost per week		
	E	C	Sig. Level p[2,3]	E	C	Sig. Level p[2,3]
Total SSD cost (revenue a/c)						
- gross	2298.78	1160.82	<.01[4]	46.32	23.61	<.01[4]
- net	2058.93	911.35	<.001[4]	41.63	18.56	<.001[4]
Residential care (revenue a/c)						
- gross	503.54	718.52	NS	9.70	14.49	NS
- net	363.18	518.23		6.99	10.45	
Day care centre (revenue a/c)						
- gross	252.54	50.30	<.05	5.01	0.97	<.05
- net	242.44	48.29		4.81	0.93	
Day care in residential home						
- gross	125.83	13.36	.06	2.47	0.30	.06
- net	114.42	12.14		2.24	0.28	
Age Concern day care						
- gross	30.64	12.97	NS	0.59	0.36	NS
- net	25.53	10.81		0.49	0.30	
Home help						
- gross	373.17	229.01	NS	7.53	4.60	NS
- net	312.09	191.52		6.30	3.84	
Meals on wheels						
- gross	20.78	13.95	NS	0.40	0.28	NS
- net	12.01	8.06		0.23	0.16	
Lunch club						
- gross	7.94	1.09	.10	0.16	0.02	.10
- net	4.92	0.68		0.10	0.01	
Area team social worker	0.00	106.36	<.001	0.00	2.26	<.001
Community Care social wkr.	366.15	-	<.001	7.81	-	<.001
Assistant Community Care social worker	26.65	-	<.05	0.51	-	<.05
Community Care helper costs						
- fees	426.78	-	<.001	8.72	-	<.001
- expenses	100.65	-	<.001	2.17	-	<.001
SSD occupational therapist	0.00	0.83	NS	0.00	0.02	NS
Telephone for disabled person	3.87	4.91	NS	0.07	0.09	NS
Sheltered housing subsidy	57.38	6.28	<.01	1.12	0.15	<.01
SSD aids discounted at 5%	2.87	3.24	NS	0.06	0.07	NS
Weeks alive in area	48.55	46.75	NS			
Sample size	32	32		32	32	

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Mann-Whitney U test, unless otherwise stated.
3. NS: Not significant.
4. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. Because costs were normally distributed, an analysis of variance could then be used in determining significance levels.

Table 8.3 Costs of matched groups[1], annually and per week of survival to the National Health Service in Sheppey, £ at 1982 prices

	Annual Cost			Cost per week		
	E	C	Sig. Level p[2,3]	E	C	Sig. Level p[2,3]
Total NHS cost (revenue a/c)	795.28	1496.28	.07[4]	18.15	41.30	<.05[4]
Hospital in-patient						
overall total	682.18	1346.68	<.05	14.89	38.20	.01
district general	198.30	228.05	NS	3.81	8.29	NS
small/mainly/partly acute	331.16	487.89	<.05	8.05	16.74	.01
long stay geriatric	114.38	270.19	NS	2.29	6.03	NS
psychiatric	38.34	360.56	<.05	0.74	7.15	<.05
Total NHS community cost						
(including hospital out-patients)	113.10	149.60	NS	3.26	3.11	NS
Hospital out-patient						
Medical	0.51	10.19	NS	0.01	0.20	NS
Physiotherapy	6.11	5.09	NS	0.13	0.10	NS
Hospital accident & emergcy. visit	0.71	0.71	NS	0.01	0.01	NS
Day hospital						
geriatric	0.00	3.81	NS	0.00	0.07	NS
psychiatric	0.00	0.00	NS	0.00	0.00	NS
Domiciliary visits						
Community Nurse	93.42	116.57	NS	2.85	2.47	NS
Community Psychiatric Nurse	0.00	0.00	NS	0.00	0.00	NS
Health Visitor	0.00	2.21	NS	0.00	0.04	NS
Chiropodist	3.76	2.17	<.05	0.07	0.04	<.05
NHS occupational therapist	0.00	8.86	NS	0.00	0.00	NS
Geriatrician	0.89	0.00	NS	0.02	0.00	NS
NHS aids discounted at 5%	7.70	7.92	NS	0.16	0.17	NS
Weeks alive in area	48.55	46.75	NS			
Sample size	32	32		32	32	

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Mann-Whitney U test, unless otherwise stated.
3. NS: Not significant.
4. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. Because costs were approximately normally distributed, an analysis of variance could then be used in determining significance levels.

Although the combined average weekly opportunity cost to both agencies of the Community Care cases (£66.34) worked out to be slightly less than that for the comparison cases (£69.07) the annual Community Care cost (£3,185) was slightly more than for standard provision (£2,830), due to the greater longevity of older people in the scheme. However these differences are statistically quite insignificant. Thus, although the provision of Community Care led to no significant change in overall combined cost to the two agencies, the social services department took over from the National Health Service in financing the bulk of the care. This provides strong grounds for ensuring a shift of finance from the health services to the social services in areas with the same pattern of health provision as in Sheppey. No redistribution of costs between agencies was found in the Thanet Community Care Scheme or in the outer zone of the Gateshead Social Care scheme, though in the inner city area of the Gateshead Scheme, the redistribution occurred

in the opposite direction. This was as a result of care managers negotiating with the health service for much greater use of NHS resources in an area which was normally under-provided.

Table 8.4 Average total costs by matched group[1] to different budgets in Sheppey with significance levels, £ at 1982 prices

Cost account	Annual cost £			Weekly cost £		
	E	C	Sig. Level p[2,3]	E	C	Sig. Level p[2,3]
SSD revenue cost						
gross	2299	1161	<0.01	46.32	23.61	<0.01
net	2059	911	<0.001	41.63	18.56	<0.001
SSD opportunity cost						
5%	2341	1220	<0.01	47.14	24.79	<0.01
7%	2378	1263	0.01	47.85	25.67	<0.01
NHS revenue cost	795	1496	0.07(<.05)[4]	18.15	41.30	<.05
NHS opportunity cost						
5%	844	1610	0.06(<.05)[4]	19.20	44.28	<0.05
7%	861	1650	0.06(<.05)[4]	19.59	45.33	<0.05
Combined revenue cost to SSD (net) and NHS	2854	2408	NS	59.78	59.87	NS
Combined opportunity cost to SSD and NHS						
5%	3185	2829	NS	66.34	69.07	NS
7%	3239	2914	NS	67.43	71.01	NS
Private residential care	0	254	<.05[5]	0.00	4.94	<.05[5]
Informal carers	25	47	<.05[5]	0.63	0.94	<.05[5]
Weeks alive in area	48.55	46.75				
Sample size	32	32		32	32	

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. Also, as distributions were normal unless otherwise stated, an analysis of variance could then be used in determining significance levels.
3. NS: Not significant.
4. The effect of including covariates to allow for group differences at the initial assessment is given in brackets.
5. As distribution not normal, Mann-Whitney U test used.

Table 8.5 Costs of matched groups[1], annually and per week of survival to the social services department in Tonbridge, £ at 1982 prices

	Annual Cost			Cost per week		
	E	C	Sig. Level p[2,3]	E	C	Sig. Level p[2,3]
Total SSD cost (revenue a/c)						
- gross	1490.42	1092.95	NS[4]	29.64	22.44	NS[4]
- net	1376.09	957.91	.10(NS)[4,5]	27.34	19.69	NS[4]
Residential care (revenue ac)						
- gross	141.19	212.78	NS	3.01	4.09	NS
- net	101.83	153.47		2.17	2.95	
Day care centre (revenue a/c)						
- gross	140.68	558.50	<.01	2.71	11.44	<.01
- net	135.06	536.17		2.60	10.99	
Day care in residential home						
- gross	54.29	14.57	<.05	1.14	0.28	<.05
- net	49.36	13.25		1.04	0.26	
Age Concern day care						
- gross	0.00	0.30	NS	0.00	0.01	NS
- net	0.00	0.25		0.00	0.01	
Home help						
- gross	255.80	198.82	NS	5.00	4.46	NS
- net	213.93	166.28		4.18	3.73	
Meals on wheels						
- gross	52.63	46.14	NS	1.01	0.95	NS
- net	30.41	26.66		0.59	0.55	
Lunch club						
- gross	0.87	0.00	NS	0.03	0.00	NS
- net	0.54	0.00		0.02	0.00	
Area team social worker	0.66	52.66	<.01	0.01	1.03	<.01
Community Care social worker	156.15	-	<.001	3.13	-	<.001
Assistant Community Care social worker	166.68	-	<.001	3.35	-	<.001
Community Care helper costs - fees	411.90	-	<.001	8.14	-	<.001
- expenses	94.47	-	<.001	1.82	-	<.001
SSD occupational therapist	3.46	2.31	NS	0.07	0.04	NS
Telephone - disabled person	0.00	2.69	NS	0.00	0.05	NS
Sheltered housing subsidy	8.91	0.00	NS	0.17	0.00	NS
SSD aids discounted at 5%	2.73	4.18	NS	0.05	0.09	NS
Weeks alive in area	49.81	48.46	NS			
Sample size	23	23		23	23	

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Mann-Whitney U test, unless otherwise stated.
3. NS: Not significant.
4. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. Because costs were normally distributed, an analysis of variance could then be used in determining significance levels.
5. The effect of including covariates to allow for group differences at the initial assessment is given in brackets.

Table 8.6 Costs of matched groups[1], annually and per week of survival to the National Health Service in Tonbridge, £ at 1982 prices

	Annual Cost			Cost per week		
	E	C	Sig. Level p[2,3]	E	C	Sig. Level p[2,3]
Total NHS cost (revenue a/c)	578.09	1812.33	<.05[4]	11.35	38.60	<.05[4]
Hospital in-patient						
overall total	329.17	1644.72	.05	6.40	35.37	<.05
district general	48.28	379.36	.05	1.00	10.64	.05
small/mainly/partly acute	73.95	756.54	.05	1.42	14.94	<.05
long stay geriatric	98.99	502.47	NS	1.90	9.66	NS
psychiatric	107.95	6.35	NS	2.08	0.12	NS
Total NHS community cost						
(including hospital out-patients)	248.93	167.62	NS	4.95	3.23	NS
Hospital out-patient						
medical	0.71	3.54	NS	0.01	0.07	NS
physiotherapy	0.00	0.00	NS	0.00	0.00	NS
Hospital accident and emergency visit	0.00	0.00	NS	0.00	0.00	NS
Day hospital						
geriatric	104.15	77.32	NS	2.00	1.49	NS
psychiatric	0.00	0.00	NS	0.00	0.00	NS
Domiciliary visits						
Community Nurse	136.39	65.39	NS	2.78	1.26	NS
Community Psychiatric Nurse	0.00	2.41	NS	0.00	0.05	NS
Health Visitor	0.00	6.79	NS	0.00	0.13	NS
Chiropodist	1.77	1.69	NS	0.03	0.03	NS
NHS occupational therapist	0.00	0.00	NS	0.00	0.00	NS
Geriatrician	0.00	0.00	NS	0.00	0.00	NS
NHS aids discounted at 5%	5.91	10.48	NS	0.11	0.21	NS
Weeks alive in area	49.81	48.46	NS			
Sample size	23	23		23	23	

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Mann-Whitney U test, unless otherwise stated.
3. NS: Not significant.
4. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. Because costs were approximately normally distributed, an analysis of variance could then be used in determining significance levels.

Tonbridge

The annual and weekly components of cost to the social services department and National Health Service for matched groups are shown in Tables 8.5 and 8.6 respectively. Overall cost totals to each of the main cost accounts are compared by matched group with significance tests in Table 8.7. While in Sheppey the annual opportunity cost to the social services department at a 5 per cent discount rate for Community Care was almost double that for the comparison group, in Tonbridge it was only 35 per cent bigger and statistically insignificant. This was as a result of the lower expenditure on domiciliary services amongst Community Care cases in Tonbridge than in Sheppey, while at the same time day care centre costs for the Tonbridge comparison group were much greater than for Community Care. However the corresponding difference in opportunity cost of the National Health Service at a 5 per cent discount rate was so great that Community Care

costs were only one third of comparison group costs, compared with about one half in Sheppey. This vastly reduced level of National Health Service expenditure in the scheme, a result significant at the 5 per cent level, was brought about by much smaller expenditure on acute and long-stay geriatric hospital care, amounting to less than one seventh of that for the comparison group. In a typical year the Community Care cases spent, in round figures, 5 days less in local authority residential care, made 26 fewer day centre attendances, spent 4 days less in a district general hospital, 16 fewer days in a Cottage hospital and a fortnight less in a long-stay geriatric hospital. However, they spent half a week more in psychiatric hospital as well as one day more in private residential care. As was the case in Sheppey, the difference in the availability of resources shown in Table A1.4 of Appendix 1 for Tonbridge (where some of the Community Care cases and all the comparison cases were based) and Malling (where the remaining Community Care cases were situated) was insufficient to account for more than a small proportion of these effects.

Table 8.7 Average total costs by matched group[1] to different budgets in Tonbridge with significance levels, £ at 1982 prices

Cost account	Annual cost £			Weekly cost £		
	E	C	Sig. Level p[2,3]	E	C	Sig. Level p[2,3]
SSD revenue cost						
gross	1490	1093	NS	29.64	22.44	NS
net	1376	958	0.10(NS)[4]	27.33	19.69	NS
SSD opportunity cost						
5%	1503	1113	NS	29.90	22.83	NS
7%	1515	1141	NS	30.15	23.39	NS
NHS revenue cost	578	1812	0.05	11.35	38.59	<0.05
NHS opportunity cost						
5%	648	1967	0.05	12.69	41.72	<0.05
7%	672	2021	0.05	13.17	42.83	<0.05
Combined revenue cost to SSD (net) and NHS	1954	2770	NS(<0.1)[4]	38.68	58.28	0.09(<.05)[4]
Combined opportunity cost to SSD and NHS						
5%	2150	3080	NS(<0.1)[4]	42.59	64.55	0.08(<.05)[4]
7%	2187	3162	NS(<0.1)[4]	43.32	66.21	0.08(<.05)[4]
Private residential care	179	165	NS[5]	3.52	3.17	NS[5]
Informal carers	104	92	NS[5]	2.02	1.77	NS[5]
Weeks alive in area	48.81	48.46	NS			
Sample size	23	23		23	23	

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. Also, as distributions were normal unless otherwise stated, an analysis of variance could then be used in determining significance levels.
3. NS: Not significant.
4. The effect of including covariates to allow for group differences at the initial assessment is given in brackets.
5. As distribution not normal, Mann-Whitney U test used.

The combined weekly opportunity cost to both agencies was now greater for the comparison group (£64.55) than the Community Care group (£42.59), this difference being significant ($p<.05$) following the inclusion of covariates to correct for group differences at time 1. This result contrasts with Sheppey, where the corresponding combined costs were similar for each group. The proportion of this cost due to the social services department for Community Care cases in Tonbridge (70 per cent) was double that for the comparison group (35 per cent). Thus, as in Sheppey, there was a considerable shift in the distribution of expenditure from the National Health Service (for comparison cases) to the social services department (for Community Care). Once again, this provides strong grounds for a shift in finance from the social services department to the National Health Service. These important results concerning the combined weekly opportunity cost to both agencies are discussed further in sections 2.2 and 2.4 of Chapter 12.

3 Group differences in the extent of hospital bed blocking

It emerged from the previous section that Community Care cases in both areas consumed fewer hospital in-patient resources than their matched comparison groups. Clearly it is of interest to policy makers as to whether the use of Community Care would influence the degree to which different types of hospital bed are occupied for extensive periods, with its effect on throughput of patients. Because care managers are trained to assist in identifying medical problems and in acting as advocates to ensure that these problems are treated, it might have been expected that the hospital treatment received by the Community Care group caused more blocking of acute or mainly acute beds than in the comparison group. Conversely, because one aim of Community Care is to reduce the frequency of admissions to long-term geriatric and psychiatric hospital, bed blocking for these categories might be expected to be less for the Community Care group. To what extent did results match these expectations?

Group differences have been investigated using a number of measures of bed blocking in Table 8.8, for Sheppey and Tonbridge separately, and the main findings are now summarised. It can be seen that the overall cost of in-patient care (row 1) was much smaller for the scheme, the difference being statistically significant in each area, while if in-patient days are considered in place of costs (row 8), then it was only in Sheppey that usage by Community Care cases was significantly less. One measure of bed blocking would be the number of stays of at least four weeks, this period constituting one possible definition of long-term hospital care. Note, however, that in Table 8.8, 'long-term' refers to a judgement made by the evaluator, which does not always agree with the 28 day definition. Once again there was the result that this number of stays was larger in the Community Care group (row 2), though in this case the result was only statistically significant in Sheppey. In order to tease out the causes of this difference it is helpful to examine short-term/acute and long-term stays separately. If these stays are restricted to 'long-term' then, as expected, such stays were less frequent amongst Community Care cases, with the result again being only statistically significant in Sheppey (row 4). When the duration of such stays was considered, the result was still significant in Sheppey (row 7).

When in-patient stays were restricted to acute or mainly acute, then the number of days (row 12) and the associated cost (row 13) were, unexpectedly, lower in the Community Care group, the difference being statistically significant in each area.

Table 8.8 Measures of differences in hospital bed blocking by matched group[2] in Sheppey and Tonbridge

Bed blocking measure[1]	Sheppey					Tonbridge				
	Sample size		Mean		Sig. level[4]	Sample size		Mean		Sig. level[4]
	E	C	E	C		E	C	E	C	
1. Total cost of in-patient consumption (£)	32	32	730	1459	<.05	23	23	359	1769	.05
2. Number of stays (S/T or L/T)[3] of at least 28 days	32	32	0.16	0.50	<.05	23	23	0.13	0.35	NS
3. Number of short-term stays of at least 28 days	32	32	0.13	0.28	.19	23	23	0.09	0.26	.12
4. Number of long-term stays of at least 28 days	32	32	0.03	0.22	<.05	23	23	0.04	0.09	NS
5. Duration (days) of stays (S/T or L/T)[3] of at least 28 days	32	32	11.06	27.22	<.05	23	23	6.96	28.78	NS
6. Duration (days) of short-term stays of at least 28 days	32	32	8.19	13.84	NS	23	23	3.26	17.78	.10
7. Duration (days) of long-term stays of at least 28 days	32	32	2.88	13.38	<.05	23	23	3.70	11.00	NS
8. Total number of in-patient days consumed	32	32	15.38	35.78	<.05	23	23	9.43	39.78	.08
9. Cost (£) of stays (S/T or L/T)[3] of at least 28 days	32	32	456	956	<.05	23	23	244	1183	.19
10. Cost (£) of short-term stays of at least 28 days	32	32	364	513	NS	23	23	124	832	.08
11. Cost (£) of long-term stays of at least 28 days	32	32	92	442	<.05	23	23	120	351	NS
12. Total in-patient days in acute care	32	32	10.09	14.06	<.05	23	23	2.30	22.13	<.01
13. Total in-patient cost in acute care (£)	32	32	561	760	<.05	23	23	129	1205	<.01
14. Total in-patient days in geriatric care	32	32	3.97	9.38	NS	23	23	3.43	17.43	NS
15. Total in-patient days in psychiatric care	32	32	1.31	12.34	<.05	23	23	3.70	.22	NS
16. Duration (days) of acute stays (S/T or L/T)[3] of at least 28 days	32	32	6.88	5.50	NS	23	23	1.35	13.30	.14
17. Cost (£) of acute stays (S/T or L/T)[3] of at least 28 days	32	32	321	257	NS	23	23	63	689	.14
18. Duration (days) of geriatric stays (S/T or L/T)[3] of at least 28 days	32	32	2.88	9.38	.18	23	23	1.91	15.48	.14
19. Duration of psychiatric stays (S/T or L/T)[3] of at least 28 days	32	32	1.31	12.34	<.05	23	23	3.70	0.00	NS
20. Duration (days) of short-term acute stays of at least 28 days	32	32	6.88	4.56	NS	23	23	1.35	13.30	.14
21. Cost (£) of short-term acute stays of at least 28 days	32	32	321	213	NS	23	23	63	689	.14
22. Duration (days) of short-term geriatric stays of at least 28 days	32	32	0.00	0.00	NS	23	23	1.91	4.48	NS
23. Duration (days) of short-term psychiatric stays of at least 28 days	32	32	1.31	9.28	.17	23	23	0.00	0.00	NS
24. Duration (days) of long-term acute stays of at least 28 days	32	32	0.00	0.94	NS	23	23	0.00	0.00	NS
25. Cost (£) of long-term acute stays of at least 28 days	32	32	0.00	43.82	NS	23	23	0.00	0.00	NS
26. Duration (days) of long-term geriatric stays of at least 28 days	32	32	2.88	9.38	.18	23	23	0.00	11.00	.15
27. Duration (days) of long-term psychiatric stays of at least 28 days	32	32	2.88	9.38	.15	23	23	3.70	0.00	NS

Notes:

1. Costs were expressed as 1982 opportunity costs, with capital costs calculated assuming upgrading of buildings at a 5 per cent discount rate.
2. User groups: E = Experimental (Community Care), C = Control (Comparison).
3. S/T = short-term, L/T = long-term.
4. Mann-Whitney U significance test: NS = Not significant.

When focusing on the duration of stays of at least four weeks in long-term geriatric hospital (row 26), the scheme was indeed successful in greatly reducing this in both areas, though the result was statistically insignificant. The same was true for long-term psychiatric patients in Sheppey, but not in Tonbridge. However, the greater availability of long-term psychiatric beds in the Tonbridge Community Care area could have contributed to this result.

It may therefore be concluded that, as expected, evidence pointed to long-term hospital care being generally less used amongst Community Care cases, whichever measure was adopted, though the differences were not always sufficiently great to be statistically significant. However the Community Care group also consumed much less acute and mainly acute care than the comparison group. Assuming that both groups had similar medical needs at the initial assessment, two explanations of this second result are possible. Firstly, acute medical conditions for which comparison cases were admitted to acute hospital could have been more frequently coped with at home for Community Care cases. In Sheppey there was evidence that this included the prevention of acute admissions to psychiatric hospital. Secondly, the success of the scheme in reducing the users' health problems could have lowered the admission rate to acute hospital. Davies and Challis (1986) attributed a similar success of the Thanet Community Care Project to firstly care managers enabling some older people to receive treatment in the community who would otherwise not have done so and secondly through helpers being encouraged to take out older people wherever possible to stimulate their independence when previously they had been effectively housebound. Certainly in Sheppey the new day centre could offer treatment in the community through providing access to facilities like those found in the Thanet day hospital such as Physiotherapy and chiropody. Moreover, it is clear from Tables 7.14 and 7.15 of Chapter 7 that in both Sheppey and Tonbridge the frequency with which older people went out per week was almost double for Community Care cases. In addition helpers in Sheppey and Tonbridge were encouraged to enable their users to lead as independent a life as possible within the home. There is no evidence that care managers were facilitating the use of acute hospital beds by their users. In Sheppey, the use of GP beds was infrequent since the lack of stimulation often led to physical deterioration. This lesser use of acute hospital care amongst Community Care cases is an important ingredient in the result that total NHS expenditure was much less amongst Community Care cases.

4 Weekly costs by matched group while at home

Sheppey

Tables 8.2 to 8.4, which have just been referred to, show the average use of resources over the evaluation year, taking into account periods spent both at home and in institutional care. In contrast, Table 8.9 shows the average weekly consumption of SSD and NHS resources while the older person is at home, excluding periods in short-term or long-term institutional care.

Overall, the average weekly Community Care cost to the social services department of £40.68 was more than three times the value of £11.99 for the comparison group. At the same time, average weekly costs to the National Health Service for Community Care of £2.71 were little more than half that for the comparison group of £4.56. Only 6 per cent of Community Care costs were borne by the National Health Service compared with 28 per cent for comparison group costs. Thus, the Community Care package was resourced through greatly increased expenditure by the Social Services department, the contribution from the National Health Service becoming still smaller. The main contributions to the

additional costs to the social services department of Community Care were from helper fees and expenses, Care management time, day care and home help. The reduction in National Health Service costs was due mainly to the cutting back of community nursing hours. This normally involved Community Care helpers taking over some of the non-medical tasks from community nurses, such as helping with getting up and going to bed, bathing and administering medication.

Table 8.9 Components of net weekly revenue cost to the social services department and National Health Service while at home for matched groups[1] in Sheppey, £ at 1982 prices

	Average number of units of resource consumed per week		Average weekly cost, £		Sig. level p[2,3]
	E	C	E	C	
(1) SSD Resources					
Average wkly. net SSD cost of care at home			42.91	15.88	<.001
Days day care in an old people's home	0.81	0.13	3.09	0.49	.06
Day centre attendances	0.39	0.07	6.04	1.11	<.05
Days in Age Concern day centre	0.33	0.22	0.63	0.41	NS
Hours of home help	2.62	2.31	7.35	6.50	NS
Meals on wheels	0.51	0.42	0.26	0.22	NS
Lunch club attendance	0.20	0.02	0.13	0.02	.10
Area team social worker hours	0.00	1.31	0.00	6.62	<.001
Case manager hours	1.65	-	10.80	-	<.001
Assistant case manager hours	0.10	-	0.52	-	<.05
Community Care helper fees			9.89	-	<.001
Community Care helper expenses			2.40	-	<.001
SSD Occupational Therapist hours			0.00	0.03	NS
SSD telephone rental weeks	0.00	0.01	0.07	0.19	NS
Sheltered housing subsidy weeks	0.06	0.16	1.66	0.20	<.01
SSD aids and adaptations	0.42	0.05	0.07	0.11	NS
(2) NHS resources					
Average weekly NHS cost of care at home			3.64	4.26	NS
Accident and emergency attendances	0.001	0.004	0.01	0.10	NS
Out-patient appointments - medical	0.001	0.02	0.01	0.28	NS
- physiotherapy	0.01	0.01	0.14	0.10	NS
Geriatric day hospital attendances	0.00	0.02	0.00	0.14	NS
Community nursing hours	0.50	0.53	3.15	3.31	NS
Health Visitor hours	0.00	0.01	0.00	0.05	NS
Chiropody appointments	0.05	0.03	0.10	0.07	<.05
Geriatrician hours	0.001	0.00	0.02	0.00	NS
NHS aids and adaptations			0.22	0.21	NS
Combined cost to SSD and NHS at home			46.56	20.15	<.001
Average number of weeks at home	41.69	32.79			<.05
Sample size	32	32	32	32	

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Mann-Whitney U test.
3. NS: Not significant.

It can be seen that the average Community Care weekly package in round figures consisted principally of one day's day care, 2½ hours home help, one meal on wheels or lunch club attendance, 1½ hours care management time, £10 in helper fees, £2.50 in helper expenses and 20 minutes community nursing. The corresponding comparison group package was a day's day care every third week, 2 hours home help, a fortnightly meal on wheels, 40 minutes area team social work time, 40 minutes community nursing and 20 minutes health visitor time.

Table 8.10 Components of net weekly revenue cost to the social services department and National Health Service while at home for matched groups[1] in Tonbridge, £ at 1982 prices

	Average number of units of resource consumed per week		Average weekly cost, £		Sig. level p[2,3]
	E	C	E	C	
(1) SSD Resources					
Average wkly. net SSD cost of care at home			27.57	19.22	.08
Days day care in an old people's home	0.29	0.07	1.12	0.27	<.05
Day centre attendances	0.18	0.77	2.75	12.06	<.01
Days in Age Concern day centre	0.00	0.003	0.00	0.01	NS
Hours of home help	1.71	1.60	4.80	4.49	NS
Meals on wheels	1.19	1.31	0.62	0.68	NS
Lunch club attendance	0.04	0.00	0.02	0.00	NS
Area team social worker hours	0.004	0.30	0.02	1.50	<.01
Case manager hours	0.58	-	3.81	-	<.001
Assistant case manager hours	0.68	-	3.44	-	<.001
Community Care helper fees			8.72	-	<.001
Community Care helper expenses			1.96	-	<.001
SSD Occupational Therapist hours	0.01	0.01	0.08	0.05	NS
SSD telephone rental weeks	0.00	0.04	0.00	0.05	NS
Sheltered housing subsidy weeks	0.05	0.00	0.18	0.00	NS
SSD aids and adaptations			0.05	0.10	NS
(2) NHS resources					
Average weekly NHS cost of care at home			5.22	4.96	NS
Out-patient appointments - medical	0.001	0.004	0.01	0.07	NS
Geriatric day hospital attendances	0.26	0.26	2.14	2.12	NS
Community nursing hours	0.46	0.34	2.90	2.16	NS
Community psychiatric nursing hrs.	0.00	0.007	0.00	0.05	NS
Health Visitor hours	0.00	0.02	0.00	0.14	NS
Chiropody appointments	0.02	0.02	0.04	0.05	NS
NHS aids and adaptations			0.13	0.37	NS
Combined cost to SSD and NHS at home			32.79	24.17	.10
Average number of weeks at home	45.04	38.80			
Sample size	23	23	23	23	NS

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Mann-Whitney U test.
3. NS: Not significant.

Tonbridge

The weekly costs of care to both matched groups during periods spent at home are shown in Table 8.10. The cost to the social services department, at £28.29 per week, was much less than in Sheppey (£40.68 per week) and not far above that for comparison group cases (£20.73 per week). However, the National Health Service weekly cost of £5.53 was about double that for Sheppey and greater than that for the Tonbridge comparison group of £4.32 per week. In Tonbridge the proportion of the joint cost borne by the National Health Service was about the same for both groups at around 17 per cent. There was no evidence for the withdrawal of Community Nursing found in the Community Care Scheme on Sheppey; on the contrary, cases in the Tonbridge scheme consumed nearly twice as much of this resource as the Tonbridge comparison group.

The average Community Care weekly package for Tonbridge in round figures comprised one day's day care on alternate weeks, one and a half hours home help, one meal on wheels, one and a quarter hours care management time, £9.00 in helper fees, £2.00 in helper expenses, one geriatric day hospital attendance every third week and 30 minutes Community nursing. This package is fairly similar to that for Sheppey, though with somewhat smaller quantities for most items. The corresponding comparison group package was one day's day care every week, one and a half hours home help, one meal on wheels, fifteen minutes area team social work, one geriatric day hospital attendance per month and fifteen minutes community nursing. The main reason for this comparison group package being relatively expensive to the social services department, at £20.73 per week, was the high level of day centre attendance which made up two-thirds of this cost.

5 Overview of cost results

The results of this demonstrate strikingly that the improved outcomes in both schemes were achieved at no additional combined cost to the social services department and National Health Service, whether annual or weekly costs were considered. Indeed, the weekly combined cost in Tonbridge was significantly smaller for the Community Care group. However, some of this apparent saving arose from the method of selecting the comparison group through the day centre, their much greater consumption of day care (some eight pounds per week more) accounting for over one third of the difference. If day care costs are excluded, the combined agency cost is no longer significantly less at the five per cent level for the experimental group. This matter is returned to in section 2.2 of Chapter 12.

In both schemes there was a major transfer of expenditure from the National Health Service to the social services department, brought about by a much smaller usage of hospital beds. Area differences in the availability of institutional care beds were much too small to account for this group difference. Assuming the schemes were responsible, they would have had the effect of substantially reducing the blocking of both hospital beds and consequently residential care beds, allowing more scope for respite care.

While in Sheppey both annual and weekly SSD costs of the Community Care group were significantly more than for the comparison group, in Tonbridge this difference was smaller and insignificant. In both areas weekly costs to the NHS were significantly smaller in the Community Care group. In examining costs for the period spent at home, group differences in SSD expenditure showed a broadly similar pattern to costs based on the whole year, the greater cost of the Community Care group being attributed largely to

expenditure on care management time and on helpers. However, NHS costs now showed no significant group difference in either scheme.

The discussion of these important cost results will be expanded upon in the concluding chapter.

CHAPTER 9

COSTS OF OUTCOMES

It was found in Chapter 7, section 4 that older people receiving Community Care benefited significantly during a twelve month period over a range of aspects of their quality of life, quality of care, health status and circumstances of their informal carers, when compared with those receiving standard services. Moreover, Chapter 8 demonstrated that these improvements were achieved at no greater combined cost to the social services department and National Health Service, though Community Care did require a significant redistribution of the cost burden from the National Health Service to the social services department. However, neither the benefits to the scheme nor the absence of an overall increase in cost were in themselves the ideal criteria for success. Instead, it is desirable to determine the costs to various parties of outcome combinations likely to be the most appropriate choices for managers.

Two types of cost-output relationship have been examined. The first type involved predicting total annual cost both to the social services department and to the National Health Service, including periods spent in institutional care. This included testing to what extent relationships already derived for the Thanet Community Care Project were valid in Sheppey and Tonbridge. The second type of relationship involved predicting cost while at home, broken down into care management cost and other community-based service costs. The extent to which care management activity could reduce other community-based service costs was investigated.

1 Outcomes and annual cost: SSD and NHS

The approach used was a modification of that adopted for the Thanet Community Care Project (Challis and Davies 1986; Davies and Challis 1986), in which annual costs to the social services department and National Health Service were each expressed for matched groups as a cost function (Chapter 3) in terms of initial user characteristics and the outcomes achieved over the evaluation year. This method was modified in two respects for Sheppey and Tonbridge. Initial characteristics and outputs relating to informal carers were included in the analysis. This is because improving the welfare of informal carers was an important part of the care manager's strategy. Thus annual costs to the social services department were predicted for each matched group separately in terms of both the initial characteristics of the older person and carer and the outputs achieved. The outputs considered involved percentage improvements in both quality of care and morale of the older person and relief of stress in the informal carer. The items for consideration as predictors of cost to the National Health Service were initial user characteristics and, as outputs, percentage improvements in general health and activities of daily living score - with again terms for informal carers. In predicting costs to each budget, survival time was included as a possible outcome. Although the circumstances leading to an early death are sometimes extraneous to the care process, there are grounds for assuming that enhanced care, coupled with improved communication between agencies could lead to increased longevity (Challis and Davies 1986, Davies and Challis 1986).

There were stronger grounds than in Thanet for believing that SSD expenditure would reduce that for the NHS and vice versa, at least for the Community Care group. Firstly, it has already been observed that Community Care involved considerable additional

expenditure to the social services department, while reducing expenditure to the health service. Secondly, the care managers reported that the introduction of the scheme had led to some tasks being off-loaded from community nurses to CCS helpers. Thirdly, the presence of the scheme led to some cases being returned prematurely to CCS following periods in hospital. Fourthly, the scheme enabled some illnesses or other health problems to be cared for at home rather than in hospital. Finally good Community Care practice had appeared to result in an improvement in the health of some users; in other words, expenditure by the social services department through Community Care might be expected to have a preventative effect in reducing the need for NHS involvement.

There were also reasons for expecting that a relationship between costs to the two agencies might be found in standard provision. Thus an admission to local authority residential care could frequently reduce the need for a hospital admission. Local authority homes often retained cases suffering from conditions such as incontinence or brain failure for which hospital care could also have been an option.

Hence, the second modification of the Thanet approach required that the method of two stage least squares be adopted, already introduced in Chapter 3. By this means, the predicted value of NHS cost from the second equation could be included as a predictor in the first equation, while predicted SSD cost from the first equation could be included as predictor in the second equation. The outputs, together with the list of initial characteristics (quasi-inputs) used in predicting the costs to each agency are shown in Table 9.1. The list covered aspects of the older person's health and dependency, social support, attitude to help and physical environment.

To take account of the interrelationship between different types of output, known as joint supply (Chapter 3), product terms between outputs were allowed to enter each equation. Relationships between costs and improvements (outputs) may not always be linear; for example, it may be more than twice as expensive to improve morale by 20 per cent than by 10 per cent. Consequently squared outcome terms were allowed to enter the equations.

1.1 Testing Thanet cost-outcome relationships on Sheppey and Tonbridge data

Sheppey

Before deriving the best relationships for predicting Sheppey costs, it was first of interest to test the relationships found in the earlier Thanet Project, to see whether these still held. Because the Thanet equations referred to costs at their 1977 levels, the predicted cost was increased in proportion to the increase in the Community Care spending limit of two-thirds the cost of a place in a local authority residential home. The testing of the Thanet relationships was undertaken in three stages. Firstly, the goodness of fit of the Thanet equations to the Sheppey data was tested. Secondly, the average predicted cost was adjusted to make it equal to the average actual cost, by adding an appropriate constant term to the cost function, and the improvement in the goodness of fit determined. Thirdly, a still better fit was obtained by continuing to use the same predictors in the relationship as in Thanet, but by allowing the coefficients to vary. Now that the Thanet equations had been tested, the final step was to let other predictors enter or leave the relationship, drawn from the list in Table 9.1 as well as allowing for simultaneity between SSD and NHS cost using two stage least squares, in order that the best equation for the Sheppey data might be obtained.

Table 9.1 Predictor variables used in the cost estimation

Variable	Variable form
Outputs	
Quality of care	Per cent improvement or decline
Subjective well-being	Per cent improvement or decline
Survival	Weeks survived
General health	Per cent improvement or decline
Activities of daily living	Per cent improvement or decline
Malaise	Per cent improvement or decline
Quasi-inputs	
Health and dependency	
Eyesight difficulties	None, moderate, severe
Hearing difficulties	None, moderate, severe
Giddiness	None, moderate, severe
Breathlessness	None, moderate, severe
Risk of falling	None, moderate, severe
Incontinence of urine	None, occasional, frequent
Incontinence of faeces	None, occasional, frequent
Dependency states	Dependency Groups 1, 2, 3 and 4
Confusion/disorientation	Sum of responses to items concerning behaviour, appearance, memory: range 0-9
Depressed mood	None, mild, moderate, severe
Felt capacity to cope	Sum of responses to four questions concerning capacity to cope with different areas of daily living: range 4-16
Loneliness	Sum of responses to two questions concerning felt loneliness and dissatisfaction: range 0-6
Anxiety	None, mild, moderate, severe
Social support	Total weekly social contacts
All formal/informal care	Present or absent
Support of spouse	Weekly social contacts
Support from children	Weekly social contacts
Support from relatives	Weekly social contacts
Support from neighbours and friends	
Personality and attitudes to help	Characteristic present or absent
Hostile/rejecting attitude to help	Characteristic present or absent
Passive/dependent attitude to help	Characteristic present or absent
Dependent/demanding attitude to help	
Physical environment and other factors	Number of identified problems
Shortcomings in housing	Suitable, unsuitable, detrimental
Overall suitability of housing	Number of reasons
Older person's dissatisfaction with housing	Years
Age	Whether female
Sex	Yes/No
Whether retired to area	Yes/No
Bereavement during past year	

Because the Thanet equations were not fitted to the Sheppey data, the usual parameters for measuring goodness of fit, namely R^2 and adjusted R^2, were more difficult to interpret. Instead, the average absolute error in predicting cost, E, was used, expressed as a fraction of the average spread (mean absolute deviation) about the average cost. This gave a convenient measure of the error involved in using the particular equation being tested. In the case of a perfect fit, E would take on the value 0. Clearly if E is greater than one, in other words the error is greater than that which would result by setting predicted cost to average cost, the fit is unsatisfactory.

It can be seen from Table 9.2 that the Thanet equation for annual costs to the social services department of Community Care gave a poor fit with E = 1.04, though the average predicted cost of £2433 was not much higher than the average actual cost of £2059. If the constant term was adjusted to give the correct mean predicted cost, E fell only slightly to 0.98. However, when all the coefficients of variables in the Thanet equation were allowed to vary, the fit became excellent, with E at only 0.29. Finally, if any variables in Table 2.14 were allowed to enter the equation, the fit became still better. Although E rose slightly from 0.29 to 0.33, this was due to the much smaller number of variables in the equation (7 instead of 16). Because these last two equations were least squares fits, they could be compared more effectively by means of the adjusted R^2 statistic. This gave a measure of the proportion of the variation explained by the equation, after allowance was made for the number of cases and variables involved. It can be seen that this rose from 0.77 to 0.83.

The Thanet equation for standard provision gave a considerably worse fit, with E amounting to 2.46 and an average predicted cost of -£411! In other words, Sheppey comparison cases were costing considerably more than would be predicted using the Thanet equation. Even after adjusting the constant term to give the correct average of £911, E was still high at 2.17.

In the case of National Health Service annual costs, the Community Care equation was the worse of the two, with E at 2.30 and the average predicted cost of £2109 far exceeding the average actual cost of £844. The predicted NHS cost of standard provision of £1445 was only slightly below the true value of £1610, though the fit was still poor (E = 1.22). These results reflect the large shift in resource consumption from the NHS to the SSD for the care managed scheme in Sheppey. Such a shift was not found in Thanet.

It may be concluded from Table 9.2 that even when all coefficients in the Thanet equations were allowed to vary, the fits were still very poor except for the costs to the social services department for Community Care cases. For this group, in other words, the factors determining cost to the social services department were similar to those for Thanet, but operated through different types of relationship as shown by the different relative sizes of coefficients of the predictors.

It is unsurprising that the best cost predictions were achieved when the limitations of the Thanet relationships were not imposed, and all variables in Table 9.2 were free to enter the equations allowing for the option of simultaneity between SSD and NHS costs using 2SLS. The improvement in fit is demonstrated by the reasonably high values of adjusted R^2 in Table 9.2 found in the fourth row of each group.

Table 9.2 Showing how explained variation in costs for Sheppey improved as the constraints inherent in the cost functions used for Thanet were successively relaxed

Cost account	Group[1, 2]	Cost function	R^2	adj R^2	Average error as a fraction of average deviation €	sig F[4]	No. of independent variables	Average predicted cost[3] £
Social services department	E	Thanet equation	-	-	1.04	-	17	2433
		Constant term allowed to vary	-	-	0.98	-	17	2059
		All coefficients allowed to vary	0.89	0.77	0.29	0.001	16	2059
		Combination of variables drawn from same pool as for Thanet is optimised	0.86	0.83	0.33	<0.001	7	2059
	C	Thanet equation	-	-	2.46	-	13	411
		Constant term allowed to vary	-	-	2.17	-	13	911
		All coefficients allowed to vary	0.42	-0.01	0.88	NS	13	911
		Combination of variables drawn from same pool as for Thanet is optimised	0.46	0.38	0.83	<0.01	4	911
National Health Service	E	Thanet equation	-	-	2.30	-	15	2109
		Constant term allowed to vary	-	-	1.80	-	15	844
		All coefficients allowed to vary	0.32	-0.31	0.92	NS	15	844
		Combination of variables drawn from same pool as for Thanet is optimised	0.72	0.58	0.92	<0.01	10	844
	C	Thanet equation	-	-	1.22	-	12	1445
		Constant term allowed to vary	-	-	1.22	-	12	1610
		All coefficients allowed to vary	0.37	-0.03	0.80	NS	12	1610
		Combination of variables drawn from same pool as for Thanet is optimised	0.79	0.69	0.80	<0.001	10	1610

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Sample size: 32 cases per group.
3. 1982 prices.
4. NS: Not significant.

Table 9.3 Showing how explained variation in costs for Tonbridge improved as constraints inherent in the cost functions used for Thanet were successively relaxed

Cost account	Group [1,2]	Cost function	R^2	adj R^2	Average error as a fraction of average deviation €	sig F [4]	No. of independent variables	Average predicted cost [3] £
Social services department	E	Thanet equation	-	-	1.72	-	16	2347
		Constant term allowed to vary	-	-	1.20	-	16	1376
		All coefficients allowed to vary	0.82	0.36	0.38	NS	16	1376
		Combination of variables drawn from same pool as for Thanet is optimised	0.77	0.57	0.44	0.01	10	1376
	C	Thanet equation	-	-	2.68	-	14	751
		Constant term allowed to vary	-	-	1.91	-	14	958
		All coefficients allowed to vary	0.48	-0.43	0.69	NS	14	958
		Combination of variables drawn from same pool as for Thanet is optimised	0.76	0.63	0.42	<0.01	8	958
National Health Service	E	Thanet equation	-	-	3.29	-	15	2258
		Constant term allowed to vary	-	-	2.51	-	15	648
		All coefficients allowed to vary	0.37	-0.99	0.76	NS	15	648
		Combination of variables drawn from same pool as for Thanet is optimised	0.62	0.45	0.55	<0.05	7	648
	C	Thanet equation	-	-	0.98	-	12	2077
		Constant term allowed to vary	-	-	0.96	-	12	1967
		All coefficients allowed to vary	0.82	0.61	0.43	NS	12	1967
		Combination of variables drawn from same pool as for Thanet is optimised	0.94	0.90	0.55	<0.001	9	1967

Notes:

1. E: Experimental (Community Care) group; C: Control (Comparison) group.
2. Sample size: 32 cases per group.
3. 1982 prices.
4. NS: Not significant.

Tonbridge

The first stage was to try out how well the Thanet equations succeeded in predicting the Tonbridge costs. The results are shown in Table 9.3. In predicting the cost to the social services department of the Tonbridge Community Care Scheme, the Thanet equation was still less successful than for the Sheppey scheme, the ratio, E, of average error to average deviation being as high as 1.72. Part of this error was due to the average predicted annual cost of £2347 being much higher than the average actual cost of £1376. By adjusting the constant term in the equation to make the average cost correct, the value of E fell somewhat, but was still 1.20. When the coefficients of all the terms in the equation were allowed to vary, E fell to 0.38, corresponding to an adjusted R^2 of 0.36. It was only when the variables were selected to give the equation with the best possible fit that the adjusted R^2 rose to a reasonable value, 0.57.

In the case of standard provision, the Thanet equation was worse still in predicting the cost to Tonbridge cases, the error E being 2.68 and the average predicted cost being negative which was also the case with the Sheppey data. Thus Tonbridge comparison cases, like those in Sheppey, cost far more to the SSD than would be predicted from the Thanet equations. Even after adjusting the constant term and then allowing the other coefficients to vary for a best fit, the adjusted R^2 was still very poor at -0.43. It was only when there was free choice over the variables entering the equation that the adjusted R^2 could rise to a reasonable value of 0.63.

In predicting the cost to the National Health Service of the Tonbridge Community Care Scheme, the Thanet equation gave an extremely poor fit, the error, E, reaching 3.29. The average predicted annual cost of £2258 was far higher than the average for the Tonbridge data of £648. A similar effect was found for the Sheppey data and the result is again consistent with the finding that in Community Care, the social services department took over from the National Health Service in funding the bulk of the care.

The Thanet equation which predicted the cost of standard provision to the National Health Service was a little more successful, the error, E, amounting to 0.98. The average predicted annual cost of £2077 was already close to the average for the Tonbridge comparison cases of £1967, so little adjustment of the constant term was required. When the coefficients of all the terms were allowed to vary, the adjusted R^2 of 0.61 indicated a reasonable fit. When the equation was no longer restricted to the variables found in the Thanet equation, the fit improved still further with an adjusted R^2 of 0.90.

The equations which result when the limits imposed by the Thanet equations are no longer applied are considered in the next section. To illustrate how each term in an equation can assist in interpretation, the equations for SSD and NHS costs for each group in Sheppey have been considered in detail, though subsequent equations have had much of the self-evident results omitted from the commentary.

1.2 Social services department cost-outcome relationships in Sheppey

The predictors appearing in the right hand side of the cost function for the social service department are shown in the first pair of columns of Tables 9.4 and 9.5 for the Community Care and comparison groups respectively. The column labelled 'cost effect' shows the coefficient by which each predictor is multiplied. The left-hand side of the equation, representing the predicted annual cost to the social services department, could now be

worked out for each case from the values of the predictors on the right-hand side of the equation.

Because the predicted cost to the social services department entered as a predictor in the NHS cost function for the Community Care group, using the method of two stage least squares, it was necessary to include all the other NHS cost predictors in the equation for SSD costs in Table 9.4, even though these were mainly insignificant. In the following commentary only the significant terms are considered. However, the predicted cost to the NHS would not enter as a predictor in the SSD cost function for either group.

Table 9.4 Annual cost of outputs to the social services department and National Health Service in matched Sheppey Community Care cases, £ at 1982 prices

Variable type	Variable	SSD equation[1]		NHS equation[1]	
		Cost effect £	Sig t^2	Cost effect £	Sig t^2
Cost to other budget					
Annual net SSD revenue cost				-.757	<.05
Outputs					
Q (Quality of care)		-26.08	.05		
Q^2 (Quality of care)^2		.166	<.01		
Survival (weeks)		74.56	<.001	89.38	.08
Quasi-inputs					
Health and dependency					
Dependency group 1		-880.96	<.001		
Incontinence of faeces		708.71	.01		
Depressed mood		-229.43	.07	734.12	<.05
Initial health status					
Initial adl score		-93.52	NS	568.40	.01
Social support					
Lives with spouse		377.91	NS	-2285.14	.17
Other factors					
Age		34.84	<.05		
Sex (whether female)		-218.96	NS	-1526.83	<.05
Bereavement during past year		246.50	NS	1382.53	<.05
(Constant)		-3546.08	.08	-1648.27	NS
SSD equation: R^2 = .89	Adj R^2 = .84	F = 15.33	sig F <.001		
NHS equation: R^2 = .42	Adj R^2 = .25	F = 2.4	sig F = .05		

Sample size 32

Notes:

1. The two equations were obtained using two stage least squares. Although predicted net SSD cost entered the equation for NHS cost, predicted NHS cost would not enter equation for SSD cost.
2. NS: Not significant.

Table 9.5 Annual cost of outputs to the social services department and National Health Service in matched Sheppey comparison cases, £ at 1982 prices

Variable type	Variable	SSD equation[1]		NHS equation[1]	
		Cost effect £	Sig t	Cost effect £	Sig t[2]
Outputs					
	Q^2 (Quality of care)^2	.096	.01		
	M^2 Q^2 (Morale)^2 x (Quality of care)^2	$-1.94.10^{-6}$	.09		
	G General health			-22.91	<.01
Quasi-inputs					
Health and dependency					
	Incontinence of urine			1362.69	.01
	Depressed mood			913.13	<.05
	Confusion/disorientation	271.96	.01		
Other factors					
	Age of user			58.59	.10
(Constant)		2228.19	<.05	-3041.59	NS
SSD equation: R^2 = .43	Adj R^2 = .37	F = 7.00	sig F = .001		
NHS equation: R^2 = .40	Adj R^2 = .31	F = 4.48	sig F <.01		

Sample size 32

Notes:

1. Using two stage least squares no evidence of simultaneity could be found, so each equation was obtained independently using ordinary least squares.
2. NS: Not significant.

Quasi-inputs

Health and dependency

Of the initial characteristics which influenced cost to the Community Care group, cases in dependency group 1 were most affected, being on average £880.96 cheaper per annum. This was the lowest dependency group, for which essential help was needed only once a day or less and for which Community Care costs were therefore understandably lower. Since cases in the comparison group were more likely to receive a low level of provision whatever their level of need, it is perhaps unsurprising that this term did not enter that equation. Incontinence of faeces contributed towards higher cost of the Community Care group. Because all cases of faecal incontinence in the comparison group died within the year, the annual cost over these shorter periods was not significantly above average; hence their absence from the cost function. Community Care cases suffering from depressed mood cost less to the SSD though spent more time in acute and psychiatric hospitals. In the comparison group, cognitive impairment or disorientation was the only initial characteristic predicting increased expenditure. Standard provision could frequently not maintain this group in the community for any length of time, and while only 35 per cent of the non-cognitively impaired older people were admitted to long-term institutional care within the year, 55 per cent were admitted from the cognitively impaired group, including proportionately more to local authority residential care. Amongst the Community Care cases the proportions admitted to long-term institutional care from the non-confused and confused groups were about the same at around 20 per cent. Indeed the cognitively impaired cases spent on average fewer weeks in local authority residential care and cognitive impairment did not enter the Community Care cost function for costs to the social services department.

Other factors

There is abundant evidence that the needs of older people increase with age (Peek *et al.* 1997). This variable did enter the Community Care equation, accounting for an extra annual expenditure of £348 for each additional ten years of age. Thus the scheme appeared able to respond with increased resources to the additional needs of older cases.

Outputs

With regard to outputs, Community Care cases were more expensive the longer they survived during the one year evaluation period, as expected. Although comparison group cases who lived longer did have a slightly greater annual cost, this relationship was not sufficiently strong to enter the equation. This was mainly as a result of cases who died within the year having consumed local authority residential care for longer as a result of their greater need. Thus, although their average weekly cost was greater, it applied over a shorter period. In Community Care, where admissions to local authority residential care were less frequent, those who lived longer were more likely to cost more.

The other highly significant output term to enter the Community Care equation was a squared quality of care term, representing a law of diminishing returns in achieving improvement in quality of care. A similar term entered the comparison group equation, combined with a negative squared product term between subjective well being and quality of care. This represented an effect of joint supply, whereby resources spent in improving quality of care also improved subjective well-being and vice versa.

The predicted cost to the social services department of achieving different levels of improvement in quality of care and subjective well-being are shown in Table 9.6. Other variables in the equation were set at the mean values in the combined matched groups in order that cost differences arising through miss-match between the two groups were eliminated. It can be seen that the annual cost was always greater for the Community Care group. The difference became negligible for large improvements in quality of care but no improvement in subjective well being, when comparison group cases were relatively expensive. These conditions were typical of those comparison group cases entering long-term residential care.

When the marginal cost of an additional one per cent increase in quality of care was considered, it can be seen that the Community Care group cost less than the comparison group for small improvements in both quality of care and subjective well-being. These Community Care cases all remained at home, so the range of costs was rather less than for corresponding comparison cases, some of which entered local authority residential care. However, in the Community Care group the average improvement in quality of care was large at around 50 per cent, and at these levels marginal cost was less for the comparison group. Although these comparisons appear to indicate that Community Care provides a more expensive service distributed with a lesser degree of efficiency under most circumstances, they do not take account of the large saving made to the National Health Service.

Table 9.6 Annual and marginal costs to the social services department of achieving different levels of outputs[1,2] in Sheppey, £ at 1982 prices

	% Improvement in subjective well-being											
	0			20			40			60		
	% Improvement in quality of care											
	0	20	40	0	20	40	20	40	60	20	40	60
Average cost												
Community care	1022	1232	1558	1022	1232	1558	1232	1558	2000	1232	1558	2000
Comparison group	810	1147	1545	724	1024	1377	878	1180	1527	711	951	1229
Cost advantage to comparison group	212	85	13	298	208	181	354	378	473	521	607	771
Marginal cost of a 1% increase in Q^3												
Community care	7.57	13.39	19.21	7.57	13.39	19.21	13.39	19.21	25.03	13.39	19.21	25.03
Comparison group	15.31	18.37	21.44	13.60	16.33	19.05	13.90	16.22	18.54	11.11	12.96	14.81
Cost advantage to community care	7.74	4.98	2.23	6.03	2.94	-0.16	0.51	-2.99	-6.49	-2.28	-6.25	-10.22

Notes:

1. Results were calculated from the corresponding SSD cost equations in Tables 9.4 and 9.5.
2. Other variables in the equations were set at the mean values for the combined matched groups.
3. Q: Quality of care outcome.

1.3 National Health Service cost-outcomes relationships in Sheppey

The factors which emerged as predictors of cost to the National Health Service are shown in the second pair of columns of Tables 9.4 and 9.5 for the Community Care and comparison groups respectively.

Cost to other budget

The cost to the social services department only affected health services costs for the Community Care group. It can be seen that for every £1 spent by the care manager on social services department costs, 76p was saved by the National Health Service.

Quasi-inputs

Health and dependency

Regarding the initial characteristics of the older people affecting cost, depressed mood was associated with an increased cost to the National Health Service in both groups, through a greater usage of acute and psychiatric hospital beds. In the comparison group, cases having incontinence of urine incurred a greater cost to the health service, particularly through greater usage of acute, geriatric and psychiatric in-patient beds. The fact that incontinence of urine does not enter the Community Care group equation reflects the ability of scheme to take on board these problems without significant extra cost to the National Health Service. However, the increased SSD cost of cases with faecal incontinence, whose presence is highly correlated with incontinence of urine, suggests that in the Community Care group there may have been a transfer of responsibility for tackling problems of incontinence from the NHS to the SSD. This is confirmed by the finding that, while in the community, care managed cases had daily incontinence problems tackled by Community Care helpers rather than community nurses.

Initial health status

Anderson, James, Miller, Worley and Longino (1998) comment on the close association between functional disability and morbidity. In the Community Care group it was found that cases with a higher initial ADL score cost more to the NHS, suggesting that more NHS resources were deployed on those cases with greater disability.

Social support

Amongst Community Care cases, those living with a spouse cost £2285 per annum less to the National Health Service. Although the effect was not quite statistically significant ($p=.17$), the term was included as it allowed other terms to enter significantly. It suggests that the presence of a spouse may reduce the need for hospital in-patient admissions.

Other factors

Amongst Community Care cases a recent bereavement was associated with additional NHS cost through hospital admissions, particularly amongst men. In this group, older men consumed considerably more hospital in-patient resources than women, costing an extra £1527 per year to the NHS. This occurred despite the fact that these males lived on average for a much smaller proportion of the evaluation year than the females, a similar result to that found by Anderson *et al.* (1998) for a group of older people over a two year period. This high rate of hospital in-patient care for males in the Sheppey Community Care scheme is also consistent with the result in Table 7.8 (Chapter 7) that, for those users in Sheppey living alone and receiving Community Care, men are more likely to be admitted to permanent institutional care than women ($p<.01$) during the first twelve

months. In the comparison group, the age of the older person may have contributed towards health services costs (p=.10).

Outputs

An output term representing an improvement in ADL score or general health did not enter the Community Care equation for NHS cost. This does not necessarily imply that Community Care did not achieve improvements in health status; indeed, the results of comparing outcomes by group suggested there were positive effects. Instead these effects may be masked by the fact that those cases receiving Community Care which deteriorated most in general health and ADL capacity tended to have the most NHS resources targeted on them. This is encapsulated in the fact that such cases were most likely to be admitted to hospital. Indeed, a negative general health output term, G, entered the comparison group equation, indicating that the targeting of resources on cases deteriorating in health was the dominant effect.

Table 9.7 Annual cost of outputs to the social services department and National Health Service in matched Tonbridge Community Care cases, £ at 1982 prices

Variable type	Variable	SSD equation[1]		NHS equation[1]	
		Cost effect £	Sig t	Cost effect £	Sig t
Outputs					
	Q Quality of care	24.48	.06		
	M Morale	33.50	.05		
	MQ (Morale) x (Quality of care)	-.247	.05		
	Reduction in activities of daily livg. score			8.75	.07
	Survival (weeks)	78.96	<.01		
Quasi-inputs					
	Health and dependency				
	Hearing difficulties	476.60	.14	525.27	.10
	Giddiness			526.10	.09
	Risk of falling	-764.12	.01		
	Depressed mood			-557.51	.01
	Initial health status				
	Initial adl score			214.99	.01
	Initial level of well-being				
	Quality of care shortfall	198.80	<.01		
	Social support				
	Social contact score	41.41	.01		
	Other factors				
	Sex (whether female)			1077.08	.01
	Bereavement during past year			1068.99	.01
	Whether retired to area	905.97	.07		
(Constant)		-7503.63	<.01	-2639.90	<.05

SSD equation: R^2 = .73 Adj R^2 = .55 F = 3.9 sig F = .01
NHS equation: R^2 = .62 Adj R^2 = .45 F = 3.56 sig F <.05

Sample size 23

Note:

1. Using two stage least squares no evidence of simultaneity could be found, so each equation was obtained independently using ordinary least squares.

1.4 Social services department cost-outcomes relationships in Tonbridge

The equations explaining variations in annual cost to the social service department in Tonbridge are shown in the first pair of columns of Tables 9.7 and 9.8 for Community Care and comparison group cases respectively. In contrast to Sheppey, SSD cost entered as a predictor of NHS cost only in the comparison group. This could have arisen through the beneficial effects on health of a large day care input. Because two stage least squares required the predictors of NHS cost to enter the equation for SSD cost, there are some insignificant terms in this last equation.

Table 9.8 Annual cost of outputs to the social services department and National Health Service in matched Tonbridge comparison cases, £ at 1982 prices

Variable type	Variable	SSD equation[1] Cost effect £	SSD equation[1] Sig t[2]	NHS equation[1] Cost effect £	NHS equation[1] Sig t
Cost to other budget					
	Annual cost to SSD			-1.25	.001
Outputs					
	Q (Quality of care)	34.90	.11		
	Q^2 (Quality of care)^2	-.161	.08		
	G^2 (General health)^2	.0314	.09	-.0509	.06
	Survival (weeks)	35.95	<.05		
Quasi-inputs					
	Health and Dependency				
	Dependency group 4	558.93	NS	6101.20	<.001
	Initial level of well-being				
	Quality of care shortfall	243.88	<.05		
	Initial health status				
	ADL score	-14.82	NS	643.29	<.001
	Social support				
	Social contact score	74.52	<.01		
	Lives with spouse	-2517.98	<.001		
	Contact with children	-118.23	<.01	-89.03	.07
	Attitude to help				
	Passive/dependent attitude	-726.03	NS	5946.90	<.001
(Constant)		-4311.76	<.05	2359.26	<.001

SSD equation: $R^2 = .79$ Adj $R^2 = .58$ F = 3.82 sig F <.05
NHS equation: $R^2 = .91$ Adj $R^2 = .88$ F = 27.63 sig F <.001

Sample size 23

Notes:

1. The two equations were obtained using two stage least squares. Although predicted net SSD cost entered the equation for NHS cost, predicted NHS cost would not enter equation for SSD cost.
2. NS: Not significant.

Quasi-inputs

(i) Health and dependency

Community Care cases at risk of falling cost significantly less. The quality of care shortfall for these cases was frequently high, since ideally the older person would need supervision whenever they were on their feet. In practice, given limited resources, the Community Care Scheme tended to provide frequent pop-in visits to minimise the opportunities for falling and avoid the 'long-lie' should a fall take place. Consequently, helper costs were smaller for these cases, making the annual cost less than that suggested by the quality of care shortfall term in the equation.

(ii) Initial level of well being

As anticipated, expenditure to both groups increased the greater the quality of care shortfall. In Community Care this took the form of more use of helpers, home help and day care, while in the comparison group there was a greater use of local authority residential care.

(iii) Social support

Those older people with more informal contacts tended to cost more to both groups. This arose because cases in need of most help had already attracted a large number of social contacts, both informal and through visits from community nurses and home helps, though this still left much of the need for care unmet. Consequently, Community Care cases with a high social contact score tended to attract more community resources, while the corresponding comparison cases were more likely to end up in local authority residential care. Amongst comparison group cases, those with a spouse cost £2518 p.a. less to the social services department. This arose because the spouse was left to provide a large proportion of the care. As with the informal carers of cognitively impaired older people referred to earlier, this frequently left the spouse in a stressed condition. Amongst Community Care cases extra resources were provided by the scheme in providing relief to the spouse. The cost saving to the comparison group due to contacts with children of £118 p.a. per weekly contact was much smaller, reflecting their smaller role in the provision of informal support.

(iv) Other factors

Amongst Community Care cases it was found that older people who had retired to the area cost more to the social services department. This was hardly surprising as they received less support from relatives despite having a greater quality of care shortfall. The scheme responded by more visits from home helps and particularly Community Care helpers.

Outputs

For cases receiving Community Care, increases in subjective well being, M, and quality of care, Q, both entered the equation, together with a joint supply term, MQ. In other words, some of the cost used in improving quality of care also improved subjective well being and vice-versa. However, as the joint supply term was stronger than the quality of care term, cost decreased as Q increased except when there was a decrease in morale, which only applied in some forty per cent of cases. When an increase in cost was associated with a decrease in quality of care, this implied that resources were being targeted at cases whose quality of care was deteriorating. In these circumstances Q was acting as a quasi-input, not an output.

Table 9.9 Annual cost to the social services department of achieving different levels of outputs[1,2] in Tonbridge, £ at 1982 prices

	% Improvement in subjective well-being											
	0			20			40			60		
	% Improvement in quality of care											
Average cost	0	20	40	0	20	40	20	40	60	20	40	60
Community care	1133	1128	1123	1308	1205	1102	1282	1080	877	1359	1058	757
Comparison group	1172	1258	1236	1172	1258	1236	1258	1236	1106	1258	1236	1106

Notes:

1. Results were calculated from the corresponding SSD cost functions in Tables 9.7 and 9.8
2. Other variables in the cost functions were set at the mean values for the combined matched groups.

For cases receiving standard provision, quality of care entered both as a positive Q term and as a negative Q^2 term. This meant that for values of Q smaller than 108 – that is, for nearly 80 per cent of cases - it cost more to achieve a further improvement, though this extra cost decreased as Q increased. The costs of achieving different percentage improvements in subjective well being and quality of care for each matched group are compared in Table 9.9. As with Sheppey, the values of other predictors in the two equations were taken as the mean for the two matched groups combined. It can be seen that, except when small improvements in quality of care were combined with large improvements in subjective well-being, the Community Care group worked out to be cheaper than the comparison group. The cost saving was greatest when large improvements in both subjective well being and quality of care were achieved, a result of the joint supply effect which did not apply for the comparison group. This result provides clear evidence of the superior efficiency of the Community Care Scheme in achieving improvements in both subjective well being and quality of care at a lower cost than in standard provision under most circumstances. For most values of M and Q, the marginal annual net SSD cost of a one per cent increase in Q was negative for both matched groups. Since this would make a group comparison of marginal costs difficult to interpret, these were excluded from Table 9.9 for Tonbridge.

Amongst comparison group cases, SSD cost increased with the square of the reduction in health problems; that is, according to the law of diminishing returns. This reduction is perhaps most likely to arise from the improvement of those cases suffering an acute episode at time 1.

A variable specifying whether the user lived in Tonbridge or Malling would not enter the equation for Community Care cases. Also a variable indicating whether a Community Care case had been evaluated during the period of disruption of the care management team also would not enter. This suggests that both area effects and the period of disruption had a negligible impact on the Community Care equation.

1.5 National Health Service cost-outcomes relationships in Tonbridge

The equations explaining variations in annual cost to the National Health Service are shown in the second pair of columns of Tables 9.7 and 9.8 for Community Care and comparison group cases respectively.

Cost to other budget

Social services expenditure had no effect on health services costs of the Community Care group. However increased social services expenditure amongst comparison group cases had the effect of reducing expenditure to the National Health Service. For every £100 extra spent on social services resources, a saving of £125 was made on health services resources. Clearly, during time spent in local authority residential care, consuming social services resources, there would be no consumption of domiciliary health resources or day hospital. Indeed the attention to physical needs such as warmth and nutrition in residential care might have the effect of reducing the need for hospital care. Moreover, the substantial consumption of day care amongst the comparison group is likely to reduce the need for day hospital and community nursing. This should be compared with the result for Sheppey, where social services expenditure only reduced health services costs in the Community Care group.

Quasi-inputs

(i) Health and dependency

Both hearing difficulties and giddiness were associated with higher NHS cost to the Community Care group. These terms entered both in their own right and because they were positively correlated with other types of health problems such as breathlessness and incontinence of faeces. These problems could frequently be tackled through community resources such as district nursing or through hospital in-patient treatment. Those cases suffering from depressed mood worked out cheaper to the National Health Service for cases in the scheme, the reverse effect to that found in Sheppey, and the average age of these cases was six years less than for the overall group. Their main source of extra support was from Community Care helpers, and once this support had eased their depression, they became much less costly. Although they received rather more community nursing support, they spent much less time in hospital. Indeed none of them ended up in long-term institutional care. At the same time, they showed a great improvement in subjective well being. For a few of the Tonbridge cases, depression was one of the main problems, and Community Care allowed these people to be supported at home at a modest cost to the social services department and very little to the National Health Service.

Amongst the comparison group, cases in dependency group 4 cost considerably more to the National Health Service, through greater consumption of acute hospital care.

(ii) Initial health status

It was unsurprising that the initial ADL score was a predictor of higher NHS cost in both groups; in other words, NHS resources were targeted at cases with higher ADL scores, which tend to suffer greater morbidity (Anderson *et al.* 1998).

(iii) Social support

Community Care costs were not affected by the level of informal support. However, comparison group cases whose children were involved in providing support were considerably cheaper to the health service, through lower consumption of both acute and long-term geriatric hospital in-patient care. However, considerable demands may have been made on these children in providing nursing support at home.

(iv) Attitudes to help

Although Community Care costs were not affected by attitude to help, comparison cases with a dependent and passive attitude to help were more likely to incur higher health service costs apparently through their reduced readiness to cope. The absence of this term from the Community Care group equation suggests that the care package could accommodate these cases without undue health service expenditure.

(v) Other factors

Female Community Care cases cost more to the health service. They were more socially isolated, received more community nursing and spent longer in hospital. Also cases in the scheme who had suffered a recent bereavement were more expensive to the health service, through greater costs to acute and geriatric hospital care, and to geriatric day hospital for this vulnerable group.

Outputs

The only output to enter the equation for the Community Care group was an improvement in ADL score. This implies that health service resources can be used to improve an older

person's capacity to perform activities of daily living, the result being almost significant at the 5 per cent level (p = .07). This helps to justify the finding that NHS resources were targeted at high ADL score cases. The cost of a 1 per cent improvement in ADL score was £8.75. For comparison group cases, a squared improvement in general health term was the only output to enter the equation and this term had a negative sign, meaning that most health service money was spent on those cases whose health deteriorated the most. In other words, the term is acting as a quasi-input rather than an output. For cases whose health is rapidly deteriorating, hospital in-patient treatment, though costly, may be unable to halt the deterioration altogether, but simply slow down the process.

Once again, the Community Care equation was tested to see whether location in Tonbridge or Malling, or whether the older person was evaluated during the period of disruption, influenced the equation. No statistically significant effect could be found. Also if the predicted value of NHS cost was included as a predictor in the corresponding equation for SSD cost from section 1.4, this term entered insignificantly for each group, as had been the case for Sheppey.

2 Cost-outcome relationships in Sheppey for the period spent at home

2.1 Methodology of domiciliary costs and outcomes investigations

So far the cost-output relationships considered have been based on the full evaluation year and so take account of any periods spent in institutional care. In section 4 of Chapter 8 average weekly costs of care at home were presented, when periods in both short-term and long-term institutional care were excluded. In order to investigate the relationship between costs and outputs for the period spent at home, cost-output relationships were determined as before but only domiciliary contributions of annual costs were included. Because an important aspect of the Community Care costs was the usage of the care manager's time, this was included separately as the first annual component of cost. In the case of the comparison group, care management costs referred to the costs of social worker time. The time allocated by the home help organiser to each user was assumed to be negligible. When care management costs are excluded, all other community-based service costs, both to the social services department and National Health Service, were summed together as a second annual cost component. These other costs included short-term care in a local authority home for older people, but excluded expenditure on short-term hospital care, since expenditure on these acute episodes was regarded as being due partly to exogenous causes, and only partly a result of the cost-outcomes relationships. However, the number of days spent in the Community Care Scheme was allowed to include short-term care both in residential care and for the first six weeks of any period in hospital, in view of the continued activity of the care manager during the periods of acute care.

Sheppey

One limitation of this approach was that, as in cost-outcomes relationships over the full evaluation year, outcomes for cases who died were missing, and the substitution of group mean values for survivors could introduce distortions. Therefore, because only six Community Care cases died or moved away within the evaluation year, these were removed from the group of matched Community Care cases. At the same time the six comparison cases to which these were matched were excluded from the comparison group, in order that both groups remained matched. In this way two matched groups of 26 cases resulted.

Table 9.10 Location of follow up interviews of matched groups in Sheppey[1] and Tonbridge[2]

Location of follow up interviews	Sheppey		Tonbridge	
	Community care	Comparison group	Community care	Comparison group
Interviewed				
- at home	19	13	16	9
- in residential care	5	7	2	5
Not interviewed				
- at home	1		1	2
- long-term hospital care	1	2	1	2
- died		4		2
Sample size	26	26	20	20

Notes:

1. In Sheppey, the six community care cases that died or moved away and the six comparison cases to which they were matched were excluded.
2. In Tonbridge, the three community care cases that died or moved away and the three comparison cases to which they were matched were excluded.

Another problem was that not all of these remaining cases received follow up interviews at home. The locations of these interviews are shown in Table 9.10. As in the case of cost-outcomes analyses over the full evaluation year, cases who did not receive a follow up interview were assigned the mean value for the group for each outcome measurement. It is possible that admissions to institutional care could have a significant effect on outcomes to both older people and their informal carers. A variable was therefore always made available to enter the cost-outcomes relationship which indicated whether the follow up interview had taken place in residential care. By this means, any significant distortions to the outcomes caused by institutionalisation could be eliminated.

Tonbridge

As in Sheppey, the relationship between costs and outputs was determined for the period spent at home. Once again, to reduce the problem of missing outcome indicators for cases who had died, the three Community Care cases who had died, together with the three comparison cases to whom they were matched, were excluded from the analysis. This left two matched groups of 20 cases. From Table 9.10 it follows that there were only two Community Care cases and six comparison cases who were not interviewed, and for which group means had to be substituted for missing values.

2.2 The dependence of other costs on care management costs

It was anticipated that care management intervention could have the effect of reducing the cost of other resources deployed through improved efficiency. Consequently, care management cost was regarded as one of the items which might enter an equation for other costs. Moreover, since NHS resource deployment was sometimes out of the control of the care manager and could influence care manager activity, it followed that the cost of other resources could affect care manager costs. Because of the interdependence between care management and other costs, the method of ordinary least squares could not be applied. Instead, the method of two stage least squares was adopted, in which the predicted value of other community-based service costs could be included as a predictor in the equation for care management costs, while the predicted value of care management cost could enter as a predictor of other community-based service costs.

Table 9.11 Predictor variables used in the domiciliary cost estimation

Variable	Variable form
Outputs	
Improved quality of care	Per cent improvement or decline
Improved subjective well-being	Per cent improvement or decline
Days spent receiving community care	
Survival	Weeks alive in area
Cost of long-term institutional care	Units of 2/3 cost of a week in a care home
Cost to informal carer	Units of 2/3 cost of a week in a care home
Reduction in general health problem score	Per cent improvement or decline
Reduction in activities of daily living score, including instrumental activities of daily living	Per cent improvement or decline
Reduction in malaise of informal carer	Per cent improvement or decline
Reduction in lifestyle problems of caring	Per cent improvement or decline
Quasi-inputs	
Health and dependency	
Incontinence	None, occasional, frequent
Cognitive impairment	None, mild, moderate, severe
Depressed mood	None, mild, moderate, severe
Loneliness	Sum of responses to two questions concerning felt loneliness and dissatisfaction; range 0-6
Anxiety	None, mild, moderate, severe
Social support	
Lives with spouse	Yes/No
Lives with family	Yes/No
Support of informal carer	Yes/No
Personality and attitudes to help	
Independent - requires persuasion	Characteristic present or absent
Accepting attitude to help	Characteristic present or absent
Dependent attitude to help	Characteristic present or absent
Other factors	
Sex	Whether female
Age of older person in years	
Bereavement during past year	Yes/No
Presence of confidant	Yes/No
Whether informal carer expressed hostility towards user	None, minimal, covert, overt hostility

The pool of variables from which the predictors of both costs are drawn is shown in Table 9.11. It can be seen that this is essentially a selection of the more important variables in Table 9.1. Because care management is expected to affect the consumption of long-term institutional care and the cost to any informal carer, these were both included as outputs. The cost-outcomes relationships for each group are now considered in turn.

2.3 Care management cost-outcomes relationships in Sheppey

The relationship between domiciliary care management costs and outcomes for Community Care cases is shown in the first pair of columns in Table 9.12. Because the predicted care management cost entered as a predictor in the equation for other community-based service costs, using the method of two stage least squares, it was

necessary to include all the remaining other community-based service cost predictors in the care management cost function, even though these were mostly insignificant. However the predicted other community-based service cost would not enter as a predictor in the care management cost function for either group. The corresponding relationship for comparison cases is shown in the first pair of columns in Table 9.13.

Table 9.12 Annual cost of outputs due to care management time and other community-based service costs in matched Sheppey Community Care cases, £ at 1982 prices

Variable type	Variable	Care management cost function		Other community-based service cost function	
		Cost effect £	Sig t[1]	Cost effect £	Sig t
Cost to other budget					
	Predicted annual care management cost			-65.22	.25
Outputs					
	M (Morale)	.523	NS	18.94	<.001
	Q^2 (Quality of care)^2	$3.54.10^{-4}$	NS	.119	<.001
	M^2Q^2 (Morale)^2 x (Quality of care)^2	$3.95.10^{-8}$	NS	$-1.94.10^{-6}$	<.01
	Reduction in carer's lifestyle problems	4.42	<.05		
	Carer's malaise score	1.51	.19	6.78	.19
	Weeks spent in scheme	-.812	NS	64.47	<.001
Quasi-inputs					
	Health and Dependency				
	Cognitive impairment	90.06	.01	303.83	.07
	Depressed mood	21.01	NS	-539.34	.001
	Initial level of well-being				
	Quality of care	28.57	<.05		
	Morale	26.19	<.05		
	Initial health status				
	ADL + IADL score	33.44	.06		
	Other user factors				
	Sex -whether female	1.30	NS	-369.57	.20
	Initial effect on informal carer				
	Carer's malaise score	-19.46	.141	74.02	<.001
(Constant)		536.23	.078	-4763.47	<.001

The two equations were obtained using two stage least squares. Although predicted care management cost entered the equation for other community-based service costs, (albeit at a low level of significance), predicted other community-based service cost would not enter equation for care management cost.

Care management cost function:	$R^2 = .80$	Adj $R^2 = .59$	$F = 3.75$	sig F = .01
Other community-based service cost function:	$R^2 = .91$	Adj $R^2 = .84$	$F = 14.3$	sig F < .001

Sample size 26

Note:

1. NS: Not significant.

Table 9.13 Annual cost of outputs due to area team social worker time and other community-based service costs in matched Sheppey comparison cases, £ at 1982 prices

Variable type	Variable	Care management cost function		Other community-based service cost function	
		Cost effect £	Sig t	Cost effect £	Sig t
Outputs					
	G (General health)	-1.74	<.05	-76.09	<.001
	G^2 (General health)^2			.466	<.001
	M (Morale)			-6.52	<.01
	Q^2 (Quality of care)^2			.0402	.07
	Annual cost to SSD, NHS and private sector of long-term institutional care	-1.87	<.05	-9.89	.01
	Annual cost to informal carer			-263.98	<.01
	Weeks alive	-9.32	.14		
Quasi-inputs					
	Health and Dependency				
	Cognitive impairment	85.92	<.05	652.18	<.001
	Initial health status				
	General health problems			115.94	<.05
	Social support				
	Presence of principal informal carer			-9357.17	<.001
	Other user factors				
	Sex -whether female	-247.41	<.01		
	Bereavement during past year			446.69	<.05
	Effect on informal carer				
	Carer's lifestyle problems			1424.44	<.01
	Hostility expressed towards older person			4387.18	<.001
(Constant)		1162.53	<.01	2799.18	<.001

Using two stage least squares no evidence of simultaneity could be found, so each equation was obtained independently, using ordinary least squares.

Care management cost function:	$R^2 = .60$	Adj $R^2 = .50$	$F = 5.92$	sig F<.01
Other community-based service cost function:	$R^2 = .91$	Adj $R^2 = .82$	$F = 10.61$	sig F<.001

Sample size 26

Outputs

It can be seen that care management time for the Community Care group was successful in reducing the informal carer's lifestyle problems, though led to no significant improvement in morale or quality of care of the older person. In the comparison group, the general health output term is negative. This is because a deterioration in health acted as a proxy for an initial poor medical prognosis, which the evaluator's assessment could not readily tease out. Area team social workers were therefore targeting resources at those cases whose health was deteriorating most rapidly.

Quasi-inputs

A clear relationship was found between care management expenditure on the Community Care group and both the extent of quality of care shortfall and the combined ADL and

IADL score. Thus, care managers were targeting their time on those users who need a lot of help and where there was a large need shortfall. More time was also spent with cognitively impaired cases. In the comparison group, area team social work input was greater for men (an extra £247 per year) and for the cognitively impaired (an extra £86 per year for each level of cognitive impairment, close to the £90 result for the Community Care group).

The lower proportion of the variation in care management cost explained by the equation for the comparison group, as expressed by a smaller adjusted R^2, suggests that more hidden and random factors affected usage of area team social worker time for comparison cases; in other words, the rationale behind their use of time was less systematic than in care-managed Community Care.

2.4 Other community-based service cost-outcomes relationships in Sheppey

The predictors of other community-based service costs are shown in the second pair of columns of Tables 9.12 and 9.13 for Community Care and comparison cases respectively.

Cost of care management time

For Community Care cases it can be seen that the use of care management time appeared to achieve some reduction in the costs of other services, though the effect was rather weak and not statistically significant (sig t = .25). The cost to other services of the comparison group was found to have no dependency on the area team social worker time. In other words, area team social workers were ineffective in their ability to use other services more efficiently.

Outputs

In the Community Care group, these other costs were effective in improving both quality of care (through a squared relationship) and morale. The negative, squared, cross-product term, $(MQ)^2$, represents a reduction in cost for a particular level of output. This increased efficiency resulted from joint supply. In addition, the deployment of other services appeared to cause some reduction in the stress placed on informal carers as measured by their malaise score. This was achieved by providing relief for informal carers through such means as day care, respite care or supervision by helpers of the older person. However, the effect was only significant at a 20 per cent level. In the comparison group, although no relationship emerged between improved outputs and increased cost of the area team social worker, other community-based service costs for this comparison group were dominated by two general health terms. The negative sign of the first health term meant that large deteriorations in health, resulting from medical conditions which the evaluator could not always detect at the initial assessment, were associated with increased cost. However, for deteriorations in health of less than 18 per cent or improvements in health, the second positive squared health term was stronger, meaning that increased cost was associated with improved health according to the law of diminishing returns. This suggests that expenditure on other services was effective in improving the older person's health except in cases of severe health problems. Area team social workers may also have achieved improvements in quality of care (through a squared relationship): p=0.07. However, a negative morale term suggested that this was not acting as an output, but that resources were being targeted on cases who were deteriorating in morale.

Quasi-inputs

The lower cost in the Community Care group associated with those older people suffering from depressed mood was as a consequence of the lower physical needs of this group. Cases were more likely to be in need of counselling by the care manager, included separately under care management costs, or of companionship from helpers, which was unlikely to prove expensive. However, other community-based service costs will exclude the costs of any periods spent in hospital, which were shown to be above average for depressed cases. Other community-based service costs were found to increase with any informal carer's initial malaise score. In other words the care manager deployed more resources on cases having stressed carers.

Other community-based service costs in the comparison group increased with the level of general health problems, reflecting partly the greater use of community nursing. Costs increased with the level of cognitive impairment at more than double the rate for the Community Care group, this amounting to £652 per year for each level of cognitive impairment, indicating that resources were being targeted on this particularly problematic user group. Thus, even though these cases were admitted sooner to institutional care amongst the comparison group, their additional cost while in the community was much greater. Cases who had suffered a bereavement during the past year cost an additional £447 per year. Without a full care managed intervention, these vulnerable cases consumed a high level of resources. Cases with a principal informal carer cost considerably less overall (£9357 per year), indicating that without a care managed approach, these carers, when available, were providing the bulk of the support. However, more formal resources were deployed in instances where the carer was experiencing problems; annual cost increased by £1424 for each additional lifestyle problem and by £4387 for each level of hostility expressed towards the older person.

The low significance of the effect of care management time in reducing costs of other services for recipients of Community Care merited further investigation, since there were likely to be aspects of the care manager's activity which would substantially reduce these other costs. This was substantiated by the finding that although other costs of Community Care cases were highly positively correlated with care management costs, with a Pearson correlation coefficient of 0.40, predicted care management cost, instead of entering with a strong positive sign, had entered with a weak negative sign. It was therefore decided to break down care management costs of the Community Care group into components of activity, to see how these components entered the cost functions. This forms the subject of section 3. First, however, the corresponding cost and outcomes relationships in Tonbridge are presented.

2.5 Care management cost-outcomes relationships in Tonbridge

The relationship between domiciliary care management costs and outcomes is shown in the first pair of columns of Table 9.14 for the Community Care group and Table 9.15 for the comparison group.

Outputs

It can be seen that the ability of Community Care cases to perform activities of daily living and instrumental activities of daily living was a significant output. As the term was squared it obeyed the law of diminishing returns and was likely to indicate a recovery following a period of acute care at time 1 for some cases, which would have required more

care management input. This contrasts with Sheppey, where no user output term entered significantly. In common with Sheppey, the reduction in lifestyle problems of the informal carer would only enter the care management cost function as an output for the Community Care group. No output terms entered the comparison group equation for care management costs significantly.

Table 9.14 Annual cost of outputs due to care management time and other community-based service costs in matched Tonbridge Community Care cases, £ at 1982 prices

Variable type	Variable	Care management cost function		Other community-based service cost function	
		Cost effect £	Sig t[1]	Cost effect £	Sig t
Outputs					
	Reduction in ADL + IADL score			5.28	.13
	(Reduction in ADL + IADL score)^2	.0116	<.001		
	Carer's malaise score			-11.39	<.01
	Reduction in carer lifestyle problems	2.02	<.001		
Quasi-inputs					
	Health and Dependency				
	Cognitive impairment	34.16	<.05		
	Anxiety	-63.15	<.01		
	Initial health status				
	ADL + IADL score	-42.96	<.001		
	(ADL + IADL score)^2			11.59	.08
	General health problems			-136.65	<.05
	Initial level of well-being				
	Quality of care	51.76	<.001	172.36	<.05
	Social support				
	Lives with spouse			905.28	<.05
	Lives with family	179.61	<.001		
	Has principal informal carer	319.36	<.001		
	Initial effect on informal carer				
	Carer's malaise score			229.30	<.05
	Carer's lifestyle problems	-67.81	<.001		
	Hostility expressed towards user			-1417.71	<.01
(Constant)		-11.90	NS	1324.02	<.01

Using two stage least squares no evidence of simultaneity could be found, so each equation was obtained independently, using ordinary least squares.

Care management cost function:	R^2 = .98	Adj R^2 = .96	F = 48.29	sig F<.001
Other community-based service cost function:	R^2 = .87	Adj R^2 = .78	F = 9.27	sig F<.001

Sample size 20

Note:

1. NS: Not significant.

Table 9.15 Annual cost of outputs due to area team social worker time and other community-based service costs in matched Tonbridge comparison cases, £ at 1982 prices

Variable type	Variable	Care management cost function		Other community-based service cost function	
		Cost effect £	Sig t[1]	Cost effect £	Sig t
Cost to other budget					
	Predicted care management cost (of area team social worker)			120.08	.01
Outputs					
	M (Morale)	.207	NS	7.82	<.01
	Survival (weeks)	1.21	NS	30.90	<.001
	Whether ended up in long-term residential care	69.88	.12	-1399.07	<.001
Quasi-inputs					
	Health and Dependency				
	Cognitive impairment	-32.40	.07	-276.40	<.01
	Depressed mood	-74.53	<.01		
	Initial health status				
	ADL + IADL score	-81.78	.01		
	(ADL + IADL score)^2	6.06	.07	24.22	<.001
	Initial level of well-being				
	Quality of care	38.10	.001		
	Initial effect on informal carer				
	Carer's lifestyle problems	7.45	NS	-488.10	<.001
(Constant)		110.77	NS	-873.71	.06

The two equations were obtained using two stage least squares. Although predicted care management cost entered the cost function for other community-based service costs, predicted other community-based service cost would not enter the care management cost function.

Care management cost function:	$R^2 = .86$	Adj $R^2 = .74$	F = 7.0	sig F<.01
Other community-based service cost function:	$R^2 = .91$	Adj $R^2 = .86$	F = 18.0	sig F<.001

Sample size 20

Note:

1. NS: Not significant

Quasi-inputs

Care management costs for the Community Care Scheme increased with both quality of care shortfall and degree of cognitive impairment. Cases suffering from anxiety consumed less care management time, as a result of increased admission rates to residential care during the evaluation period and hence spending less time in the Community Care scheme. The negative signs attached to the terms representing ADL/IADL score and carer lifestyle problems are misleading since both are positively correlated with care management costs. The first arose because the squared improvement in ADL/IADL term tended to act as a proxy for initial ADL/IADL score. The second was due to the family as a living group entering as a proxy for initial carer lifestyle problems. In the comparison group, a

dominant quasi-input was quality of care shortfall. Cases who were depressed usually had fewer problems of disability so took up less area team social work time.

2.6 Other community-based service cost-outcomes relationships in Tonbridge

The equations for other community-based service costs are shown in the second pair of columns of Tables 9.14 and 9.15 for the Community Care and comparison groups respectively.

Cost of care management time

For the Community Care group it was found that the predicted cost of care management was not included in the equation for other community-based service costs. However, in the comparison group other costs turned out to be *larger*, the greater the use of area team social work time. This indicated a less efficient deployment of resources than had been the case in the Community Care scheme.

Outputs

The ADL/IADL output term entered as it had done for care management cost though not as a squared term and not quite significantly (p=.13). As in the care management cost function, this probably represented a recovery following an acute phase. The negative malaise score output was misleading and could only enter since living with spouse was acting as a proxy for this term. In the comparison group, increased expenditure on other costs did achieve a significant improvement in morale. Since day care was an important feature of this group, increased day care may be leading to improved morale.

Quasi-inputs

In the Community Care group, older people living with a spouse cost more to other services as a result of the extreme frailty of these users and the inability of their spouses to provide substantial help without adversely affecting their own health. The carer's expression of hostility towards the older person entered with a negative sign due to its association with the presence of spouse term: another misleading result. Location of cases in Tonbridge or Malling and whether cases were evaluated during the period of disruption to the care management team were not factors which would significantly enter the equation.

In the comparison group, the square of the ADL+IADL score was the strongest quasi-input term to enter. Cognitively impaired cases were cheaper because they were in better physical health and because of the absence of resources appropriate for this user group in standard provision. Finally, cases where informal carers suffered from lifestyle problems cost less to other services because the informal carers were taking on so many of the tasks themselves.

As in Sheppey, it was decided to pursue further the reason why predicted care management cost did not significantly reduce the cost of other services for Community Care cases. The effect of breaking down care management input into separate components of activity in each scheme is now considered.

3 Cost-outcome relationships at home using disaggregated care management costs

3.1 The components of care management cost

It was postulated that the factors contributing to the cost of care management (CCM) fell into three categories, which are now described in turn and summarised in Table 9.16.

- Transactional costs (CCM_t) were incurred through the time spent by the care manager in co-ordinating visitors to the older person from statutory agencies.
- Volatility and change costs (CCM_v) reflected the care management activity in response to the fluctuating needs of the older person. This was superimposed upon a core component of activity which remained unchanged throughout the period spent at home, obtained by summing the first and third components.
- Relational and attitudinal costs (CCM_r) covered the time spent in reconciling the attitude of the older person and any informal carers to the types of help required. Also included was the time spent in helping to defuse relationship problems.
- It was therefore hypothesised that total care management cost,

$$CCM=CCM_t+CCM_v+CCM_r+constant$$

Table 9.16 The three categories of care management cost

Care management activity has been divided into three categories. A list of possible predictors is included under each category.

1.Transactional activity

This covers the time spent by the care manager in co-ordinating the care providers.

a. Number of people from statutory agencies in touch with the care manager who visit the older person.
b. The number of visits to the older person each week due to people from statutory agencies in touch with the care manager.

2. Volatility and change

The variation in care management activity in response to the fluctuating needs of the older person.

a. Variation over the period spent at home in costs to the social services department[1].
b. Variation over the period spent at home in care management costs.
c. Number of changes in location; e.g. respite care, acute hospital admission and holidays with relatives.
d. Increase in ADL score.
e. Increase in cognitive impairment/disorientation.
f. Number of severe life events.
g. Increase in Malaise score of informal carer.
h. Increase in strain on informal carer.
i. Increase in tension in home of informal carer.

3. Relational and attitudinal

This activity covers time spent in coping with the attitude of the older person and any informal carers towards receiving help.

a. Independent attitude to help - needs persuading.
b. Accepting attitude to help.
c. Dependent - demanding attitude to help.
d. Dependent - passive attitude to help.
e. Whether carer derives a lot of satisfaction from caring.
f. Older person wilfully uncooperative towards informal carer causing personality conflict.
g. Hostility expressed towards older person in initial interview.
h. Warmth expressed towards older person in initial interview.

Note:

1. Variation in SSD cost was measured as the standard deviation of the cost when broken down into four-weekly intervals, divided by the mean four-weekly cost.

Table 9.17 The components of activity predicting care management costs[1] for Community Care cases in Sheppey, £ at 1982 prices

Variable category	Variable		Coefficient	Sig t
Transactional activity				
No. of visits per week made to user by statutory agencies, f			.442	<.00005
Volatility and change				
Variation in costs to the social services department, g			7.68	.030
(Constant)			.282	.856
Equation:	Degrees of freedom	- regression: 2	R^2 = .59	adj R^2 = .55
		- residual: 23	F = 16.46	sig F <.00005

Sample size 26

Notes:

1. Overall care management cost may now be expressed as

$$CCM = .442 \times f + 7.68 \times g + .282$$

Examining the right hand side of this equation, the first term represents transitional activity (CCM_t) and the second term volatility and change (CCM_v). No relational and attitudinal terms enter, so the corresponding cost, CCM_r, is zero.

Hence

$$CCM = CCM_t + CCM_v + .282$$

3.2 Disaggregated care management costs and outcomes in Sheppey

The first step in the analysis was to determine which of a list of possible predictors of care management cost shown in Table 9.16 gave a statistically significant effect, using the method of ordinary least squares. The resulting equation, in which only two predictors entered, is summarised in Table 9.17. The total care management cost reduces to the sum of the contributions from transactional activity and costs incurred through volatility and change, the relational and attitudinal contribution being zero.

The method of two stage least squares was again used to determine the cost of other services. In the first stage, the estimated values of the transactional component and of the volatility and change component of care management cost were determined using ordinary least squares regression analysis. Most of the predictors were drawn from the pool of variables shown in Table 9.11, together with a selection of those from Table 9.16. The results are shown in Table 9.18. Because both these equations were included in the first stage of 2SLS, they each had to include the same predictor variables; hence the presence of some insignificant terms. Although the predictors of transactional cost behave straightforwardly, those in the volatility and change equation require some explanation.

Examining outputs, increased volatility and change care management cost led to a reduction in the carer's lifestyle problems. However an increase in quality of care or reduction in cognitive impairment/disorientation both had negative coefficients. Instead of acting as outputs, these two terms signified that volatility and change care management resources were being targeted on those cases for whom quality of care or cognitive impairment/disorientation were getting worse. With the exception of incontinence of urine the quasi-input terms suggested higher need was associated with lower volatility and change. Because higher need cases required a more substantial combination of ongoing

core services present at all times, the proportion of cost which could be brought about by volatility and change was less. This was confirmed by the Pearson correlation coefficient between cost variability to the social services department and that cost itself being -.53, a strong negative correlation which was significant at the 5 per cent level.

Table 9.18 Equations predicting the transactional and volatility and change components of care management cost for Community Care cases in Sheppey, £ at 1982 prices

Variable type	Variable	Transactional component of care management cost function		Volatility and change component of care management cost function	
		Cost effect £	Sig t[1]	Cost effect £	Sig t[1]
Outputs					
	M (Morale)	2.10	<.001	-.264	NS
	Q (Quality of care)	2.62	<.001	-.709	<.05
	Reduction in confusion/disorientation	7.56	NS	-15.74	.07
	Reduction in carer's lifestyle problems	1.07	.06	.606	.08
	Weeks spent in scheme	.0546	.08	-.0123	NS
Quasi-inputs					
	Health and Dependency				
	Presence of severe arthritis	-26.81	NS	-5.59	NS
	Giddiness	-38.46	.16	-45.81	.01
	Cognitive impairment	96.79	<.001	-11.44	NS
	Incontinence of urine	-33.49	NS	40.27	<.05
	Depressed mood	-75.05	<.01	-5.80	NS
	Social support				
	Social contact score	-4.82	<.05	2.58	NS
	Other user factors				
	Age	14.60	.001	-1.97	NS
	Initial effect on informal carer				
	Carer's lifestyle problems	27.07	NS	-62.22	.01
(Constant)		-1652.70	<.001	409.42	<.05

The two equations were obtained using two stage least squares. The predicted values of both components of care management cost entered the cost function for other community-based service costs in Table 9.19. However, the predicted value of other community-based service cost would not enter either of these two cost functions.

Transitional component of care management cost function:

$R^2 = .91$ Adj $R^2 = .82$ $F = 9.55$ sig $F = <.001$

Volatility and change component of care management cost function:

$R^2 = .79$ Adj $R^2 = .56$ $F = 3.41$ sig $F = <.05$

Sample size 26

Note:

1. NS: Not significant

3.3 Other community-based service costs and outcomes in Sheppey

The second stage of the two stage least squares process was to include the predicted values of the transactional and volatility and change components of care management cost with the pool of variables in Table 9.11 for use as predictors of the cost of other services. The equation for these other costs is shown in Table 9.19. It can be seen that while the predicted transactional component of care management cost entered with a positive coefficient, the predicted volatility and change component entered with a negative sign. Transactional costs will tend to be higher when the care services received are more intensive and hence the cost of other services greater, a feature of higher need cases. However, as explained in section 3.2, higher volatility and change was associated with lower need and hence lower total cost to the social services department. The negative volatility and change term therefore represents the fact that low need cases cost less overall to other services.

In other words, Table 9.19 indicates how one aspect of need is represented by a low volatility and change cost of care management and another aspect of need by a high transactional cost of care management. The outputs achieved through expenditure on other community-based service costs were now an improvement in quality of care together with the suggestion of an improvement in general health, which entered as a squared output term (p=.06), indicating a law of diminishing returns. In addition, a reduction in carer lifestyle problems was achieved.

Table 9.19 Equations predicting other community-based service costs for Community Care cases in Sheppey, £ at 1982 prices.

Variable type	Variable	Cost effect £	Sig t
Costs to other budgets			
	Predicted transactional component of care management cost	119.05	<.01
	Predicted volatility and change component of care management cost	-242.75	<.01
Outputs			
	Q (Quality of care)	8.44	<.001
	G^2 (Reduction in general health problems)^2	.0206	.06
	Reduction in carer lifestyle problems	7.35	<.01
	Weeks receiving community care	36.96	<.001
Quasi-inputs			
	Health and Dependency		
	Presence of severe arthritis	839.03	<.001
	Other factors		
	Sex - whether female	-459.11	<.05
(Constant)		-2039.86	<.01

This equation, together with the two equations in Table 9.18, was obtained using two stage least squares.

$R^2 = .93$ Adj $R^2 = .89$ $F = 27.0$ sig F <.001

Sample size 26

3.4 Disaggregated care management costs and outcomes in Tonbridge

Following the procedure adopted in the Sheppey analysis, care management costs were divided into transactional costs, volatility and change cost and relational and attitudinal costs. The equation predicting care management costs in terms of variables from each of these three domains is shown in Table 9.20.

Here the transactional component,

$$CCM_t = .713NPERS,$$

where NPERS is the number of people from statutory agencies in touch with the care manager who visited the older person. This is highly correlated with the number of visits they made every week, which was the transactional term found for Sheppey Community Care cases.

The volatility and change component was given by

$$CCM_v = -5.96S - 3.15D + 1.05R,$$

where S is a measure of the variability of monthly care management cost, D is the increase in cognitive impairment/disorientation and R is the increase in Malaise score for the informal carer. Care management cost variability entered with a negative sign, because care management costs tended to be high in cases for which a high proportion was made up of regular core care management activity, so that variability was small.

Table 9.20 The components of activity predicting care management costs for Community Care cases in Tonbridge, £ at 1982 prices

Variable category	Variable	Coefficient	Sig t[1]
Transactional activity			
No. of people from statutory agencies in touch with care manager who visit user		.713	<.05
Volatility and change activity			
Variability in care management costs over the evaluation period		-5.96	<.01
Increase in confusion/disorientation over the evaluation year		-3.15	<.05
Increase in malaise score of informal carers		1.05	<.01
Relational and attitudinal activity			
Warmth expressed by carer towards user		3.72	.01
Hostility expressed by carer towards user		1.72	<.05
(Constant)		-3.74	NS
Equation	Degrees of freedom - regression: 6	$R^2 = .73$	adj $R^2 = .61$
	- residual: 13	F = 5.91	sig F < .01

Sample size 20

Note:

1. NS: Not significant.

The decrease in cognitive impairment/disorientation for cases of higher care management cost implies that it was acting as an output variable. In other words, the use of care management time was effective in reducing disorientation.

Both the warmth and the hostility expressed by an informal carer towards the older person made up the relational and attitudinal component of care management cost. These factors may be understood as different manifestations of expressed emotion. It therefore follows that where the level of expressed emotion was high, care management costs tended to be greater. The relational and attitudinal component was then

$$CCM_r = 3.72(\text{warmth}) + 1.72(\text{hostility}).$$

Hence the total care management cost,

$$CCM = CCM_t + CCM_v + CCM_r - 3.74.$$

In order to derive equations predicting both the three components of care management cost and the cost of other services, the method of two stage least squares was again used. In the first stage the cost of each of the three care management components was predicted using the method adopted in Sheppey. These three predicted components could then be included in the pool of variables used in selecting the equation for the cost of other services.

The equations used to predict the three components of care management cost are shown in Table 9.21. Although it is clear from the first pair of columns of figures that increased transactional costs were associated with an improvement in combined ADL and IADL performance, the strain on the informal carer increased. This may reflect the fact that in cases of high care management involvement, the demands made by the older person were likely to be great, causing increased strain on the informal carer, even when provided with substantial relief by the scheme.

It can be seen from Table 9.20 that the volatility and change component of care management cost in Tonbridge decreases with increasing variability in care management cost. As breathing difficulties can contribute to volatility of care management cost through, say, the dependence of bronchitis on cold, damp weather, the presence of these difficulties should reduce the overall volatility and change component of care management cost; hence the negative sign of breathing difficulties in the second pair of columns of figures in Table 9.21.

It has already been noted that the relational and attitudinal component of care management costs coincided with high expressed emotion of the informal carer towards the older person. In other words, care managers tended to become most involved with informal carers presenting a high level of expressed emotion. This involvement was apparently productive since, from the third pair of columns in Table 9.21, a reduction in the strain experienced by the informal carer was achieved as well as an increase in the morale of the older person. Those cases with an accepting attitude to help consumed less of this type of care management. Care managers reported that much time could be spent, particularly in the initial stages, in enabling a more independent older person to accept help. Moreover, cases who were demanding could understandably be time-consuming, particularly if they then rejected the help offered, as time could then be taken up in substituting different helpers.

Table 9.21 Cost functions predicting the transactional, volatility and change and relational and attitudinal components of care management cost for Community Care cases in Tonbridge, £ at 1982 prices

Variable type	Variable	Transactional component of care management cost function		Volatility and change component of care management cost function		Relational/attitudinal component of care management cost function	
		Cost effect £	Sig t	Cost effect £	Sig t	Cost effect £	Sig t
Outputs							
	M (Morale)					.828	<.05
	(Reduction in ADL + IADL score)^2	.00543	.01				
	Reduction in carer's lifestyle problems			2.19	<.01		
Volatility and change							
	N of severe life events within past yr.	16.30	.18				
	Increase in strain on informal carer	49.64	.09	329.71	<.001	-104.04	.08
Quasi-inputs							
	Health and dependency						
	Severe arthritis			71.95	<.05		
	Breathing difficulties			-129.92	<.001		
	Initial level of well-being						
	Quality of care shortfall	8.33	.01			10.46	.07
	Social support						
	Lives with family					105.07	.10
	Attitude to help						
	Accepting attitude to help	26.24	.11			-59.52	.11
	Other factors						
	Sex - whether female			-116.98	<.01		
(Constant)		44.67	<.05	-92.65	NS	387.16	<.001

Using two stage least squares no evidence of simultaneity could be found between these three components of care management cost and other community-based service costs, so each cost function was obtained independently using ordinary least squares.

Transactional component of care management cost: $R^2 = .73$ Adj $R^2 = .63$ F = 7.53 sig F = .001
Volatility and change component of care management cost: $R^2 = .83$ Adj $R^2 = .76$ F = 13.36 sig F = .001
Relational and attitudinal component of care management cost: $R^2 = .67$ Adj $R^2 = .55$ F = 5.61 sig F < .01
Sample size 20

3.5 Other community-based service costs and outcomes in Tonbridge

In the second stage of the two-stages least squares process, the predicted values for the three components of care management cost were included in the pool of variables from which an equation for the cost of other services was obtained. The result is shown in Table 9.22. None of the three care management cost components were included in the equation. The most significant component, volatility and change, would have entered with a negative coefficient but a significance of only 0.22. It can therefore be concluded that although the volatility and change component of care management may have caused a slight reduction in the total cost of other services, the overall effect of care management in reducing the cost of other services in the Tonbridge Community Care scheme was statistically insignificant.

4 Overview of cost-outcomes analyses

This chapter has examined firstly the extent to which the cost-outcomes relationships for the whole evaluation year derived for the Thanet Community Care Project were valid in Sheppey and Tonbridge, secondly the relationships which best fitted the data over the whole evaluation year for matched groups in Sheppey and Tonbridge and thirdly the relationships when costs were obtained for the period spent at home, excluding any time in long-term institutional care.

The equations for annual cost to the social services department and to the National Health Service derived for the Thanet Project were extremely poor at predicting cost-outcomes relationships in Sheppey and Tonbridge. In general, not only was the average predicted group cost greatly in error, but also the predictor variables entering the equations were either different or, if the same, had quite different coefficients.

Table 9.22 Equation predicting other community-based service costs for Community Care cases in Tonbridge, £ at 1982 prices.

	Coefficient	Sig t
Outputs		
(Reduction in adl+iadl score 0-10)^2	.0973	<.01
Weeks receiving community care	66.30	<.01
Quasi-inputs		
Attitude to help		
Accepting	756.73	<.05
Other factors		
Recent bereavement	745.34	.10
(Constant)	-3086.45	.01
Equation:	R^2 = .59 adj R^2 = .48	
	F = 5.37 sig F < .01	

Sample size: 20

In determining the best cost-outcomes relationships over the full evaluation year, the predicted annual cost to the social services department for the Community Care group in Sheppey entered the equation for health costs with a negative sign, implying that social services input reduced health services expenditure. However, in Tonbridge predicted SSD cost for the Community Care group did not significantly reduce NHS cost, despite the annual NHS cost being significantly lower than that for the comparison group (Chapter 8). In Sheppey and Tonbridge, the equations for SSD and NHS cost to both the Community Care and comparison groups were useful in clarifying how resources were targeted according to user characteristics and in indicating the outputs achieved. Although both average and marginal costs to the social services department in Sheppey were greater for the Community Care group than the comparison group, it does not necessarily follow that the Community Care group was less efficient or effective, since it ignores the great savings made to the National Health Service. In Tonbridge, the average annual cost to the social services department of achieving different levels of improvement in quality of care and morale worked out to be less for the Community Care group, except when small improvements in quality of care were combined with large improvements in subjective well-being. This greater efficiency of the Community Care group in achieving improvements in quality of care and morale at lower cost was brought about partly by the beneficial effect of joint supply, which was not significant in the comparison group. However, as in Sheppey, this result presents only a partial picture, through ignoring NHS cost.

In modelling care management cost for the period spent at home, there was a suggestion that for the Community Care group in Sheppey, care management activity may have been effective in reducing expenditure on other community-based service costs, though the result was of very low significance ($p=.25$). No such term entered the corresponding equation for Tonbridge. These equations for care management cost and other community-based service costs in Sheppey and Tonbridge Community Care and comparison groups for the period spent at home showed how domiciliary care resources were targeted according to user characteristics and indicated the outputs achieved.

Finally, when care management costs are disaggregated into the three components of transactional, volatility and change and relational and attitudinal costs, it was found for Sheppey Community Care cases that while transactional activity was associated with increased other community-based service costs, volatility and change activity appeared to reduce these costs. However, these three components appeared to have no significant effect on other community-based service costs of the Tonbridge Community Care group.

CHAPTER 10

HELPER DEPLOYMENT AND MANAGEMENT, MOTIVATIONS AND REWARDS

1 Theoretical context

In planning a scheme to provide care at home for frail older people, a clear need emerged for additional assistance at home particularly with personal care and emotional support, which conventional services could not adequately provide. The possible sources available in meeting this shortfall included:

Formal service inputs

- Extra formal help by paid SSD staff such as home helps
- Negotiating formal help from other agencies such as community nursing

Private and voluntary sector inputs

- Private sector help such as private organisation home helps
- Voluntary sector help such as voluntary organisation volunteers

Quasi-informal care

- Use of unpaid helpers (volunteers) recruited by the scheme, receiving expenses only
- Use of fee-paid helpers recruited by the scheme, but who do not benefit from the conditions of service of a paid employee.

Informal care

- Relatives, friends and neighbours

The use of such sources could include:

- Use of the telephone to provide companionship and check-ups
- Innovations, such as organising quasi-informal helpers to provide a mini-day care facility

In choosing between these options, consideration was given to the potential supply of each resource and whether this could be sustained, the quality and flexibility of the care provided and the cost, both in terms of the salary or fees/expenses paid and the time and support needed from the care manager. The supply would vary between areas. Indeed, the supply of fee-paid helpers would depend upon the level of payment offered and how this related to local levels of unemployment and pay.

At the time the schemes in Sheppey and Tonbridge were first being implemented the opportunity to negotiate for extra assistance from the home help service was very limited, and this was initially restricted to household care rather than personal care. Although social services management could have released funds to increase the size and scope of the home help service, such developments in Kent only occurred after this evaluation:

- The extension of duties to cover personal care tasks (1983)
- An amalgamation of the home help and Community Care services (1987)
- Increased funding following the community care reforms (1993).

Moreover, the community nursing service was attempting to reduce its involvement with social care tasks in order to concentrate on health care tasks. The supply of home helps and volunteers from the private and voluntary sector was restricted and assistance normally excluded personal care. However, SSDs have traditionally been reluctant to allow volunteers to become involved with more severe problems (Stevenson and Parsloe 1978), so there may have been some scope for this type of help to be developed.

Nevertheless, care managers were left with the need to provide the bulk of care by recruiting either unpaid or paid helpers.

The Thanet scheme had initially sought to make maximum use of unpaid helpers, since these were seen as having a greater likelihood of being motivated by altruism rather than commercialism (Qureshi *et al.* 1989). However, their supply was limited. Moreover, since the project offered fees to other helpers, an expectation emerged as the scheme evolved that newly recruited helpers would want to be paid a fee. Hence the proportion of unpaid helpers rapidly decreased. This confirmed Titmuss' assertion that fee-paying, once started, would take over from voluntary help (Titmuss 1970).

In Sheppey, where the pool of helpers was much younger, many having family commitments, no unpaid helpers were found. In Tonbridge, where the standard of living was higher, a few helpers preferred to waive a fee, particularly when this would have led to additional deductions of tax and national insurance contributions. However, in both areas there turned out to be a substantial supply of potential fee-paid helpers to tap.

The use of helpers raises three important issues:

- What are the effects of recruiting helpers from the labour market?
- What features characterise the support of users by helpers?
- Does the deployment of helpers lead to their providing more informal help outside the scheme (multiplier effect)?

1.1 The effects of recruiting helpers from the labour market

The payment of a fee to helpers provides a disincentive to offering voluntary work. Ideally, social policy institutions should provide incentives for altruism (Titmuss 1970). However, if helpers had been all unpaid, the supply would have been totally inadequate in meeting the demands of the users.

If there were not compensating benefits to helpers, it could be argued that the use of paid helpers was a form of exploitation. The helpers did not benefit from the conditions of service of paid employees, such as guaranteed hours of work and paid holidays. This was particularly the case in Sheppey, where the level of unemployment was high so potential helpers might not have alternative jobs available to them. Helpers sometimes had to wait some time before a suitable user became available. This exploitation could have been avoided if instead part of the care manager's budget had been used to extend the home help service both in scale and to encompass personal care tasks: these developments took place more recently.

However, there were some substantial advantages both to helpers and to the scheme of deploying them as fee-paid rather than as paid employees. The helpers benefited from the flexibility of being able to fit in their visits around their other daily commitments so long as this was convenient to the user. They could ask the care manager to limit their workload to what they could reasonably manage. Paid helpers were also allowed to let their relationship with the user evolve away from the initial formal basis as specified by the contract if this satisfied the user and was what the helper was willing to provide. Indeed, it could be argued that paid carer schemes were less exploitative than both unpaid informal care and care provided in the market sector through greater freedom to develop initiative (Leat and Gay 1987, Qureshi *et al.* 1989). This could have led to greater life satisfaction.

The *scheme* also benefited from using paid helpers. There was no need to redeploy a helper immediately after a case had been closed, which could have led to difficulties in finding a suitable match to a user. The payment of helpers by the task rather than per hour encouraged helpers to spend extra time with the user, especially at times when the user appeared particularly needy. The use of helpers also made the scheme cheaper to run and hence more cost-effective. Nevertheless, care managers sought to avoid the risk of exploitation, and fees were set at levels which were felt to be acceptable for the tasks in question, their lower levels in relation to paid employment taking account of the extra flexibility offered to helpers.

1.2 The process of helpers providing support to users

The caring process can be understood as a form of exchange (Abrams 1977). In the case of informal or voluntary care when no money exchanges hands, the older person receives the benefit of the care provided, while the donor is emotionally rewarded. In order for such help to be sustained, Anderson (1971) argued that the donor should be motivated, rewarded, and offered incentives. With the increasing value placed on time, it becomes increasingly likely that potential donors will instead seek other sources of satisfaction (Becker 1965). A fee can be increasingly seen as a necessary incentive to provide care (Schopler 1970), through balancing the care provided. In Sheppey and Tonbridge the fee was set at a level which was seen as offering an incentive to helpers to become involved and sustain this involvement, without it acting as a bait for more commercially minded helpers or unnecessarily wasting funds, using as a guide the helper payment bands already described. In this way the helpers recruited would be likely to have been motivated by other causes as well as the commercial one, and would resemble volunteers more closely than paid employees.

Moreover, users tend to prefer paid help, otherwise they may feel the need to contribute something, to avoid the stigma of being seen as a receiver, not a giver (Pinker 1971, Qureshi *et al.* 1989).

There is a danger that the provision of paid help could reduce the level of informal care (Abrams 1977). The scheme aimed to avoid this whenever possible by not taking over the roles of the existing informal network, except by providing relief to informal carers to reduce stress and avoid the informal care network breaking down.

1.3 Multiplier effects

As well as these possible negative effects of paid help on the supply of volunteers and informal help, three types of positive effect could also occur:

- The emotional rewards derived by a helper from their work for the scheme might encourage them to offer help informally outside the scheme.
- Boulding (1973) has suggested that altruistic behaviour can have multiplier effects in a community through starting a chain reaction characterised by A helping B encouraging B to help C and so on. Such a process would be desirable in the support which helpers provide each other.
- Motivations to help others can arise not only from consideration of a person who might need help but also from observing rewards received by another person giving help (Berkowitz and Aderman 1970). This could lead to a helper's friends becoming motivated to join the scheme.

1.4 Research questions and data collection

These considerations of the role of helpers in the caring process allow us to formulate some research questions which are addressed later in the chapter:

- What motivations led to helpers joining the scheme?
- What rewards did they in fact receive?
- What types of task were performed?
- What difficulties did helpers experience?
- In what ways could the care manager most effectively support a helper?
- What factors led to helpers continuing to work for the scheme?
- Was the quality of both the relationship with the user and the care provided comparable to those found in informal care?
- What evidence was there of multiplier effects?
- How did the helpers compare with those in other schemes?

In order to address such questions, those helpers who were recruited during the first four years of the Sheppey scheme were systematically interviewed by the evaluator wherever possible. Out of the first 54 helpers selected for the scheme, it was possible to arrange interviews with 46. Most of these were seen between six months and eighteen months after joining the scheme. The interviews were designed to obtain information on the recruitment of helpers and their basic characteristics. Their motivations for joining the scheme and the rewards they derived from the work were studied and the reasons for drop-out investigated. The types of tasks undertaken by helpers were noted. The helper's relationship with the user, family, friends and neighbours and the care manager were enquired after, and any difficulties in the work discussed.

As no parallel study of helpers was undertaken in Tonbridge, comparisons between Sheppey and Tonbridge were not normally possible. However, comparisons with the helpers drawn from the Thanet and Gateshead social care programmes have been made when data was available (Qureshi *et al.* 1989; Challis *et al.* 2001).

2 Basic details of helpers, their selection, training and support

No male helpers were recruited in Sheppey, and only two per cent in Gateshead, this being a result of the lack of male applicants rather than a policy by the care manager; on the contrary, male helpers can be useful in a wide variety of circumstances. It may be that in these largely working class areas, the tasks of a Community Care helper were seen by men as being essentially 'women's work', and the pay would not normally have been adequate as a main source of income. In the Tonbridge scheme, which was based in an area with a larger middle class population, male helpers were sometimes successfully used, particularly in circumstances where the involvement of a man was seen as being more appropriate. This had also been the case in the Thanet programme, where six per cent of helpers had been male. Eighty per cent of the helpers were married (87 per cent in Gateshead), compared to less than two-thirds in Thanet, and nearly three-quarters had at least one child under seventeen living at home (69 per cent in Gateshead), compared to only 30 per cent in Thanet. This latter difference can be partly understood in terms of the much younger age range of the Sheppey helpers, with 90 per cent aged 50 or under compared to only 55 per cent in Thanet. The age distributions for Sheppey and Thanet are compared in Table 10.1. It can be seen that most Sheppey helpers were aged between 31 and 50, with only 5 per cent over pensionable age. This distribution is fairly similar to that for Gateshead though contrasts sharply with Thanet where the younger older people, as Community Care helpers, provided an important part of care for the aged older people.

Table 10.1 Age of helpers in Sheppey compared to Thanet

Age	Sheppey %	Thanet %
Under 21	2	5
21-30	5	8
31-40	51	27
41-50	32	15
51-60	5	25
Over 60	5	20
Total	100	100
Sample size	46	40

Table 10.2 Basic information on Community Care helpers in Sheppey

	%
Method of travel to house of main user:	
Walk	31
Bicycle/moped	13
Car (regular use)	54
Train	2
Distance from helper's house of first user's residence:	
Near neighbour	4
Less than half a mile	37
Between half and one mile	24
Between one and three miles	28
Over three miles	7
Means by which helper identified by Care Manager:	
Through user's informal support network	2
By advertising in local newspaper	43
Through community	24
Recommendation of another professional	14
Application for home help	3
Through voluntary organisation	7
Other	7
Lengths of involvement in scheme at time of interview by evaluator	
3-10 weeks	11
11 weeks - 6 months	9
6 months - 1 year	17
1 - 2 years	54
Over 2 years	9
Sample size	46

Some basic additional information on the 46 Sheppey helpers interviewed is shown in Table 10.2. It can be seen that nearly two-thirds of the helpers lived within one mile of their first user, whom they normally visited either by foot or by car. Although 85 per cent of helpers experienced no difficulty in travelling, 7 per cent found the bus service they used irregular and unreliable.

Although information on occupation of spouse was not available to grade by social class directly, the previous occupations of helper, compared with Thanet in Table 10.3, suggest that the majority of helpers were 'working class', probably an even greater proportion than in Thanet. The most frequent occupations were being a care assistant, nurse or home help, all caring occupations.

Table 10.3 Former occupation of helpers in Sheppey compared to Thanet

	Sheppey %	Thanet %
Manager or executive		8
Ran small business with spouse		5
Technician (pathology)		3
Fostering supervisor	2	
Nurse	7	20
Sales rep	2	
Secretary/clerk/telephonist	2	27
Assistant warden - sheltered housing	4	
Care assistant with elderly/mentally handicapped	13	
Factory worker	4	
Assistant to vet	2	
Nursing auxiliary or home help	7	10
In service, shop work, bus conductress	9	12
Escort for AHA	4	
Piecework at home	2	
Door-to-door leaflet deliverer		2
At school or college	2	8
Housewife always	40	5
Total	100	100
Sample size	46	40

Table 10.4 Previous relevant paid work experience with older people of helpers in Sheppey compared to Thanet

	Sheppey %	Thanet %
Nurse	4	13
Nursing auxiliary/home help/care assistant	18	34
Other (community worker, sheltered housing etc)		5
Hospital domestic/domestic cleaner		6
All helpers with relevant work experience	22	58
Sample size	46	40

Table 10.5 Helpers' previous experience with older people in Sheppey compared with Thanet

	Sheppey %	Thanet %
1. Family only	17	10
2. Friends and neighbours only	13	13
3. Family and neighbourly help only		25
Total whose experience includes informal help only (1+2+3)	30	48
Work for voluntary organisations helping older people	17	10
Total with only informal and voluntary experience with older people	47	58
Involvement in voluntary work excluding older people (all helpers)	17	30
All helpers with relevant paid work experience with older people	22	35
Sample size	46	40

Practically all the helpers recruited had some type of previous caring experience. Sometimes the experience had taken the form of paid work with older people. Table 10.4 shows how the proportion with this type of experience in Sheppey differed from that in the Thanet project. It is clear that Thanet helpers had more experience of this type in all areas.

For the helpers without such experience, Table 10.5 shows the proportions who had undertaken different types of voluntary or informal work with older people in Sheppey and Thanet. However this still left 31 per cent of helpers in Sheppey with no prior experience of working with older people, compared to only 7 per cent in Thanet. Nevertheless many of these Sheppey helpers had experience with other user groups. The 31 per cent could be broken down into 9 per cent with previous paid work experience of this type, 5 per cent with voluntary experience and 13 per cent with informal experience with family, friends and neighbours, leaving only 4 per cent with no caring experience of any kind. As well as the total proportion with previous paid experience with older people being much less in Sheppey, it can be seen from Table 10.5 that the proportion with previous voluntary experience was rather less.

It is clear from Table 10.2 that most helpers were recruited through advertising in the local newspaper (43 per cent), particularly during the early stages of the scheme, or through the local community (24 per cent) which became an increasingly effective means once the scheme had become established. This method had the advantage that applicants usually had an idea of what the job entailed, and they were mainly of the caring type. It reflects the multiplier effect referred to earlier that an individual can be motivated to join the scheme through observing the rewards received by a helper. Advertising through a job centre was only tried once, since some applicants were expecting a job with guaranteed hours. Some informal carers were offered the opportunity to become fee paid helpers when there was a need for a regular commitment to care. However, in practice only one helper was identified through the older person's informal support network. This contrasts with the approach adopted in the Gwynedd scheme in Anglesey, North Wales. In this very rural area the most effective means found for recruiting helpers was through the user's informal network. Over one quarter of the Sheppey helpers recruited had been seeking other work, too. In view of the high level of unemployment on the island, this was hardly surprising. Thirteen per cent had been looking for home help or nursing work, 4 per cent other skilled

work and 11 per cent unskilled work. A further 9 per cent were looking for voluntary or informal caring work. Nevertheless very few helpers were recruited from families with unemployment problems. Most helpers came from two parent families with a main wage earner, and only one single parent mother was appointed as a helper. Just two helpers in their 60s had a retired husband and were receiving a pension. One helper was receiving supplementary benefit so could only earn £4 per week, though would like to have done more. She made a lot of extra visits on a voluntary basis as well as the two paid visits she was contracted to make.

In over 90 per cent of cases the initial contact with the care manager was through a visit to the helper's home. This interview with the helper was used as a basis for selection. In choosing a helper the care manager would have to supplement the information from this interview by obtaining satisfactory personal references as to the prospective helper's honesty, trustworthiness and reliability. The need for paid work was not seen as a sufficient reason for the applicant being suitably motivated for the work. The main criterion for selection was the ability to care. Without this, helpers would be unlikely to stay in the scheme because of the tasks they would be called upon to carry out and the spare time commitment. Thus the original principle of the scheme that payment should not be the principal motivation was being upheld. For example, one helper was working long hours for the scheme seven days a week, and doing a great deal. She was available at any time. The helper and her family were relying on this Community Care income. However, in view of her caring approach, it was clear that she was not in the work just for the money. Prospective helpers would also need to be sympathetic and understanding of older people's needs. The local office index was consulted to see whether the applicant was already known to the department.

Once recruited, a helper would have to wait until the care manager had an older person in their caseload for whom that particular helper appeared a suitable match. For this to be the case, the helper would need to be available at the times needed by the user and have the appropriate personality, skills and experience. Thus new helpers would not be placed with a very cognitively impaired user straight away. After having met a user once or twice, the care manager had a feel for their type of personality and could then decide whether to look for an extrovert or more gentle helper. Alternatively a particular interest in common could be used as a means of selecting a suitable helper. For example, one user came from Germany and her family was still out there. The user kept in contact with the family but suffered a severe stroke. One aspect of the loss experienced by having the stroke was the grief that she might never be able to return to see her family in Germany. Fortunately the care manager could arrange a German helper who lived nearby, and they were able to hold conversations in German. In another example a devoutly Catholic user was matched very successfully to a helper for whom Catholicism played an important part in life. In other cases the matching process was less obvious: perhaps just a feeling of the care manager. Sometimes choice was restricted to whoever was available. These matches were not always ideal, though a definitely unsuitable helper would still be avoided.

The pool of helpers offered a very wide and diverse wealth of experience. Sometimes the helper would have obtained the required skills from previous employment in the field of caring, such as in nursing. In other instances it was possible for the care manager to train the helper in specific tasks, such as in assisting the older person with transfer. In parallel with this individual training, the care manager organised monthly coffee mornings for helpers. In this way they were able to benefit socially from meeting other helpers. At these rather noisy events, the opportunity for helpers to talk over with each other and ventilate

the difficulties involved in caring, and to recognise that other helpers often experienced similar problems, was a valuable means of support and an important multiplier effect. Also if a helper needed to contact another during out of office hours it was easier to get in touch with someone they already knew. The meetings also provided helpers with the opportunity of meeting others visiting the same user and sharing problems. This enabled them to feel part of the total process of care. The care manager and assistant would go round speaking to each helper individually.

The second half of the meeting was geared to improving skills. Sometimes an invited speaker, such as a community nurse, Community Psychiatric Nurse (CPN) or Occupational Therapist, would talk about some aspects of older people. For example instruction as to how to lift an older person was given fairly regularly. As an alternative to an outside speaker, a film might be shown on a particular aspect of the work such as medication, and this would be followed by discussion. As a third option, the care manager or assistant could provide a training session. This was frequently on a subject which they had identified as causing helpers unease, for example on uncertainty over future developments in the scheme. Attendance at the monthly coffee mornings was voluntary and unpaid.

If a new helper needed immediate training in some practical form of care, such as heavy lifting, the care manager could take a group of new helpers and home helps to the day centre or health centre for training sessions, perhaps from a physiotherapist. In addition, training was carried out on an individual basis, such as when helpers popped into the office for guidance, and in this way they felt supported. Sometimes inexperienced helpers received guidance from experienced helpers. As an example, a physiotherapist had originally taught an older man to lift his wife, who had suffered a severe stroke. As he needed some help in doing this, the care manager arranged for the physiotherapist to show how both the husband and helper together could lift his wife, as the technique for doing this was quite different from when only one person was lifting. When subsequently a new inexperienced helper was introduced, the first helper was willing to train her in her spare time to lift in twos, and this was very successful. Sometimes more experienced helpers were given the opportunity to attend more advanced training courses. For example, three helpers attended a mental health training course for 6-8 weeks, set up by a mental health team.

Nearly 60 per cent of helpers had been placed with an older person within one month of recruitment, and only 13 per cent had to wait longer than two months. The care manager always personally introduced a helper to a user before visiting commenced. Often a new helper to a particular user would make an initial visit with a helper already established with that user, to know what to expect. This was particularly helpful with new helpers to the scheme, perhaps the day before they were starting with a user. Helpers who were just starting were given as much help as possible. Normally older people who were likely to place substantial demands on the helper would be allocated helpers who had already some experience in the scheme and had shown themselves to be capable.

The care manager always provided a helper with background information on a new user and arranged a personal introduction. A written contract was drawn up stating the main tasks to be carried out. This was normally worded to allow a degree of flexibility. The length of time for a visit was not specified. This allowed a helper to vary the time spent according to the needs of the user on a particular occasion. The payment helped to seal the contractual agreement between the helper and the local authority and recognised the

helper's worth. Helpers were encouraged to perform extra tasks outside those specified in the contract when appropriate, or even make extra unpaid visits. All but one of the helpers interviewed performed tasks over and above those specified in the contract, and in 40 per cent of cases this was a frequent occurrence. For 80 per cent of users this came about as a result of the helper's initiative rather than at the user's request. Examples of these unpaid activities included taking a user for an outing, doing the gardening or making extra visits if concerned about the user's condition. This provides evidence that the quality of care and companionship offered by helpers was closer to that typical of informal carers than the regular paid help of home helps.

The care manager would continue to keep in regular touch with a helper to provide support and guidance. Only 15 per cent of helpers felt this contact had been insufficient. Support had been particularly valued during crises in the user's life (35 per cent) or when the helper had been uncertain of their role (20 per cent). Other types of support given included professional advice about specific user needs, problem solving and the assumption of responsibility for the user, as well as general encouragement.

This regular contact which care managers maintained with helpers was also a means of monitoring the user's progress and picking up any difficulties. Helpers could quickly alert the care manager about any sudden change in the user's state, 30 per cent reporting such involvement. Although recently recruited helpers often consulted the care managers when there were problems, with experience they frequently did not get in touch over their anxieties, and it was often amazing what they would cope with without support. For example, one helper would stay with a cognitively impaired user until 1a.m. to help prevent her wandering. The care manager often did not get to know about problems until later. Helpers' monthly meetings were a good opportunity to gain some of this information. However, when helpers were faced with an emergency with which they could cope, they always contacted the care manager later to report back what had happened. The care manager also monitored what helpers were doing by regularly visiting users. This combination of contacts meant that the care manager could keep in close touch with everything which occurred.

There was only one instance where disciplinary action was necessary against a helper, who had been good and caring and involved with users seven days a week. The care manager became uneasy when the helper and her husband became very involved with a user. Next, the helper accepted the user into her home without consulting the care manager and there were doubts about their intentions regarding the user's property. The area manager became involved, and the helper was asked to immediately stop visiting other Community Care users, while the GP was the only person who could continue to monitor the situation as the social services department were denied access to the helper's home. The user appeared to be fairly well cared for and died after one year in the helper's home.

In a six year period, only two helpers were obviously unsuitable. They and the care manager mutually agreed that the helper was unsuitable after some two weeks. The helpers had found the work had not been as they had expected despite the care manager having spent a lot of time with them. The care manager discussed the situation both with the helper to make sure she did not feel she had failed, and also with the user to prevent her feeling let down or guilty.

Helpers normally communicated with the care manager by telephone. In three-quarters of cases it was the helper who initiated contact rather than the care manager. Almost all

helpers felt their relationship with the care manager was based on friendship and understanding, and in two-thirds of cases helpers benefited from their knowledge of the care manager's role, too. However, 22 per cent of helpers expressed some dissatisfaction with the level of support they received. The most frequently expressed limitation was the need for a standby duty service. However, most helpers did informally arrange themselves into groups through which they could give each other support at times of difficulty during out of office hours. Also many experienced helpers acted as a pool to give advice when needed. These instances provide further evidence of multiplier effects.

In addition, the care manager's home telephone number was available to all helpers for use in an emergency. During office hours only 4 per cent of helpers had experienced difficulty in contacting the care manager, who became more accessible once the Community Care team was based in Sheppey. While the care manager and her assistant were out of the office, the Community Care clerk was very supportive, and could put the helper in touch with the appropriate person. If the care manager or assistant were aware of a difficult home situation, they would sometimes telephone the helper at the weekend to see if the helper was managing. Also the good relationships built up between the care manager and community nurses and CPNs assisted helpers in getting to know the nurses. Helpers could talk to nurses if they met at the user's home, and this could provide additional support at weekends. The officer in charge of the local county home for older people was also occasionally contacted out of office hours by helpers when the care manager and her assistant were unavailable. Helpers also frequently met each other in the high street to chat and give each other support, another example of a multiplier effect.

Table 10.6 Helpers' motivations in Sheppey, Thanet and Gateshead schemes compared

	Sheppey %	Thanet %	Gateshead[1] %
Social contact			
An interest outside the home	46	23	68
To meet people	35	30	60
To work with older people	63	-	77
To fill up spare time/do something stimulating	30	63	31
To take mind off own worries	15	23	9
Material personal gain			
To earn some money	39	40	48
Experience for a career	24	10	24
Esteem needs			
A chance to do something useful	46	43	90
To help someone in need	54	63	81
To repay help received	2	20	20
To use skills	17	-	37
To look after, or care for someone	39	-	82
Sample size	46	40	119

Notes:

1. Percentages for Gateshead are overall much bigger, probably reflecting a different interview technique.

3 Motivation of helpers

The motivations expressed by helpers for joining the scheme are shown in Table 10.6 where they are compared to those in the Thanet and Gateshead social care schemes. Following Qureshi *et al.* (1989), motivations have been classified into social contact, material personal gain and esteem needs.

Social contact

Many of the Sheppey helpers had children who were all of school age, leaving them with time on their hands. Thirty per cent wanted to fill up their spare time or do something stimulating, with a similar proportion in Gateshead. However, this was less than half the proportion found in Thanet, where helpers were on average older than in Sheppey and Gateshead with many facing extra time on their hands through their children leaving home. In Sheppey, a more frequently expressed motivation was for an interest outside the home and its incidence in Sheppey at 46 per cent was twice that for Thanet. Nearly two-thirds expressed an interest in work with older people. Fifteen per cent of helpers in Sheppey saw the work as a means of taking their minds off their own worries, a little less frequently than in Thanet.

Material personal gain

In the process of recruiting helpers, one of the original aims was to select those whose primary motivation was to care, rather than material gain. The payment of fees was to be incidental, helping to formalise the contract, and was not intended to be seen by the helper as an essential part of the work. In practice, it was not possible to recruit all helpers on this basis. Indeed, sometimes the pay of male spouses was inadequate, making helper fees an important part of the family income. Therefore, when a group of helpers made demands for increased fees, this introduced a tension between the aims of the scheme and the financial needs of some helpers. However, it was not always the helpers in financial difficulty who made these demands.

Nearly half the helpers in each scheme were motivated by the wish to earn some money. Although some Sheppey helpers appeared over-importunate in their demands for increased fees, reflecting the increasing value placed on time, and raising doubts over whether they had the right type of motivation for the work, there were others in genuine poverty whose need for a reasonable level of pay was quite understandable. Helpers from Minster were generally better housed and better off financially. However, even in Minster, payment was important to all helpers, which was understandable in view of the cost of living in relation to the typical wage. A few helpers receiving supplementary benefit who had potentially a lot to offer decided not to join the scheme because of the pay trap. Twenty-four per cent took up the work as experience for a career with a similar proportion in Gateshead. Indeed, one helper was subsequently appointed as assistant care manager in the local office, and others went on to join the staff of day centres for older people or become assistant wardens of sheltered housing. In Thanet, only 10 per cent of helpers were looking for career experience: those wanting to start a new career would probably have commenced training at a rather earlier age than the average for this helper group.

Esteem needs

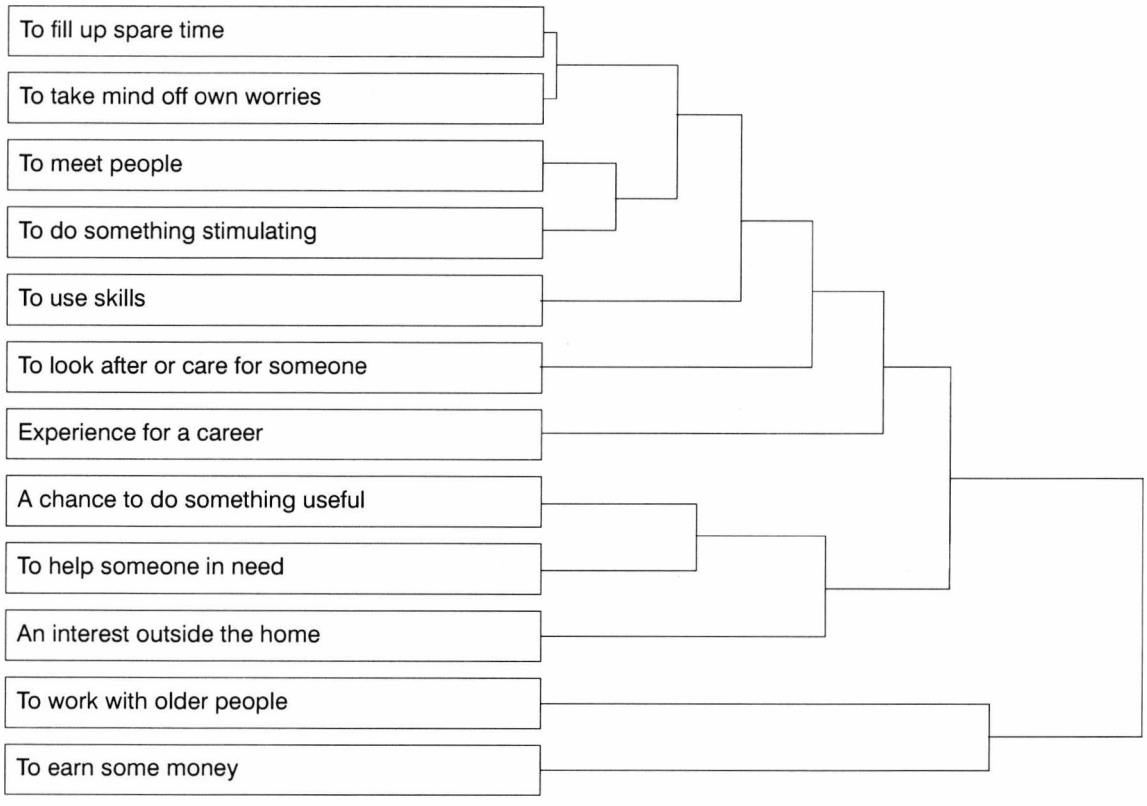
Nearly one half declared a wish to do something useful in Sheppey and Tonbridge, compared with the vast majority in Gateshead. Over half in each area wanted to help someone in need. Thirty-nine per cent of the helpers wanted to look after or care for someone, compared to roughly double this proportion in Gateshead. Moreover only 2 per cent of Sheppey helpers wished to repay help received, compared to 20 per cent in Thanet

and Gateshead. Thus Sheppey helpers appeared less frequently motivated by esteem needs than those in Thanet and particularly Gateshead.

A cluster analysis was undertaken to see how different motivations were grouped together. The strength of these groupings and their linkage was conveniently represented by a dendrogram shown in Figure 10.1. Here, the linkage between motivations or groups of motivations is represented by the vertical lines. The further these lines are displaced to the right, the weaker the link.

Figure 10.1 Clustering of motivations for helpers in the Sheppey Community Care Scheme

A cluster analysis by variable produced the following dendogram[1,2]:



Notes:

1. The motivation 'to repay help I've received' was omitted in view of the small proportion of helpers involved.
2. Sample size: 46.

It can be seen that the desire to fill up spare time and to take their mind off their own worries were closely associated. It is hardly surprising that the wish to meet people and the need for stimulation were linked. Both pairs of motivations described above were in turn linked together rather less strongly, and the wish to use skills and to look after or care for someone were also weakly associated. This larger group of motivations were likely to be associated for women whose family commitments were changing. Thus, one was a bored housewife whose youngest boy could now be left unattended. Another had three young children and wanted an outlet away from the home. She was able to do evening visits and Sunday lunch for the user while her husband was at home to look after the children. Another helper who was divorced lived with her four-year-old son in her parents' home. Community Care could easily be made to fit around looking after her boy, particularly at

weekends, at a time when her parents could baby sit. A widowed helper aged 60 who had recently retired felt a big gap in her life which the scheme was able to fill.

Another two motivations which paired together were 'a chance to do something useful' and 'to help someone in need'. Thus one helper, a widow with a fourteen-year-old son, wanted to fill the gap left after her husband died and subsequently by her son growing up. She wanted to help someone in need and to feel needed. This wish for a purpose in work was also associated with the need for an interest outside the home. Joining the scheme as experience for a career and the desire to earn some money were both virtually independent of other motivations.

There was only a limited resemblance between these associations connecting motivations and those for the Thanet project. The main feature in common was that the desires to fill up spare time and to meet people were weakly associated.

4 Tasks to be undertaken

The tasks which helpers were contracted to undertake on first working for the scheme have been classified into five categories: help with rising and retiring, help with other personal care, help with daily household tasks, help with weekly household tasks and emotional support. The distribution of tasks between these categories is shown in Table 10.7. Comparison figures for Thanet shown in the same table were collected from all the contracts issued during the first year of service for each evaluated user. The Thanet figures are therefore representative of the whole evaluation year for each case and also give greater weight to cases whose contracts frequently changed. On average each helper was asked to perform nearly three tasks on each contact, a similar proportion to Thanet. Examination of Table 10.7 shows that, as in Thanet, household tasks were the most frequently performed, accounting for 44 per cent of all activities, a little less than in Thanet (48 per cent). Personal care tasks, including those concerned with rising and retiring, covered a further 39 per cent of activities, compared to only 25 per cent in Thanet. Finally emotional support accounted for the remaining 17 per cent of tasks, which was almost that found in Thanet.

Table 10.7 Tasks which helpers were contracted to do: Sheppey and Thanet compared

	Proportions of different categories of task performed[1]	
	Sheppey on first working for Scheme[2]	Thanet as specified in contracts issued during evaluation year for each user[3]
	%	%
Help with rising and retiring	20	9
Help with personal care	19	16
Help with daily household tasks	34	29
Help with weekly household tasks	10	19
Emotional support	17	21
Help carers directly		4
Assessment or making help acceptable		2
Number of tasks	125	270
Number of helpers	46	104
Average number of tasks per contract	2.7	2.6

Notes:

1. The unit of analysis is the task category, not the helper.
2. Tasks of Sheppey helpers were divided between five categories, compared with seven for Thanet.
3. The Thanet data is not quite comparable with that for Sheppey, since some Thanet contracts apply to helpers who were already well established.

Most household tasks involved daily household care which constituted one task in every three. These nearly always involved the preparation of a meal or snack. This might appear surprising, being a task traditionally carried out by the home help or meals on wheels services. However, both services tended to be rather inflexible as to when they could provide a meal. Meals on wheels were limited to certain weekday lunches and the home help service did not normally provide a hot evening meal or weekend meals. A further limitation of conventional provision was inability to respond to the needs of those frail older people who tended to neglect themselves, not eating the food with which they were provided or having a totally inappropriate diet. Community Care helpers of such people might then be asked to cook an appetising, nourishing meal and then sit down with the user to provide companionship and encouragement while they ate. Other daily household tasks were generally performed by the home help. This provides further evidence of how the flexibility of the scheme allowed helpers to offer better quality of care and companionship than conventional services.

Weekly household care comprised ten per cent of all tasks, about half that found in Thanet, and most involved cleaning, tidying or shopping. Presumably such tasks were more frequently performed by the home help in Sheppey than in Thanet, and were normally only carried out by the helper at times when a home help would not have been available, particularly at weekends. Assistance with shopping sometimes took the form of taking the older person round the shops and allowing them the opportunity of choosing their own items of food, clothes or shoes.

Personal care tasks in Sheppey were almost equally divided between help at times of rising and retiring (20 per cent) and other personal care (19 per cent). The first of these was twice as frequent as in Thanet and probably reflects the withdrawal of community nursing support from some of these cases. Helpers could often respond far more flexibly than the community nursing or home help services in offering this help at times when the older person really needed it. Other personal care tasks were mainly covered under check up visits, managing medication and toileting, including cleaning up after incontinence, diarrhoea or vomiting. Lifting, to assist in transfer and mobility was also sometimes involved.

Finally, emotional support accounted for one task in six, almost as frequent as in Thanet. This usually took the form of offering companionship to relieve loneliness and providing stimulation. Sometimes companionship was given partly in response to the particular needs of those older people who had suffered a recent bereavement. Emotional support could also be given through offering users the opportunity to get out of the house more, such as by providing outings, usually in the helper's car. For older people who were normally housebound, these outings could add substantially to their enjoyment of life.

5 Ongoing work with users: the user-helper relationship

Some of the basic information on the caseloads of helpers is given in Table 10.8. At the time that helpers were interviewed they were visiting up to five users. One third of all helpers interviewed had already left the scheme. Out of the remaining 31 helpers, 9 per cent had no regular user at that particular time, either because no user was available or because the helpers were wishing to limit themselves to relief work for other helpers at that stage. One quarter of helpers had a single user, while at the other extreme a further quarter of helpers had a caseload of four or five.

Table 10.8 Caseload information for Community Care helpers

Number of users visited at time of helper interview (for the 31 helpers who were still in the scheme)

No. of users	%
0	9
1	25
2	22
3	19
4	14
5	11
Total	100

Time per week spent on Community Care work (a) at time of helper interview or before finishing (b) when first starting

Hours per week	At time of interview/before finishing (%)	When first starting (%)
0-2	11	18
3-5	19	46
6-10	32	18
11-20	27	14
Over 20	11	4
Total	100	100
Sample size	46	46

It can be seen that at the time of the interview or of leaving the scheme 70 per cent of helpers were working for at least six hours per week, compared with only half that percentage when they first started work. The average number of hours worked per week was 11.7 hours compared with 8.5 hours when helpers first started.

Although 72 per cent of helpers found they could manage the tasks required of them without difficulty, 17 per cent referred to the difficult personality of the user, while 7 per cent experienced problems in performing tasks and 4 per cent found poor physical facilities.

Forty-one per cent of helpers maintained that they were never worried about what they were supposed to do. Of those that did worry, the situation was usually resolved, either by clarification from the care manager or through the helper's own initiative. However, 17 per cent remained who were worried about leaving the user alone. Moreover, 11 per cent of helpers felt that all the users they visited would have been better off in residential care, and a further 13 per cent felt some of their users would have benefited from this. An important aspect of the scheme is the need to tolerate a degree of risk as the price which is often needed to be paid in allowing the older person the freedom to remain at home. This risk is something which professionals, such as GPs, often find hard to accept, so it is unsurprising that some helpers found it a problem, too. The care manager would talk these anxieties through with the helpers to make the risk taking more acceptable to them.
Most helpers found they had been able to build up a good relationship with their users. Eighty-five per cent described this as a real friendship, with a further 9 per cent feeling the relationship was developing into a real friendship. In view of some of the users having

difficult or withdrawn personalities, this was a good result and would have enhanced the rewards offered by the work.

6 Work with informal carers

An important principle of the Community Care Scheme already referred to in Chapter 2 was that intervention should not aim to take over the work of any informal caring network already providing support, except to provide relief or to improve the reliability of any assistance given. The invaluable contribution of informal carers was recognised, frequently of a high quality and based upon an exchange inspired by altruism. The evaluator asked helpers about their involvement with these carers.

It has already been noted that only a small proportion of Sheppey users had an informal carer providing regular, sustained help. Nevertheless, three-quarters of helpers had met family members, and one third were in frequent contact. Thirteen per cent of helpers had shared tasks with the family but only 4 per cent did this on a regular basis. Usually family members did not ask the helper to perform tasks, though 7 per cent of helpers were asked to carry out tasks which were not part of the contract.

Also, 70 per cent of helpers had been in contact with the user's friends or neighbours. Helpers reported that since they had been visiting their user, one half saw no change in the involvement of neighbours or friends, 4 per cent gave more help and 24 per cent helped less. These results do not indicate any extensive undermining of the existing informal care network. Just 7 per cent of helpers had shared or rotated tasks with the network. Of those helpers who were acquainted with the user's friends or neighbours, an overwhelming proportion (85 per cent) found the relationship helpful. A further 7 per cent described the relationship as cool or practical while only 7 per cent found it hostile. Ninety-three per cent of helpers felt that the fact that they were paid did not affect their relationship with the neighbour or friend in any way.

7 The effect on the helper's family

Ninety-six per cent of helpers had some family. Of these, the user had met their family in 82 per cent of cases. Where helpers had a family, three-quarters stated that their family - normally the husband or children - had called on the user, while for 20 per cent the user had visited the helper, this being a frequent occurrence in 15 per cent of cases. Helpers found that contact between their children and the older person was welcomed by both parties, and one helper regularly left her children with two of her users.

For helpers with a family, 70 per cent of families thought it a good idea for the helper to work for the scheme, the remaining 30 per cent being neutral. No family was opposed to the helper's work. In 40 per cent of cases, the helper's family became involved in helping the user.

The family sometimes missed out in some ways. In 22 per cent of cases they had to undertake more household tasks in the helper's home and in 18 per cent of cases the helper had less time to spend with her own family.

Table 10.9 Helpers' rewards in Sheppey, Thanet and Gateshead schemes compared

	Sheppey %	Thanet %	Gateshead[1] %
Social contact			
Significance of relationship with user (HN)[2]	63	53	-[4]
Something to do (HN)	26	44	49
Getting out of the house (HN)	35	17	-
Material personal gain			
Hope of social work (or other) career (HN)	20	19	40
Esteem needs			
Some sense of usefulness/purpose (HN)	52	42	97
Commitment to aims of scheme (HN)	41	-	-
Dependence of users (UN)[3]	52	50	84
Gratitude of users (UN)	33	61	80
Admiration or liking for user (UN)	59	-	86
Altruistic satisfaction over user (UN)	-	31	-
Commitment/obligations to user (UN)	11	-	-
Whether need or feelings on first joining the scheme being fulfilled	89	-	-
Sample size	46	36	119

Notes:
1. Percentages for Gateshead are overall much bigger, probably reflecting a different interview technique.
2. HN: Rewards relating mainly to helper's own needs.
3. UN: Rewards relating mainly to user's needs.
4. A dash indicates that the question was not asked.

8 Rewards and payments

In order to understand the factors which lead to helpers providing sustained involvement in the scheme, it is helpful to find out the rewards they derive from the work. A selection of some of the most frequently encountered rewards is shown in Table 10.9, where comparisons with Thanet and Gateshead are made. These rewards have been divided into those relating mainly to the helper's own needs and those relating to the user's needs. The most frequently expressed rewards in Sheppey showed some resemblance to those expressed for Thanet and Gateshead. Regarding rewards to the helper's own needs, the significance of the relationship with the user (63 per cent) and some sense of usefulness/purpose (52 per cent) dominated. When the reward related largely to the user's needs, dependence of users (52 per cent) and admiration or liking for user (59 per cent) were the most frequent. However gratitude of users (just 33 per cent) was only about half the level found in Thanet.

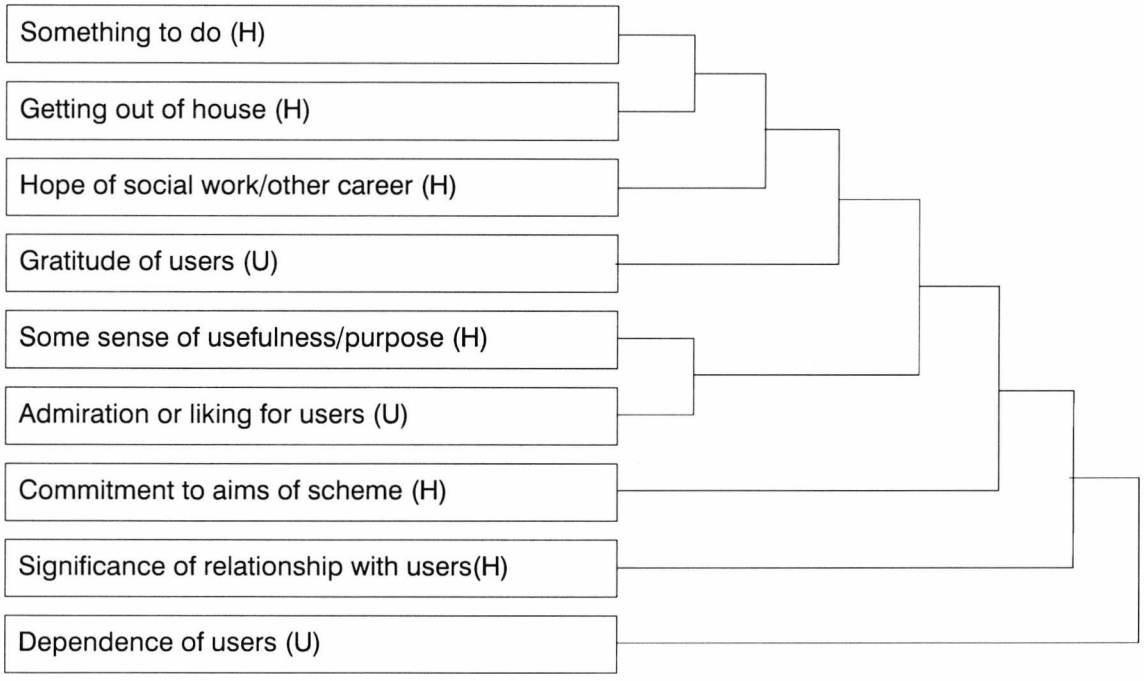
A cluster analysis of these rewards was undertaken for Sheppey to discover how they were grouped together, leading to the dendrogram shown in Figure 10.2. It can be seen that the advantage of having something to do tended to be combined with the benefit of getting out of the house, particularly in the case of mothers whose children were all at school or were old enough to be left. One helper, a school girl, enjoyed having an interest outside the house apart from time spent at school, and her favourable experience of helping at a playgroup, arranged through the school, encouraged her to extend her activities to other caring work, by applying to the scheme. This pair of rewards was more loosely associated with the hope of a social work or other career and of the gratitude expressed by users. A separate grouping of rewards was between experiencing a sense of usefulness or purpose

and an admiration or liking for the user. One such helper had already been involved in providing support to her user as a neighbour before continuing to help through the scheme. Even then she still found the work too demanding. It was her liking for the old lady which enabled her to carry on during this difficult phase until the care manager could persuade the user to accept additional assistance through a second helper. Remaining rewards were only very weakly linked to these other groups. It can be seen that user oriented rewards were often associated with helper oriented rewards. In other words, helpers were rewarded in ways which reflected both the benefit to the user and an outlet for their own needs. However, these rewards were clustered together in quite a different manner to that found for the Thanet project.

It has already been mentioned that 59 per cent of helpers were motivated to join the scheme partly as a means of earning money. It was found that 71 per cent of all helpers felt that the pay they received was sufficient and a further 11 per cent were satisfied but with certain reservations. The remaining 18 per cent were dissatisfied with their level of pay.

Figure 10.2 Clustering of rewards for helpers in the Sheppey Community Care Scheme

A cluster analysis by variable produced the following dendogram[1,2]:



Notes:

1. The reward 'commitment/obligations to user' was omitted in view of the small proportion of helpers involved.
2. H: Reward relates mainly to helper's own needs.
   U: Reward relates mainly to user's needs.
3. Sample size: 46.

9 Difficulties experienced by helpers

Twenty-two per cent of helpers sometimes felt they had too much to do, though none found this a frequent problem. The pressure came from a variety of sources, but

particularly from either the user or the helpers themselves. When things became too much, three-quarters of these helpers relied very much on themselves to cope, the remaining quarter turning to the care manager to resolve the situation. Most helpers experiencing difficulties found these strategies worked, though one in five found them only partially successful. Some helpers liked to respond to any request for help, and would not say 'no' to the care manager even when they were feeling overworked. Others found their user over-demanding, ringing up the helper at all times, or prolonging the visits indefinitely through their demands and constant chatter. This sometimes also brought about resentment from the helper's family. Some helpers found it difficult to resist these unfair demands on their time, and the care manager would then provide guidance as to how to cope. When helpers told the care manager they had too much to do, the care manager would always reduce their duties. On one occasion, when the older person had required extensive support and the helper had become exhausted, the care manager arranged a fortnight's stay for the user in local authority residential care to give the helper a break. Helpers often felt under an obligation to spend considerably more time with the older person if they were unwell or had had a fall, and this might result in their spending some nights with the user. Such situations were frequently brought about by lack of support from the GP who had failed to arrange a hospital bed when one was required.

Some helpers were grouped together in twos or threes to provide each other with relief, so that they could have regular breaks to go away on holidays. However, this meant that they would sometimes be providing relief in addition to their normal duties, and this could be very demanding. It was often difficult or impossible to obtain relief at short notice during out of office hours.

10 Reasons for drop-out

Fifteen of the helpers interviewed (one-third of the total) had already withdrawn from the scheme. Some of the reasons given for leaving are shown in Table 10.10 which includes a comparison with Gateshead. In view of the small sample size for Sheppey, any conclusions drawn may not be representative of a larger helper group. The most frequently given cause was insufficient work (33 per cent), greater than for Gateshead (20 per cent), where helpers were offered guaranteed hours. The care manager in Sheppey had to strike a balance between maintaining a sufficiently large pool of helpers to be able to respond both promptly and effectively whenever a helper's support is required, while at the same time maintaining the pool small enough to provide the majority of helpers with work. It was not possible to provide sufficient work for all helpers all of the time. As a result some helpers withdrew. When helpers were asked what they would do if the scheme could offer no more work, 44 per cent said they would look for a job while 9 per cent would look for voluntary work, though nearly one-quarter would not have wanted anything else. It tended to be those helpers who were least flexible in the range of work which they could manage who were left with insufficient work and subsequently withdrew. Only thirteen per cent of helpers withdrew because of insufficient pay, while 27 per cent left after finding alternative employment, which would frequently provide a guaranteed income. Other helpers left the scheme because of back strain (14 per cent). There was less evidence that helpers left through too much pressure (7 per cent) than in Gateshead (20 per cent).

Table 10.10 Reasons for helpers leaving the Community Care Scheme in Sheppey and Gateshead

	Sheppey %	Gateshead %
Insufficient work	33	20
Difficult/unpleasant tasks	13	3
Insufficient pay	13	25
Backstrain	13	0
Alternative employment	27	33
Community Care work unsuitable	7	3
Too much pressure	7	20
Change in personal or family circumstances	27	40
Unsuitability of other helpers	13	0
Relationship problems with user	0	10
Problems with informal carers	0	8
Dissatisfaction with CCS organisation/support	0	8
Doubts about whether CCS is worthwhile/valid	0	8
Disappointment at type of work offered	0	3
Other	0	28
Sample of helpers leaving scheme	15[1]	40[2]

Notes:

1. These 15 Sheppey helpers who had withdrawn by the time they were interviewed made up 33 per cent of the total.
2. These 40 Gateshead helpers included both those who had already withdrawn (23% of the total) and those who had considered leaving (11% of the total) by the time of the interview.

11 Clustering of motivations, rewards, dissatisfaction and sustained involvement

Following the individual cluster analyses on motivations (Figure 10.1) and rewards (Figure 10.2), an overall cluster analysis, shown in Figure 10.3, combines motivations, rewards, helper dissatisfaction and whether the helper's involvement was sustained over at least the first eighteen months. It was possible to identify five main groupings of variables, though these bore little resemblance to those for Thanet.

(1) Being motivated by having spare time and rewarded by having something to do

This was illustrated by a mother whose children were aged 8, 4 and 2 when she started, yet still found she had time on her hands. She thoroughly enjoyed Community Care work which successfully filled the gap, and hoped to do more when the youngest reached school age. The wish to take their mind off their own worries was sometimes included in this category.

(2) Being motivated by the wish to do something stimulating and rewarded by getting out of the house

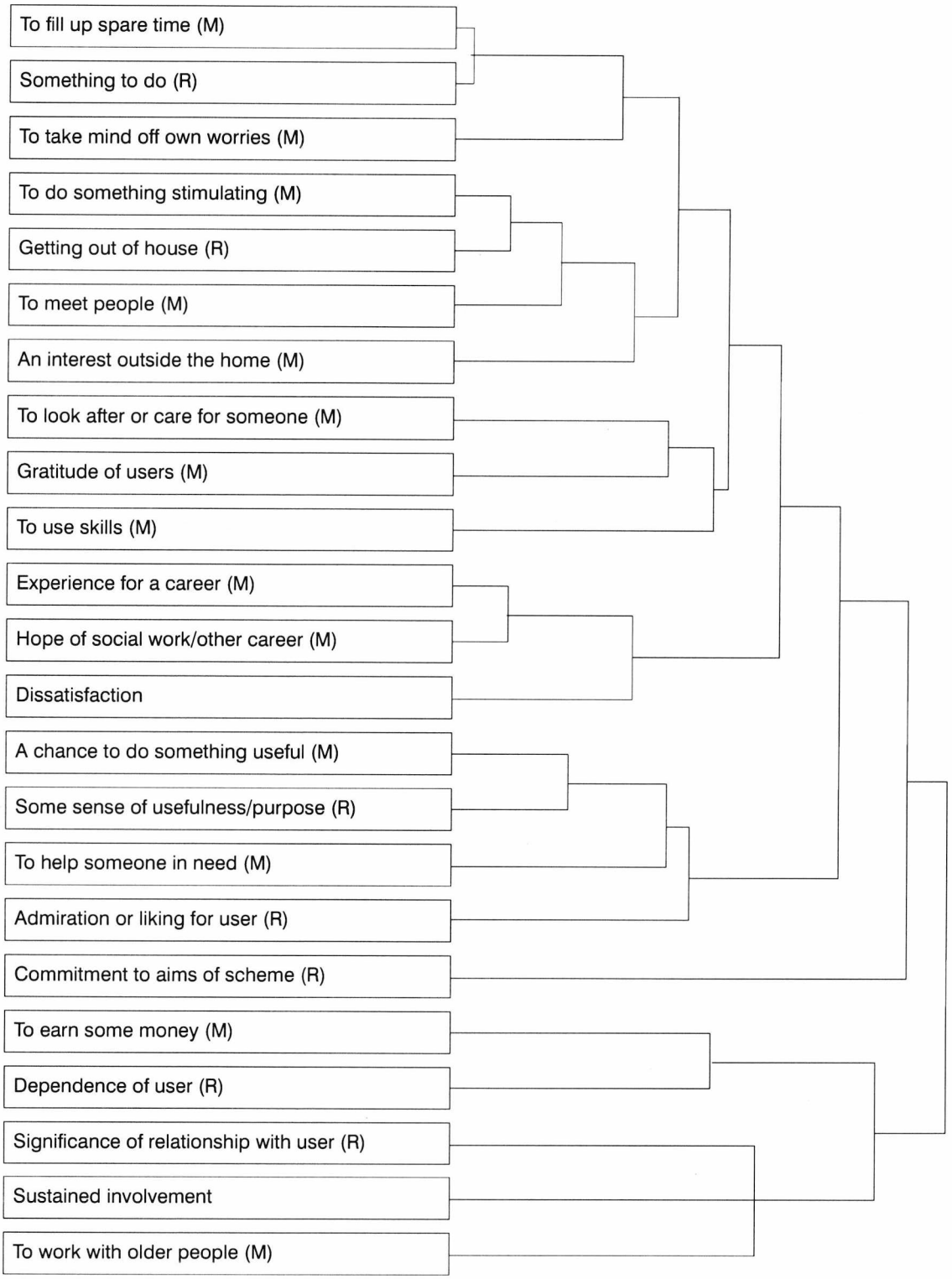
The motivation to meet people and to have an interest outside the home were linked more weakly to this group. Groups 1 and 2 were loosely linked together. Thus the helper used to illustrate group 1 was also included in group 2.

(3) Being motivated by the wish to care for someone and rewarded by gratitude

One helper who had recently retired had become depressed and decided to look for voluntary work. Her users expressed their gratitude at the care she provided. There was no feeling of rejection and this helped to compensate for the rejection she felt at having to retire.

Figure 10.3 Clustering of motivations, rewards, sustained involvement and dissatisfaction for helpers in the Sheppey Community Care Scheme

A cluster analysis by variable produced the following dendogram[1,2]:



Notes:

1. The motivation 'to repay help I've received' and the reward 'commitment/obligations to user' were omitted in view of the small proportion of helpers involved.
2. M signifies a motivation; R signifies a reward.
3. Sample size: 46.

(4) Being motivated by the wish to obtain experience for a career and rewarded by the hope of a social work or other career

For some helpers a new career had already begun, as mentioned earlier. There was also a weak association between this career-minded group and dissatisfaction.

(5) Helpers motivated by a chance to do something useful and rewarded by some sense of usefulness or purpose

These helpers were clearly rewarded by the factor which motivated them. One such helper had experience as a foster parent and with the mentally handicapped. She had a great capacity for hard work in Community Care, from which she derived enjoyment and a feeling of achievement. This was illustrated by one of her users, a retired professional man who had neglected himself and lived in filthy conditions. The helper managed to get him walking, feeding himself and continent by day. The motivation of wishing to help someone in need was more weakly associated with this group.

Other linkages in the dendrogram were too weak to be important. Although sustained involvement of the helper over at least eighteen months was not strongly linked to any items, it was very weakly associated with being motivated to work with older people. Little similarity could be found between the above groupings and those for Thanet. Although, as expected, certain motivations and their corresponding rewards, such as time to spare, experience for a career and usefulness were associated, these pairs and other variables were grouped together quite differently in the two areas.

12 Multiplier effects

The helpers were asked whether their work for the scheme had been catalytic in motivating them to take up voluntary work outside the scheme. Twenty per cent had become involved in helping someone outside the scheme, this proportion being the same whether or not the helper had already left the scheme. The person helped had normally been a neighbour. Only one helper had given up informal visiting on joining the scheme. Out of the 35 per cent of helpers who had been involved in working for a voluntary organisation on entering the scheme, three-quarters carried on this work at the same level. Nineteen per cent increased the amount of voluntary work and only one helper reduced their involvement.

One quarter of all helpers had persuaded at least one person to become a Community Care helper, usually a relative or friend.

It was clear, then, that the overall impact of the scheme upon helpers was to increase their involvement in informal neighbouring and voluntary work. At the same time helpers acted as a source of new recruits through persuading relatives and friends to apply to the scheme for work. Finally, the support which helpers offered each other was catalytic in enhancing the care they provided their users.

13 Concluding remarks on Sheppey helpers

Most helpers were married mothers and nearly one half were motivated by an interest outside the home as their children became older, with a majority wanting to work with older people. In this working class area with high unemployment there was a frequent need both for payment to supplement the husband's income and for experience for a career. Many helpers also wanted to contribute something useful. These characteristics of the helper pool account for many of the similarities with the Gateshead helpers and differences with the Thanet helpers, who included a substantial proportion of the over-50s.

Helpers were rewarded both regarding their own needs, particularly through their relationship with the user and their sense of usefulness, and regarding the user's needs such as their dependence and the helper's admiration or liking for them. One in five helpers saw the work as furthering their career.

As well as being involved with personal care, the flexibility of helpers also made them suitable for aspects of household care, particularly meal preparation. Emotional support was also important.

Helpers appeared to cope well with difficulties. Although nearly one quarter sometimes felt they had too much to do, they usually sorted this out themselves and the care manager was available when needed. Helpers frequently supported each other, particularly during out of office hours. Care managers provided helpers with much support when first starting, and a personalised introduction to a new user was always made. Regular contact with all helpers was maintained, including support provided at monthly coffee mornings. Training was provided where necessary.

Helpers most frequently left the scheme due to insufficient work or to start a job. Sustaining factors were a wish to work with older people and having a good relationship with the user. The quality of the user-helper relationship appeared high, with helpers keen to spend extra time visiting, particularly at times of greater need.

Finally, there was abundant evidence of multiplier effects. Not only were many helpers recruited through the informal network. Helpers also supported each other to a considerable extent, and one helper in five started supporting someone outside the scheme.

PART IV: CONCLUSIONS

CHAPTER 11

ACHIEVEMENTS, IMPACT AND DILEMMAS ARISING FROM THE SCHEME AND ITS EVALUATION

In Parts II and III a large quantity of observations and results have been presented arising from both process and statistical analysis. Before placing these into perspective in the concluding chapter, this present chapter focuses on a few selected themes which illustrate some of the more important achievements of the care management schemes and their evaluation, and the impact these had on practice and academic thought. Some contentious aspects of the implementations are also discussed.

The following five themes were selected and are discussed in turn:

- The costing of care management time.
- Introduction of a monitoring system: implications for computer-based systems today.
- Confounding effects in experimental design: the result of feedback to care managers on their behaviour and on the results of the study.
- The case for paying helpers by task rather than by the hour.
- The community care scheme and the development of the mixed economy of welfare.

1. Costing care management time and influence of results on care management development

The process of costing care management time was complex. The analysis incorporated important new features to avoid underestimating this important resource. The determination of the unit cost has already been addressed in Chapter 3. In order to understand how the care manager's time was distributed between their users and other more general tasks it is helpful to consider the broad types of activity involved in care management and how these change over time.

1.1 The three phases of care management activity

Each scheme progressed through three phases. In the *pre-implementation* phase, following the initial appointment of the care manager, all the activity was concerned with initial induction of the care manager, the setting up of the scheme and liaison with the evaluation team over how to proceed with the evaluation. The beginning of the *caseload-building* phase was characterised by the provision of service to the first user. It ended when the caseload of the care manager and any subsequently appointed assistant had built up to a steady level. The *steady state* phase covered all further activity, with care managers and their assistants working at full capacity.

Davies and Challis (1986) separated care management time use into firstly development costs (including research costs) and secondly running costs. Their analysis applied equally well to Sheppey and Tonbridge. Development costs included general liaison with other agencies and the setting up of new methods of working. Research costs covered the time spent in helping the evaluation team to set up and carry out the process of assessment interviewing and costing in the experimental and control areas. Running costs were divided into activities which affect only the user or their carers, and others, such as some of those associated with the recruitment and support of helpers, which were not attributable to the user. The latter were treated as overhead costs of individual users. The pre-implementation

phase consisted entirely of research and development costs, with a few general running costs. During caseload building, user specific running costs became increasingly important. General running costs were also high, as much effort was required in building up a pool of suitable helpers. Once the steady state phase had been reached, research and development costs had been reduced to a relatively low level. General running costs were also less: now that a pool of helpers had been built up, maintaining that pool was less time consuming. Most time was now spent in user-specific activity.

Table 11.1 Caseload levels since appointment of care managers

	1980		1981			1982				1983		
	1st Nov.	1st Jan.	1st Apr.	1st July	1st Oct	1st Jan.	1st Apr.	1st July	1st Oct	1st Jan.	1st Apr.	1st July
Sheppey CM	0	0	7	14	17	21	19	22	25	26	16	24
Sheppey Ass. CM										0	6	7
Tonbridge CM	0	0	11	16	21	15	16	24	28	35	33	-
Tonbridge Ass. CM					0	11	12	12	12	11	7	-

In Sheppey and Tonbridge, these three phases could be traced by means of the monitoring returns. Table 11.1 shows the pre-implementation phase, followed by the caseload-building phase in which care managers' caseloads are shown at three-monthly intervals. Caseloads of subsequently appointed assistant care managers are also included. In both schemes, the pre-implementation phase lasted for two months, from the date of appointment on 1st November 1980 until the first cases were opened on 1st January, 1981.

During the caseload-building phase, the caseload for the Sheppey care manager peaked at 26, two years after the first case was taken on, and then dipped when the assistant care manager was appointed, due to the care manager transferring cases to the assistant, and the time taken in training the assistant. The care manager's caseload subsequently reached 30, while that of the half-time assistant reached 10.

Data for the caseload-building phase in Tonbridge is presented up to 1st April, 1983, when the Tonbridge and Malling social services division was divided and the community care teams reorganised and relocated. The care manager's caseload peaked at 35, this high value reflecting the substantial proportion of (unevaluated) short-term cases taken on in the early stages of the scheme. Following reorganisation, this caseload settled down at around thirty. The caseload of the half-time assistant peaked at 12, but later settled down to 10. These caseload levels were typical of other care managers and assistants appointed following reorganisation. Thus in both Sheppey and Tonbridge caseloads reached around 30 for care managers and around 20 for a full-time equivalent assistant care manager.

The number of contacts per week with users, carers and others (mainly helpers) could be obtained from the case review forms. This also reached around 30 for care managers and 20 for a full-time equivalent assistant.

The similarity of caseload levels and of number of weekly contacts between the two schemes meant that caseload information could legitimately be compared between schemes. Each case received on average one contact per week.

All methods of measuring time use have their advantages and disadvantages. The method chosen here had some particularly attractive features. Assuming the number of contacts was roughly proportional to the total care manager time spent, the number of hours per week of care manager time on each case could be calculated. Although length of individual contacts will clearly vary, the assumption was that, when taken over a complete evaluation year, the total number of contacts will be reasonably representative of the total time taken.

Care manager time associated with each contact, assuming a 37 hour week, six weeks holidays and 30 contacts per week

$$= (37/30) \times 60 \times (46/52) \text{ minutes} = 65.5 \text{ minutes.}$$

Similarly, assistant care manager time associated with each contact

$$= (37/20) \times 60 \times (46/52) \text{ minutes} = 98.2 \text{ minutes.}$$

Attempts to estimate time spent by social workers on individual cases by examining case notes and interviewing the social worker make it likely that the overall time spent will be substantially underestimated (Carver and Edwards 1972, City of Manchester 1981). The advantage of the method used in this study is that, by relating it to total care manager time available, no such bias is introduced.

The technique requires that, once the caseload reaches a steady state, non-user specific activity is allocated in proportion between users. This will include research and development activity and general running costs.

1.2 Initial investment costs

It was assumed that during the caseload-building phase each contact was associated with the same amount of time as during the steady state phase. This implied that the care manager's time involved with users per week no longer amounted to 37 hours. The remainder was taken up in extra research and development costs and extra general running costs. By summing these extra costs during the pre-implementation and caseload building phases, the total amounted to approximately one year of a full-time equivalent care manager in both Sheppey and Tonbridge. As Davies and Challis (1986) point out, these extra costs can be treated as an initial investment.

The assumption that contact time was the same during the caseload-building phase as the steady state phase could have been tested by asking the care manager to record in detail how the work time was divided between different types of activity for sampling periods at regular intervals; for example, a whole week at six-monthly intervals. This was not attempted in view of the demands it would have placed on the care managers. If care managers had been spending longer with their users during the earlier phases of the schemes when caseloads were smaller, this would have implications for the evaluation, since care manager costs would have been underestimated. This could have led to outcomes being greater than would have occurred with a full caseload. However, such time effects were taken account of in

the modelling and if they were present they were too small to be statistically significant. Moreover, during this period care managers were less experienced so the time they offered may have been used less effectively and efficiently. In the event, both care managers worked hard in setting up the schemes and were able to start taking on cases within two months of appointment. It is therefore unlikely that they would have had much extra time to spend on their users during the early stages of the schemes. The speed at which the schemes were set up was much greater than in Thanet, reflecting the learning that had taken place in Thanet. This was subsequently passed on to care managers in other areas. Thus, part of the care manager's initial induction involved spending time with the Thanet fieldworkers.

In the Sheppey and Tonbridge costings described in Chapter 8, the initial investment was ignored. Indeed, in the long run, investment costs have an almost negligible effect. This effect can be measured by *discounting* (Chapter 3), a technique which reflects the loan payments which would be necessary if the money for the initial investment were borrowed, in this case for an indefinite period (Davies and Challis 1986). If this discounted cost were distributed between cases in proportion to their weekly contacts, an investment cost amounting to one year's care manager time would lead to an increase in cost per contact of 5 per cent (at a 5 per cent discount rate) or 7 per cent (at a 7 per cent discount rate). Because investment costs are likely to be considerably more for care managers than for area team social workers, this means that the inclusion of investment costs makes the experimental group slightly more expensive relative to the comparison group. Table 11.2 shows these investment costs in both schemes, calculated from cost data in Tables 8.2 and 8.5. In Sheppey, this investment cost of the experimental group even when discounted at the higher rate of 7 per cent amounted to only £0.55 per week, little more than 1 per cent of the total net weekly SSD cost. In Tonbridge, it was less than 1 per cent of the total.

Table 11.2 Discounted initial investment costs of care manager

Cost details for experimental group (£)	Sheppey	Tonbridge
Total net weekly SSD cost (revenue account)	41.63	27.34
Weekly cost of care manager	7.81	3.13
Investment cost, discounting at 5 %	0.39	0.16
7 %	0.55	0.22

Because the technique for measuring time use in the comparison group (Chapter 3) was not tied to the social worker's total time available, as was the case for the Community Care group, systematic errors could arise when allowance was made for under-recording social work activity. However, since comparison group fieldworker costs are much less than those for care managers, such errors are unlikely to seriously affect group comparisons of total SSD cost. Thus, in Sheppey, the estimated weekly area team social work cost of £2.26 is only 27 per cent of the combined care management cost of £8.32 (Table 8.2); in Tonbridge it was £1.03, just 16 per cent of the combined care management cost of £6.48 (Table 8.5).

1.3 Strengths of care management costing in Sheppey and Tonbridge summarised

Overall, the method of costing care management time in the Sheppey and Tonbridge evaluation had many strengths and compares favourably with that used in Thanet:

- The danger of systematically underestimating care manager time use through inadequate case recording was avoided by ensuring that all activities when

added resulted in a full working week. The result was the same however many hours in the week the care manager worked. This is because costs were based on the number of contacts made: the average number of contacts per week over all users in a full caseload was linked to the weekly cost of the care manager.

- It was assumed that the care managers' contacts with users and others took no longer before caseloads had reached their peak. Instead, the extra time was taken up as an initial investment in extra research, development and general running costs. If such contacts had taken longer, the effect was insufficient to have a significant effect on cost-outcomes relationships.
- Although initial investment costs of care management time had been ignored in the earlier analysis, estimates showed this, when discounted, to be very small in relation to other care management time.
- Although systematic bias could have been introduced in costing area team social work time in the comparison group, these costs were so much smaller than for care managers as to make any errors introduced likely to be relatively small.

1.4 Influence on subsequent debate about care management

The intensive care management social care schemes in Thanet, Gateshead, Sheppey and Tonbridge had much in common, though Thanet, and to a lesser extent Gateshead, received rather more input from the evaluation team. The evaluations of these four schemes played an important part in the future development of care management.

The Griffiths report was published at a time when results from these schemes were already available. His remit was to review the way in which public funding was being used in community care, and to report back with options to improve its use. He recognised the failures of the current system, stating that 'the ways in which money is spent on community care do not enable a comprehensive approach to needs assessment, planning and delivery of services to be achieved' (Griffiths 1988). This is almost certainly a reference to the core tasks of care management which form a central part of the four schemes. The report developed a policy for community care involving the roles of all the relevant agencies and how these might be changed.

In examining the effects of the cost results on debates about care management, it is also necessary to take account of outcomes. The evaluations suggested that the schemes could achieve improved outcomes at a joint agency cost that was not significantly higher than that for standard provision, providing a strong recommendation of the care management approach. This is consistent with Griffiths not being in favour of significant changes in the level of existing public expenditure. Instead, he proposed an alternative way of managing existing resources, with the local authority taking a leading role. He felt that local authorities should be responsible for assessing the needs of individual users and then mobilising resources to meet those needs. He advocated the use of a care manager in this assessment process who, 'in cases where a significant level of resources are involved ... should be nominated from within the social services authorities' staff to oversee the assessment and re-assessment function and manage the resulting action' (Griffiths 1988, 6.6). Rather than relying simply on services provided by the local authority, he proposed that care managers set up care packages drawn from services in the public, voluntary and private sectors, a practice becoming increasingly important in the four

intensively managed schemes, where it included the use of helpers as quasi-volunteers. Griffiths argued that the growth of the independent sector in community care would 'encourage choice, flexibility and innovation in a climate of competition' (Griffiths 1988, 3.4). This theme is taken up again in section 5 of this chapter.

Many of Griffiths' recommendations were taken up in the subsequent white paper *Caring for People*. Some of these again suggested influence from the social care schemes over the advantages of the care management approach:

- 'Enabl(ing) people to live as normal a life as possible in their own homes or in a homely environment in the community' (Department of Health 1989, 1.8). Unnecessary admissions to institutional care were to be avoided.
- User choice was an important principle, providing users with more say in how they lived their lives and the services they needed. This reflects the user centred approach of the social care schemes.
- User independence was another key ingredient, 'by provid(ing) the right amount of care and support to help people achieve maximum possible independence and, by acquiring or requiring basic living skills, help them to achieve their full potential' (Department of Health 1989, 1.8).
- Informal carers are seen as what Twigg refers to as 'resources' (Twigg 1989). The White Paper emphasises the need for them to be supported: 'The majority of carers take on these responsibilities willingly, but the government recognises that they may need help to manage what can become a heavy burden' (Department of Health, 2.3). The importance of carer support in the four social care schemes and the improvements in carer outcomes which they yielded probably contributed to the importance assigned to informal care by the White Paper (Parker 1999).

Case management was emphasised as the means which authorities would use to design services to meet individual need and specific reference was made to the approach taken in the PSSRU projects. By adopting the care management approach with its built in incentives to deploy resources equitably and efficiently, local authorities could offer better value for money. Moreover, in the NHS and Community Care Act which followed in 1990, the practice of devolved decision making and care management was confirmed as the desired approach.

Following the community care reforms, Challis (1999) has described how some aspects of care management which featured in the intensive care management schemes have become lost as it became part of standard local authority provision. In particular, the core tasks of care management, instead of being undertaken by one key worker, were frequently spread between a variety of staff. This would reduce the incentive to deploy resources efficiently. Additionally, many of the potential benefits of care management for users with more complex needs were lost, including emotional support and counselling. Moreover there was a focus on assessment at the expense of monitoring and review. Other problems were inadequate provision of information to users and carers and limited evidence of devolved budgets, due to the absence of adequate financial monitoring systems and concerns about the control of scarce resources.

The fact that many local authorities regarded the full care management approach combined with reduced caseloads as being too expensive raises three issues:

- Did managers in these local authorities fully understand the care management approach?

- Were they prepared to make use of pools of helpers as a means of offering increased flexibility whilst reducing overall cost?
- If, as in Sheppey and Tonbridge, the care management approach were to lead to increased costs to the SSD but greatly reduced NHS costs, were arrangements in place for the NHS to transfer funds from its hospital services to SSDs to pay for these savings?

If the answer to all three questions were yes, many more local authorities might see intensive care management as being not only affordable, but also offering an improved quality of life for both users and informal carers.

The emphasis on the importance of costs and outcomes relationships in the social care schemes has been another important influence. Not only could improvements in user and carer outcomes be achieved at no significant extra combined cost to the SSD and NHS. Using the production of welfare model, it was also found that within certain cost and outcome limits, increased resources produce improved outcomes. Davies and Chesterman (1995), in a comparison of the four schemes, argued that the key criterion for efficiency is the marginal cost of outcomes. Many local authorities now emphasise the importance of the relationship between costs and outcomes and the cost-effectiveness of the care management approach with its incentives for efficiency. The operation of their computer information systems is one source of evidence for this and is discussed further in section 2. Unfortunately, others still fail to acknowledge the relationship.

Some academics and social work professionals have been resistant to the idea of quantitative analysis based on a production of welfare model, arguing that such an approach loses sight of the process element in understanding social care. In practice, the PSSRU approach has tied its quantitative analyses closely to process in order to make the quantitative results meaningful and this method is becoming increasingly accepted.

The results of the evaluations have also been influential with the care of other user groups. Thus a care in the community circular in the 1980s aimed to give more attention to care management tasks (Renshaw *et al.* 1988). This theme is developed further in section 5.

2. Introduction of a monitoring system: the setting up of computer-based systems

2.1 Recognition of the need for a monitoring system

The Seebohm Report (Seebohm 1968) had emphasised the desirability of a professional approach to social work, with a need for expertise and the capacity to make complex judgements at the grass roots level, rather than a 'top down' approach. However, the social work establishment in Britain did not fully grasp the developments in social services departments and the social work profession subsequently lost much of its influence, in contrast to events in the USA, where professional social work standards were retained (Davies and Challis 1986).

There were certain features of the Community Care schemes being set up in different parts of Kent which made the introduction of a monitoring system particularly desirable. Firstly, care managers were given considerable autonomy in expenditure on their users and were accountable to the local authority as to how this was done. They were provided with a devolved budget and the county needed a means of

knowing the type of users being served by the scheme, the types of activity which care managers undertook in supporting them and the quantities of different types of resources utilised and how these were distributed between users.

Secondly, one aim of the scheme was to encourage the care manager to deploy resources as effectively and efficiently as possible. In order to achieve this it was necessary for the care manager to have a list of unit costs of services. They were then in a position to weigh up the relative merits of using their limited resources in different ways. Feedback from monitoring returns allowed care managers and their management to see how their community care budget expenditure compared with the cost of home help and day care services for their users. Changes in total expenditure between successive quarters were also shown.

Because many features of the community care scheme were innovative, there was a greater likelihood that individual schemes could diverge from the principles of the scheme and fall short of the quality of care required. Monitoring feedback could provide managers with information as to whether the user group being targeted seemed appropriate, whether social worker activities reflected good practice and whether expenditure patterns seemed acceptable. The information could also clarify how different care managers based in areas of contrasting need responded in different ways to local demands.

During the 1980s, there was a gradual change in emphasis from the focus of the Seebohm report on the activity of professional social workers to that of the new managerialism with its more bureaucratic approach and interest in such matters as cost-effectiveness and performance review. The monitoring system was designed to have features which could satisfy both these approaches.

2.2 The introduction of a monitoring system in Kent

Kent monitoring system was planned by the evaluation team in consultation with care managers and senior management in Kent. Instead of setting up the system from scratch, it was decided to base it upon the case review system pioneered by Goldberg and Warburton (1979) to monitor social work activity at the case, social worker and team level in a social services area office at Seatown. This seemed appropriate at a time when the professional social work approach was widely accepted as one on which to base a model of good practice. These authors had developed a case review form through thorough consultation with the area teams. The aim of the form was to assist social workers in reviewing their users and to address the following issues:

- the vagueness of the aims which social workers pursue;
- the difficulties social workers experience in setting plans;
- the claim that most cases are very long-term;
- the reluctance of social workers to involve other colleagues (for example, less trained), volunteers and other community resources where appropriate.

The case review form devised by Goldberg and Warburton fulfilled the following functions:

- enabling social workers to evaluate and plan their work;
- assisting supervision;
- as an information system to those planning services;
- as a research tool; for example, in allowing associations between problems pursued, aims and methods used to be explored.

Although the ongoing nature of the difficulties of frail older people means that their support is normally a relatively long-term process, some of the aspects of a more task specific time-limited approach can still be valuable; for example, a clear formulation of problems, specificity of aims and tasks and planning certain goals over a limited time. The case review form adopted by Goldberg and Warburton was developed to assist this process. It also allowed social workers and management to monitor social work activities and hence discover how skills and resources are used in relation to differing problems and aims. In addition, it encouraged social workers to distinguish between *means* (activities and resources) and *ends* (aims and plans). Social workers were encouraged to have a more evaluative attitude to their work by comparing plans with achievements, facilitated by having parallel columns of boxes for past activities and future plans. Indeed, the whole form dealt with three stages: past activities, the present situation and future plans.

The consultation process in Seatown aimed to involve social workers closely in creating their instruments, making them as relevant as possible to their needs and interests, though in a form of which was generally applicable to the varying situations of social workers in the different teams. The views of line managers and senior managers were also taken into consideration, in order that the case review form be an effective means of ensuring accountability.

The evaluation team at the PSSRU saw the benefits of adapting such a system to the community care schemes being developed in Kent. Their first step was to obtain the approval of senior management. The team were willing to organise the data input, database management and data analysis involved in providing feedback free of charge to the local authority. Fortunately, both the director and the assistant director (fieldwork) were generally very receptive to innovation and agreement was soon reached to proceed with setting up the system. Divisional directors of the schemes involved were also approached and found to be willing to support these arrangements.

At this time the care managers in Sheppey and Tonbridge had recently been appointed. The only other two schemes in Kent were the original Thanet project and its first replication in Shepway. When sounded out, care managers were agreeable in principle to a monitoring system. The evaluation team agreed to draft some monitoring forms for discussion with care managers. Quarterly costing sheets of SSD resources were already in place which recorded for each user in the scheme the number of units of each type of resource consumed each week, together with the fees and expenses paid each quarter to helpers. Before meeting with care managers, the evaluation team drafted an initial assessment form and adapted the case review form of Goldberg and Warburton to make it relevant to older people. The main differences were that firstly the list of tick boxes for practical services used was made much longer and included NHS resources; awareness of these was essential to good practice. Secondly, a new section recorded resources required but unavailable. This offered a valuable means of informing management of shortfalls in provision. Thirdly, as well as recording contacts with user/family, contacts with others (for example helpers) were included both since the last review and planned before the next review, as such contacts were an important feature of the community care scheme. These two forms were presented at a meeting as a basis for discussion. The advantages advanced in support of the system were the helpfulness of a structured

assessment document which assisted in providing a framework for the assessment interviews; the value of case reviews in encouraging good practice, in ensuring that cases were regularly reviewed, plans devised and subsequent achievements compared with these plans, and as a supervision tool; and the value of feedback.

Care managers from all four areas were willing to take part in the system. They found the case review form, which benefited from the initial detailed consultation with social workers at Seatown was acceptable in its modified form with little alteration needed. The assessment form needed rather more modification. This form would be completed just once during the first few meetings between the care manager and user. An initial review form would also be completed at this time, with follow up reviews at quarterly intervals. Care had been taken by the evaluation team not to make the monitoring process too onerous for care managers. Thus, although it would have been helpful to have had follow up assessment forms completed annually in order that the level of need and circumstances of users could be mapped through time, it was decided that the demands this would have placed on care managers would have been too great. It was estimated that completion of the assessment and review forms would involve care managers in some 2-3 hours work each week, but that this activity would reduce the need for additional case notes. Another consideration for the evaluation team was to keep the review form as near as feasible to the original form of Goldberg and Warburton, so that comparisons with their work could be readily made. Instructions for completing both forms were provided in order that user circumstances, such as level of particular needs, were precisely defined.

An acceptable feedback form was also developed, again by the evaluation team presenting to the care managers a draft form for discussion and modification. It included some features of the Seatown form. However, since it was useful to be able to compare different feedback forms, quantities were usually expressed as percentages rather than numbers. In further refining the feedback form, the needs of senior management as well as those of care managers were taken account of; for example the assistant director suggested that values for the previous six month period could be shown in brackets next to the value for the present period for comparison purposes.

The principal features of the Kent feedback forms were:

- A record of the number of care managers and assistants involved.
- Caseload information: numbers of cases opened and closed, caseload, average age, gender distribution, proportion of first reviews, locational outcomes of closed cases and average time spent in the scheme of closed cases.
- Recently opened cases: dependency level and proportion with a principal informal carer, showing how new cases are being targeted.
- Case review information on good practice, expressed in percentages: user problems tackled, social worker activities, outside agencies contacted, practical services used, resources required but unavailable and average number of contacts with user or family.
- Cost information was provided for the current quarter and the three previous quarters: average weekly SSD cost, the proportion of this cost due to home help, community care and day care, the number of cases whose average SSD cost was within ten per cent of two-thirds the cost of a place in a local

authority care home, and the total quarterly cost to the SSD and to the community care budget.

Because the system needed to process several thousands of records each year, a highly automated process was needed in the preparation of feedback forms. Completed records were sent to a central point, checked and prepared for coding to help ensure that the forms were being completed correctly. Individual workers were advised if their method for completing the forms appeared to diverge from the standard procedure adopted. Software prepared by the evaluator enabled the direct input of data at the central point. There remained four further stages in the production of feedback:

1. Data was input to a database using the *Scientific Information Retrieval* system or SIR (Robinson *et al.* 1980). This system was ideal for handling hierarchical data and non-rectangular data sets of unequal size such as this, consisting of an assessment document, a number of case reviews and a number of costing sheets for each case, the precise number dependent upon the length of time they have received the service. This procedure included an inbuilt check on data input errors. The storage of data in a SIR database allowed it to be retrieved easily for purposes other than feedback and to create files for use with other statistical packages such as SPSS, when required.
2. The information required for entering into the feedback forms was computed and written into data files by means of SIR retrieval runs.
3. The data was then read from these files by means of a fortran programme which wrote a series of some fifty different feedback form images, stored in the computer.
4. These images were converted automatically into word processing format and finally run off as hard copies from the printer.

The Kent monitoring system described above continued in that form for some seven years. The system was subsequently modified at the time that community care and home help services were integrated, and the evaluation team withdrew at that stage, leaving the social services department to organise data collection and analysis. Because no one in the department had the time or commitment to make the system work, and no feedback was organised, many care managers soon gave up completing the monitoring forms. However, in both Kent and some other local authorities, various types of computerised record systems have been developed as computing opportunities have increased. Some modern systems have certain features in common with the original Kent system, in which they may have had their source. A description of a selection of these features with illustrations from a few local authorities now follows, drawing on material on modern information systems discussed by Warburton (1999).

Linking user-based assessment, service input and cost data
Most SSDs collect assessment information. This became more widespread since the implementation of the 1990 NHS and Community Care Act in 1993. Some local authorities have information systems which link referral, assessment and care planning information, with dates. However, by the year 2000, many SSDs were still unable to relate user-based information to spending patterns, often due to old and inflexible financial information systems. This makes it impossible to account for who gets what help at what cost. Others succeeded, such as Cheshire SSD, which provided managers with integrated data on firstly users by age, dependency, location, gender and start and end dates; secondly providers by location, sector and status; and thirdly, care provision by type of service, cost and number of units purchased. The data help to improve the efficiency by which resources are deployed in purchasing care for older people.

Feedback of user data at different levels of aggregation
In many SSDs, a considerable amount of management information is being fed back routinely to all levels of staff. In some SSDs the reports are monthly or quarterly and follow a set format, including facts, figures and diagrams. Sometimes reports are available on-screen for teams and care managers. Some SSDs train their care managers in the interpretation and use of management information.

Support from senior management
All the best systems have strong support from senior managers. Management are often committed to using such information systems to underpin policy and practice.

Making field staff central to the information system
SSD mainstream information systems serve both to provide fieldwork teams with a means of recording and retrieving user-based information including feedback of data aggregated at the worker or team level and to provide raw material for management information. Most SSDs chose their information system mainly for their fieldwork uses. Having a system which is centred around use by field staff means that the data is probably more reliable and meaningful.

Involving care managers in the development of information systems and feedback
Many SSDs emphasise the importance of this, and the development of the Leeds computerised information service is a good example. This provided regular feedback to the area management teams including community and hospital-based social work teams. Following consultation, quarterly area feedbacks were developed providing detailed information on referrals, allocations, assessments and services for the current and four previous quarters, including area comparisons and commentaries highlighting key issues and exceptions. This was provided on an authority, area and social work team basis, and covered all user groups. In response to team request the feedbacks were made user-friendly in regard to the tables, charts (including bar charts) and graphs which they included. However, the data was not linked to financial and budget information. The delay between downloading the data and sending out the finished document was between six and seven weeks.

Operational uses
The Kent system had operational uses, such as in providing care managers with a check list of assessment characteristics and resources received. These operational uses have been extended in some more recent systems, such as by identifying users

at referral and producing forms and care plans. Systems that do this are likely to be cost-effective and popular with staff.

2.3 Setting up computer-based systems

The setting up of the Kent monitoring system described above raises a number of more general issues concerning the setting up of computerised systems for providing routine data for care managers and service providers and these are now discussed under the following headings:

- What are the aims of the system?
- What features are necessary for a system to run effectively?
- Learning from the Kent system: suggestions for improvement

2.3.1 The aims of a computerised information system

In setting up a computerised information system in an SSD, it is necessary to have a clear idea of its aims. Although these are likely to show some variation between local authorities depending on area circumstances and departmental attitudes and interests, certain features are likely to be common. Four key sets of aims might typically be:

- Monitoring should provide both a management strategy and a quality improvement strategy.
- Allowing care managers to input key data on each of their cases. This might cover referral information, assessment data, the nature of the care package and how this changes with time. Rapid retrieval of this data by care managers is desirable. This point is taken up again later.
- Providing regular feedback of selected parts of this data, aggregated at the caseload level for care managers, and at the team, area or authority level for line managers and senior managers. Clear performance criteria should be included.
- In addition to this routine feedback, the database would be available for performing specific analyses. These could assist management in decision making, such as in connection with strategic planning. The analyses could also help teams to understand aspects of their activity (Warburton 1999).

2.3.2 Requirements for a computerised information system to run effectively

Setting up a computerised information system can be a considerable expense to an SSD. It is also difficult to envisage what form such a system should ideally take before it is up and running. Adapting a system once it is installed can also be costly. It is therefore desirable that local authorities consult with each other and, where appropriate, collaborate in setting up such systems, so that experience can be pooled and costs shared. The ADSS Information Management Group is helping to achieve this.

Setting up, developing and maintaining computerised record systems can require much expertise and effort. For them to run effectively, it is essential to have trained and dedicated staff (Social Services Inspectorate 1996).

It is desirable that care managers play a central role in the development of the system and in being provided with regular feedback which responds to their needs. If care managers see feedback as being tailored to their own needs and representing what they have achieved in working with their caseload, not only will this information help them improve their practice and negotiate with their line manager. It will also

encourage them to enter good quality data which will improve the information fed back to management.

An information system can be much more powerful if it brings together different types of data. This is generally most effective when the user is the unit of analysis. The main types would be referral information, assessment data, and the quantity of different types of service offered from all agencies and sectors, including variations with time.

In order to adjust service levels to the changing needs of users and to register their variation with time, it is desirable to have regular reviews of cases.

2.3.3 Learning from the Kent system: suggestions for improvement

Integrating information systems within local authorities

A limitation of the Kent system was that although a county information system for social workers was being developed, no attempt had been made to integrate this with the monitoring system. Clearly, the opportunity for care managers to directly key in information which is prompted for electronically at a computer terminal would have been a great asset. Software could have been developed to also allow care managers to obtain immediate up to date access to information on current activities. In particular, graphical representation of material would make it more readily comprehensible, such as the use of histograms and pie charts. A shortcoming of this procedure might be the greater reliance placed upon individual fieldworkers to ensure they keep their records up to date, although one major incentive for them to do so would be the provision of correct information for their own use. In order to aggregate individual worker material for management information, the transfer of data to a central processing site for the county could allow a broader database to be created. This is a common feature of modern information systems. Moreover, integration of the two information systems would also have reduced the overall time spent by care managers in providing such data (Saunders 1987). Such an integration was successfully achieved in a similar monitoring system set up shortly after the Kent system for the Gateshead Social Care Scheme for frail older people (Challis *et al.* 2002).

Case recording

The SSI study 'Recording with Care' (Social Services Inspectorate 1999a) focussed on case recording – both manual and computerised. It emerged that practitioners tended to record in differing ways unless the department had a policy on case recording. Computerised user information systems provide a means of standardising at least part of the case recording process, through such records as needs assessments, care plans and regular reviews.

Conciseness of feedback

Information on feedback forms should be very selective so as to avoid valuable material being 'buried' in a mass of less useful data. Feedback forms for the Kent system covered just two sides of A4.

Monitoring outcomes

SSDs can evaluate their services by using measures such as user or carer satisfaction, user morale and carer burden. Process measures, such as how long users wait for services and the user's rating of flexibility of services, can matter a great deal to

users and carers and so be useful as outcomes. A shortcoming of the Kent system was an insufficiency of outcomes information, which was restricted to locational outcomes at case closure. This reflects the difficulty in measuring outcomes. Some organisations report a reluctance amongst care managers to quantify outcomes in terms of a simple measure; instead, they preferred to talk or write about their cases. However, this makes it difficult to measure change objectively (Warburton 1999). Such information, computerised or otherwise, is often restricted by care plans which fail to articulate objectives and outcomes. There is also a danger that care managers could bias their outcomes measure so as to favour the results for their users. Kent SSD has tackled this more recently by commissioning independent survey organisations to explore the views of older service users and then using the results to improve services. Moreover, the government white paper *Modernising Social Services* requires the use of annual satisfaction surveys in monitoring some key aspects of user satisfaction with services (Department of Health 1998a). However, in order for the results of such surveys to be of greatest use, it is desirable for these measures to be linked to other user characteristics such as level of disability, depressed mood and environmental factors. Without taking such factors into account, comparisons of satisfaction levels between different areas or periods can have little meaning (Chesterman *et al.* 2001). These other characteristics could be made available from a monitoring system.

Joint SSD-NHS costing

No attempt was made to include NHS resources in the costing of the care package, though tick boxes indicated which NHS resources were being deployed. The view of Kent SSD was that the primary aim of monitoring costs was to record expenditure to the SSD over which it had control, NHS costs being much less important to it. However, the opportunity cost of a care package should take into account NHS costs as well. Because a care manager had overall case responsibility and needed to think holistically, they should have been aware of the entire package. Excluding NHS resources from care package costs creates the wrong types of incentives for care managers and leads to reduced efficiency. Although there would have been big potential gains from improving relationships between the two agencies, the Social Services Inspectorate, who were preoccupied with a social services world, were slow at responding to this need in the 1990s and later. However, a gradual realisation of its importance has led a number of recent government white papers, such as *Modernising Social Services*, to encourage partnership between the two agencies.

It is clearly desirable for both the SSD and NHS that information on community care be shared at the case level. This has been undertaken more recently in a few authorities. Thus Wandsworth Social Services and their local health trusts linked their databases. Data on users of community care services were downloaded from the SSD database at a 'snapshot' in time. User contacts by health staff were downloaded from databases for local NHS trusts for the two weeks preceding and following the snapshot date. Records were linked when they shared the same postcode, gender and date of birth. Comparisons could then be made between groups receiving social care, health care and joint packages of care. Monitoring jointly SSD and NHS costs would also be a first step on the way to shared feedback to both the SSD and the PCT. This could assist in joint commissioning or service development. The Department of Health's initiatives for 'Joint Investment Plans' and 'Partnership in Action' should help local authorities and the NHS to share and jointly develop information.

Training of line managers
Although aggregated feedback information was available to line managers in Kent, there was a frequent lack of understanding by these managers of its value. Moreover, the value of monitoring information on individual case records was often not appreciated by team managers as a means of showing how the department's money was being spent daily and on which users (Saunders 1987). This pointed to the need for educating line managers in both care management and information systems. Kent SSD responded to this need in the late 1980s by including managers in 'in service' training courses for care managers.

User empowerment
Although the Kent schemes adopted a user centred approach, users or their representatives were not involved in any aspects of setting up the monitoring system. The Department of Health and Audit Commission (1998) found that many councils were unable to learn from the experiences of user and carers because they did not ask for feedback or reviews. In view of the greater emphasis today placed by the government on user empowerment and access to case records, it would be helpful to have information on the views of users and their carers on the use of a monitoring system before it was set up.

Adaptability
The recent considerable changes experienced by SSDs have made it difficult to build up trend information over time. In setting up an information system it is therefore important to make it as flexible as possible, so that it can be easily adapted to change.

Reducing the emphasis on a professional social work approach
In view of the trend over the last two decades for local authorities to attribute less importance to the traditional social work view, adopting instead a more service-orientated approach, SSDs today might be less receptive to a system based on the case reviews of Goldberg and Warburton. One shortcoming of the Kent system was its failure to provide a means of monitoring the level of user need over time. By reducing the amount of information on social worker activities which care managers need to supply at times of review, extra data on such need items as level of disability and possibly depression and cognitive impairment could be included in their place, without making any extra demands on the care manager.

3. Effects of feedback to care managers on their behaviour and on results of study

3.1 Introduction

The input of the evaluation team must have had a substantial effect upon the results of both the original Thanet project and, to a lesser extent, the Sheppey/Tonbridge schemes. In this section the different ways in which the team could have affected each of these evaluations are described. It is then argued that most of these effects are a desirable part of the implementation and so it is right that measurements should include them. Finally, it follows that some attempt should be made to include the time spent by the evaluation team in the costing, both as an initial investment cost and an ongoing cost. Both these costs turn out to be extremely small.

3.2 The nature of the evaluation

Before considering the various effects of the evaluation team on the study, it is worthwhile summarising the evaluation approach, in order to understand how these effects will influence it. The principal method adopted by the study is the production of welfare approach, which was applied in two ways:

- As a framework for understanding process and the causal mechanisms in place through which inputs achieve outcomes;
- As a means of quantitatively relating inputs (costs) to outcomes.

The input of the evaluation team would have affected this causal process and contributed an extra input in the quantitative models.

3.3 The sequence of social care evaluations

In research on being able to generalise the creation of a desired effect, there are distinct questions and stages to address (Shayer 1992):

1. *Study primary effect*

Any primary effect is investigated to discover whether there is an effect (whatever the cause), what the effect is, and its size. The Thanet evaluation is an illustration of this.

2. *Replication*

An attempt is made by other enthusiasts (not only by the original researcher) to see whether the effect can be replicated. This has been done both in the Gateshead social care scheme and in the Sheppey/Tonbridge evaluation. There is a limit to the extent to which the findings of one study can be generalised to account for the operation of the scheme in another area. Even two different parts of the same local authority, such as Sheppey and Tonbridge, have many important differences. In a separate study (Chesterman *et al.* 1995, Davies and Chesterman 1995) the evaluation data derived from the care-managed schemes in Thanet, Gateshead, Sheppey and Tonbridge were combined in order to determine which features of the cost function models were common, and which were area specific.

3. *Generalisability*

An investigation is made into whether the ability to implement the effect can be transferred by training and information technology to the general population of workers; namely, those without special enthusiasm or skills. The process in Kent of setting up and maintaining the monthly meetings of care managers with peer review and outside speakers, six monthly meetings of care managers and management, the small working group and the monitoring system with feedback illustrates how such training and investment can take place within the local authority, with only limited support from the evaluation team.

3.4 The different types of effect on outcomes caused by the evaluation team

A number of possible effects were identified, and these are discussed in turn:

- Hawthorne effect
- Feedback of evaluation and monitoring results
- Improving the knowledge base of care managers and their line managers

3.4.1 Hawthorne effect

The Hawthorne effect arises in management research. A series of studies on the productivity of workers manipulated various conditions, such as pay, light levels and

rest breaks, but each change resulted on average over time in productivity rising, including eventually a return to the original conditions. Clearly the variables the experimenters manipulated were neither the only nor dominant causes of productivity. One interpretation (Mayo 1933) was that the important effect here was the feeling of being studied: it is this that is now referred to as the *Hawthorne effect.* The improvements, asserted Mayo, were due to the workers feeling better in the situation, because of the sympathy and interest of the observers. The workers felt freer, not feeling supervised but more in control as a group.

The presence of a Hawthorne effect in the social care evaluations cannot be ruled out. Firstly, the researcher's attention could increase the user's effort. Although this effect is likely to be largely eliminated by the inclusion of a control group, the knowledge of the experimental users that they were in the 'preferred group' could interact with the attention effect, leading to group differences. Secondly, the attention paid by the evaluator to the helpers in Thanet, Gateshead and Sheppey, through interviewing them, could have motivated them to improve the care they provided their users. Thirdly, the Hawthorne effect could also be operating at the care manager level. This was likely to be particularly strong in Thanet. Here the interviewer spent time most days with the care management team in discussing the project and its effects on users. Moreover, the senior evaluator had regular meetings with the divisional director and a senior manager about current care management issues, and decisions made at these meetings also affected the care managers. One problem with such close contact between the evaluation teams and care managers is that it divides the loyalties of the evaluator, making honest writing up difficult (Goldberg and Connelly 1981, McGrath and Hadley 1981).

Such effects would also have been present in the Gateshead social care scheme though to a much lesser extent. In Sheppey and Tonbridge the effect was still smaller, the evaluator spending no more time with the care managers than with the control group social workers in discussing user material. However, the knowledge of the care managers that their users were in the preferred group could again interact with the attention effect, enhancing the quality of the care managers' support of their users, causing more group differences. In Sheppey and Tonbridge there were additional effects of the evaluation team on care managers which did not relate to individual users. Care managers would have received more attention from the evaluator through the monthly meetings and peer reviews, both of which were chaired by him. Moreover, monitoring feedback was organised by the evaluator and presented by him at the six-monthly meetings. These additional forms of attention paid by the evaluator to the care managers could have also influenced the care they provided their users.

There are two phenomena which are closely related to the Hawthorne effect and overlap with it:

- In the halo effect of uncontrolled novelty subjects think the intervention is wonderful and that belief is the real cause of raised outcomes. The experimenter is not important, but a materially unjustified belief, perhaps from other social media, is: or else simply the novelty rather than belief matters. A halo effect of uncontrolled novelty could have been present in the social care evaluations at the user, helper and care manager levels. A belief that the scheme was wonderful, without regard for what the scheme actually offers the user, could help raise user outcomes at all these levels.

- The John Henry effect is the opposite. It occurs when a supposedly control group, getting no intervention, compares itself to the experimental group and through extra effort gets the same effects or results; a type of counter-suggestibility. A John Henry effect was possible in one of the control teams for the Thanet project at the social worker level, where they openly admitted seeing their intervention as a challenge. It was also possible in the Sheppey control area at the social worker level. These area team social workers mainly specialised in older people and two later became care managers. They could have seen the selection of some of their users for the control group as a challenge to support them at home with enhanced quality of life for as long as possible and perhaps as a means of promotion to the community care scheme. However, there was no verbal evidence from the area team to suggest that this was the case.

If the experimental aim is to improve user outcomes and the user's experience, then it might be desirable to *maximise*, not avoid, Hawthorne effects. If outcomes can be improved by changing procedures every year, telling users this is the latest thing, then that is the ethical and practically effective thing to do. However, changes in procedures did not necessarily lead to positive outcomes. Although the Sheppey and Tonbridge care managers were generally enthusiastic about the changes brought about by the scheme, the reorganisation of the county into an area-based structure had quite the reverse effect, particularly in the Tonbridge scheme, which was disrupted by being split into two. Fortunately, there was no evidence that this disruption to care managers filtered through to users, since controlling for users who were served at the time of the disruption produced no significant effect.

3.4.2 Feedback of evaluation and monitoring results

The Kent experiments involved three types of feedback:

- Feedback of information on individual users;
- Feedback of evaluation results;
- Feedback of monitoring results.

Feedback of information on individual users

While carrying out the evaluation interviewing, the in-depth nature of the interviews meant that underlying needs might emerge which were not known to the care managers of experimental cases, or the social workers of comparison cases. The interviewer was then faced with the dilemma of whether to feed back such information to the fieldworker. The policy adopted by the evaluator was that, for ethical reasons, if the user specifically asked about help with a particular problem or appeared to be at serious risk, the information should be relayed to the fieldworker. Such feedback tended to occur only occasionally and to be fairly evenly balanced between the two groups, so was unlikely to bias the experiment in favour of a particular group.

Feedback of evaluation results

It is not normally possible to carry out social work research without being required to offer in return periodic feedback on the work in progress (McGrath and Hadley 1981). When these two researchers, in an evaluation of patch-based social services teams, were asked by the social work team for periodic feedback, they agreed for two reasons:

- as reciprocation for the team's cooperation;

- they believed that a team actively engaged in change should have the right to access to their data as soon as they could be furnished in a useable form.

In the case of the Thanet evaluation, there was no significant feedback of results during the evaluation period, because of the lengthy nature of the sophisticated analyses involved. However, parts of the Thanet research report were available not only to the Sheppey and Tonbridge care managers, but also to their senior management. In addition to the two reasons given above, this information was also provided because it could be seen as part of the learning process at different levels in the management hierarchy, leading to improvements in care management practice. As an illustration, one finding of the Thanet evaluation was that depressed users in the comparison group were often admitted long-term to a care home, because their depressed state prevented them from coping at home. After admission, these users frequently overcame much of their depression and then appeared to be no longer sufficiently needy for residential care. However, they continued to live in the care home. By providing them instead with care managed support at home from the outset, these users could be maintained in a more independent environment with greater quality of life and at a much reduced cost. Clearly, information like this can help to guide care managers in their choice of those user need groups which can most effectively be targeted. Another important finding of the Thanet evaluation, which would have influenced Kent senior management in allowing the scheme to be extended into all remaining parts of Kent, was that the scheme achieved a significant improvement in a range of outcomes relative to the comparison group at no extra overall cost. If there had not been a close relationship between the PSSRU and Kent care managers and their senior management, much of this information could have failed to reach Kent fieldworkers and management.

In the event, the results of the Sheppey and Tonbridge evaluation did not become available until well after the evaluation period. It is interesting to speculate what effect these results might have had if fed back earlier. One striking result was the huge shift in expenditure from the NHS to the SSD in both schemes. It is likely that the SSD would have been able to negotiate for the NHS to play a much greater role in the funding of the scheme, not only by financing the salaries of care managers but also in contributing to community care budgets. This could again have been viewed as part of the learning process, in this instance particularly affecting management.

Feedback of monitoring results

The feedback of evaluation results just described is an example of *action research* or *formative evaluation.* In relation to monitoring, action research might be seen as a means of developing a model information and review system which would enable fieldworkers and management to monitor their social work and social services activities in order to discover how professional skills and other social service resources are used in relation to different problems presented and to different aims pursued. It could also encourage social workers to become more explicit about both means and ends of their activities (Goldberg and Warburton 1979). Evaluation of the results of intervention is difficult, since action research necessitates ongoing feedback and hence continual change in the mode of intervention. There is also a tension between the necessity to work very closely with practitioners and middle management if real commitment is to be achieved at the fieldwork level, and the need to keep in touch with top management and to encourage their willingness to accept change.

Goldberg and Warburton applied the approach of action research to developing a case review system. Because the Kent monitoring system had many feature based on that of Goldberg and Warburton, which had already been tried and tested, this process was less protracted. It involved the evaluators in firstly proposing a modified version of the case review form which applied just to older people and which included a list of NHS resources received as well as the SSD resources already on the form, and the inclusion of the number of contacts with 'others' (such as helpers) as well as with the user or their family. Secondly, an assessment form was drafted by the evaluators which was substantially different from that of Goldberg and Warburton. The consultation process with care managers resulted in the case review form undergoing very little further modification, though the assessment form underwent rather more change.

The monitoring system of Goldberg and Warburton, for area social work teams, was designed to encourage a constant dialogue of questions and answers. 'It is hardly possible to overestimate the potentialities for learning, broadening of horizons, and opening of minds towards possibilities of change that can result from imaginative feedback of the service providers' own work' (Goldberg 1981). The Kent scheme benefited from such a dialogue in a number of ways at both care management and manager levels, and these contributed to the learning process:

- The monitoring feedback consisted of material relevant to both individual caseloads and aggregated areas, including one for all Kent. This information influenced both senior management practice and that of individual care managers and their line managers. Thus, care managers could compare their feedback forms with those for all Kent as a means of improving their practice, through such activities as improved targeting on those users in greatest need and increasing social work activity and contacts with other agencies.
- Peer review presentations were accompanied by simple analyses by the evaluator of the monitoring database which focussed on the user need in question (such as incontinence, or cognitive impairment). This allowed the presentation to be placed in the context of other work of this type in Kent.
- From the individual viewpoint, the monitoring system could enhance the self-reliance of fieldworkers, by learning from individual self-evaluation and from aggregated data how to use their skills and resources to the maximum benefit of their users.
- Group feedbacks in the Kent monitoring system, such as those for a care management team or for all Kent, could benefit from the effect of group forces in facilitating attitudes to change and a redefinition of situations (Mann and Lickert 1977). This could encourage members to carry out the decisions agreed to by the group.
- Feedback in Kent was also used by some supervisors in providing an overview of progress of individual cases and groups of cases (the caseload). Because social workers generally consult supervisors about particularly interesting or difficult cases, while other cases remain undiscussed, the feedback also offered an opportunity for the supervisor to carry out more general supervisory functions (Goldberg 1981). This could have assisted in improving good practice.
- Feedback forms for Tonbridge showed that there was a high proportion of care management activity with the cognitively impaired. This information assisted in making a bid to the NHS for funding. It resulted in the care

manager and assistant care manager in the Sevenoaks and Tonbridge team, formed after the county reorganisation of area boundaries, both having joint-funded salaries. However, this would not have had an important effect on the costing, and should not have affected the size of the caseloads carried.

- Feedback forms for all Kent included an average weekly cost per user to the SSD, showing how this had risen over the previous four quarters. This showed an inexorable rise over the first few years of the scheme. Although at least part of this rise could legitimately be attributed to the aging process with an associated increase in need of the user population in the scheme, it was eventually necessary for senior management to impose tougher budget caps in order to restrict the rise. It is doubtful whether this systematic increase in cost would have been as evident in the absence of a monitoring system. In the event, these more restrictive budget caps did not take effect until after the evaluation period, so would not have affected the results of this study.

The use of monitoring and feedback could be problematic with a small minority of care managers in Kent:

- Examination of feedback forms for individual schemes could sometimes indicate whether particular schemes were not operating according to accepted guidelines. For example, one scheme had very high caseload levels combined with very little evidence that the core tasks of care management were being effectively carried out. This information allowed senior management to intervene to discuss the best way forward. Frequently, it was a lack of understanding of care management principles by line managers which led to poor practice. Such problems were not evident in the feedback forms for Sheppey and Tonbridge, so that outcomes were unlikely to have been affected in this way.
- Some service providers have an attitude of suspecting that a monitoring system is designed to spy on them, criticise their work and disclose their shortcomings to management (Goldberg 1981). In the Kent scheme, feedback of caseload levels caused some care managers to feel under pressure from their line managers to take on more cases. Some responded by enhancing the apparent size of their caseloads through taking on a high proportion of married couples who counted as two users. These required less than twice the care management time of single users. It sometimes involved exaggerating need levels of the less disabled partner in order that they satisfied the criteria for being taken on as a user in their own right, rather than simply as a carer of the other user. This exaggeration of need levels sometimes occurred with single users as well, in order that care managers appeared to conform to an acceptable level of targeting. The perverse incentive to take on married couples could have distracted some care managers from their task of responding in the most efficient and effective way to the needs of frail older people in their area. However, there was no evidence for this having taken place in Sheppey or Tonbridge. Moreover any of the evaluated cases which appeared too 'lightweight' could have been excluded from the analysis.

3.4.3 Improving the knowledge base of care managers and their line managers

Regular time was spent by the evaluator in helping to organise:

- monthly meetings of care managers;
- six monthly meetings of care managers with their line and senior managers;

- a small working group developing ways of improving care management practice.

Monthly meetings included talks by outside speakers and peer reviews presented by care managers. The sharing of ideas and coping strategies was designed to encourage good practice. This all provided a form of in-service training for care managers. The evaluation team helped these meetings to take place by providing a venue at the University of Kent and a buffet lunch. The team also contributed to discussions over different aspects of developing good practice. In addition to these meetings, occasional induction courses lasting a few days and organised jointly by the PSSRU and KCC were laid on at the University of Kent for newly appointed care managers.

Six-monthly meetings also included important discussions of policy issues in care management. An example was the question of out of office hours support for helpers in the absence of a standby duty system. One solution was the use of helper support groups, with backup from a local care home, and from the care manager in the case of an emergency. Clearly, the presence of adequate support for helpers under difficult circumstances is likely to affect user outcomes.

The small working group met specifically to improve care management practice. For example, it developed a procedures manual for all care managers which helped to make practice more uniform across the county. It also set down payment bands for helper fees, according to broad categories of task. Its achievements could have improved outcomes for some users in the later stages of the evaluation. The evaluator was included in the group.

3.5 Were evaluation team activities interfering with research results?

In the previous section 3.4 the various ways in which the evaluation team influenced the operation of the Kent schemes have been described. These consisted of firstly Hawthorne-type effects caused by the attention paid to users and staff by the evaluator, secondly the results of feeding back information to care managers and their managers and thirdly the effect of improving the knowledge base of care managers. This section examines the implications of these effects in understanding both what is being evaluated and whether the activities of the evaluation team were interfering with this measurement.

It is helpful to consider the set of social care schemes evaluated by the PSSRU as a sequence. The original Thanet project was not a scheme set up by the county which was independently evaluated by the PSSRU. Instead, the project was set up and supported through a collaboration at both management and fieldworker levels between the local authority and the evaluation team. The evaluation aimed at assessing the effectiveness of this jointly set up project, and most of the effects of the evaluation team were an integral part of what it was desired to measure. Moreover, the PSSRU input could be seen by the local authority as a benefit which they received in exchange for allowing the scheme to be evaluated. The same was true in the Gateshead social care scheme, though the involvement of the evaluation team with the care managers was much weaker. The Sheppey and Tonbridge evaluation also aimed to assess the effect of the collaboration of the county and the PSSRU in jointly setting up the schemes and assisting in their development. Although the involvement of the evaluation team with the care managers regarding the support of individual users was minimal, the team was actively involved in developing methods

for providing group support to care managers through the various meetings arranged and in improving good practice through setting up the monitoring system. This PSSRU input can be seen as part of the learning process in the development of the schemes.

Bearing in mind this collaborative nature of the schemes, the various effects of the activities of the evaluation team are now re-examined to see how they fit in to the general evaluation structure. The Hawthorne effects result from the attention provided by the evaluation team at different levels. If users do indeed achieve better outcomes when they or their helpers are paid attention by the interviewer, then this is a desirable effect which can legitimately be included as part of what is measured. Even if the scheme were not being evaluated, extra attention could be offered in other ways, such as by offering users and helpers more care management time during assessment and review. This could also lead to more problems being identified of the type which the evaluator occasionally fed back to the care manager.

Support provided by the evaluation team to care managers can also be seen as integral to the operation of the schemes. The various activities concerned – the monthly and six-monthly meetings, the small working group, the monitoring system and feedback of the Thanet evaluation results – are all features which could have been set up and maintained by a suitably appointed worker for the local authority. Equally, the attention provided by the evaluators to the care managers could have instead been offered by this Kent worker, giving a comparable Hawthorne effect.

The only effect which cannot legitimately be argued to be part of the implementation process is the John Henry effect, since this operated in the control area. This could have encouraged some area team social workers for the comparison groups to enable their users to achieve particularly high outcomes, perceiving this as a challenge. Any such effect would have biased the evaluation against the experimental group, so the performance of this group would, if anything, be underestimated.

3.6 Inclusion of PSSRU input in the costing

As the contribution of the evaluation team to developing the scheme is taken into account in the measurement of outputs, then some estimate of the time this involved should be included in the costing. This was not allowed for in Chapter 8 on costs or Chapter 9 on costs of outcomes. A correction to the costing could be made by adopting the following approach for Sheppey and Tonbridge.

The work of the evaluation team could be taken into account by supposing that they had been seconded to the local authority to provide the same input. This work should be restricted to that part which contributed to the development of the scheme or improved user, helper or care manager well-being. Because the time spent by the senior members of the evaluation team was much smaller than that of the evaluation interviewer, an estimate could be based on this one evaluator. The contribution would be made up of an initial investment in such activities as setting up the monitoring system and writing the software, and ongoing work involving spending time in organising and attending meetings, overseeing the management of the monitoring database and periodic feedback, and any effects of the evaluation interviewing. This last effect could be ruled out since a Hawthorne effect would be present at both time 1 and time 2. Hence as outcome measures are expressed as

changes over the evaluation year, the two would tend to cancel. The remaining effects could be allowed for in the costing by using the following illustrative figures.

Investment cost of evaluator
Setting up the monitoring system might have taken up some 5 weeks of the evaluator's time. At an annual salary of around £8000 p.a. at 1982 prices, this investment cost would work out at around £800. Discounting this at 5 per cent for an indefinite period would give an annual cost of £40. However, this investment led to the system catering for thirty care managers, including their assistants. Hence the annual cost per care manager would be (£40/30) or £1.30. With a caseload of 30, the annual cost per user would be £0.04, completely negligible.

Ongoing cost of evaluator
The ongoing work in connection with monthly and six-monthly meetings, the small working group, managing the monitoring database and providing feedback would have taken some 25 per cent of the evaluator's time, costing £2000 p.a. To this should be added the overheads of punching in the data, typically £5 per week, which amounts to £250 p.a. During the evaluation period in Sheppey and Tonbridge, these costs would have been spread between typically fifteen care managers, including their assistants. Hence the cost per care manager would have been (£2250/15) or £150 p.a. With a caseload of 30, the annual cost per user would be £5 p.a., or £0.10 per week, very small, and amounting to only about 0.25 per cent of the total SSD cost in Sheppey or Tonbridge.

3.7 Concluding comments on effects of evaluation team input on research results

The input of the PSSRU in the social care schemes for frail older people formed an essential part of their setting up and support; a collaboration with the local authority. It was therefore felt that the effects of the contribution of the evaluation team should be included in the measurement of outcomes. This contribution included involvement with monthly and six-monthly meetings of care managers and the small working group, as well as the setting up and maintenance of the monitoring system. The attention paid by the interviewer to the user could also be seen as part of the care package and could have been achieved equally well through offering slightly more care manager time.

By including these evaluation team inputs as legitimate parts of the implementation, the corresponding evaluation team costs should also be included. In Sheppey and Tonbridge the main contribution to implementation costs due to the PSSRU came from the author, whose time could be distributed between an initial investment cost and ongoing costs. The investment cost was completely negligible and the ongoing cost at 10p per user per week was very small. Consequently, the decision to omit these costs from the evaluation is perfectly justifiable. Nevertheless, the effect of this evaluation team input on good practice and hence on improved outcomes was likely to be substantial. This had been achieved at a negligible cost by pooling resources: the contribution of the evaluation team benefited care managers across the entire county.

4. The case for paying helpers by task rather than by the hour

An important respect in which the Community Care scheme differed from more conventional domiciliary care was that helpers were paid according to the tasks they

performed rather than by the hour. These tasks were specified in a contract in fairly general terms, to allow greater flexibility of response. In the original Thanet Project the level of helper fees for a particular set of tasks was agreed by negotiation between care manager and helper. Indeed, some helpers decided to work as unpaid volunteers. The intention was that helpers should be motivated primarily by altruism, with payment simply offering a degree of compensation for the commitment made, and sealing the contract (Qureshi *et al.* 1989, Davies and Challis 1986). Chapter 6, section 3.1 includes a description of how the levels of payment of helpers in the Sheppey and Tonbridge schemes were confined to certain payment bands according to the tasks which they performed and their likely duration. The use of these bands to replace the Thanet system of negotiating fees for individual contracts signals a step towards a job perception of the work. Box 11.1 demonstrates the range of tasks performed in the Gateshead Social Care Scheme (Challis *et al.* 2002). Most of these are fairly typical of other intensively care-managed social care schemes such as those in Kent.

It is helpful to examine how staffing arrangements in community care across England have progressed generally since the original social care schemes, both in the Kent and Gateshead intensively care managed social care schemes as they developed during the late1980s and more generally across England following the community care reforms in the 1990s. The effect of conditions of work and pay of the Kent helpers on both helper and user are discussed. The question as to whether helpers were being exploited is examined and the feasibility of using helpers paid by task in community care provision today considered.

In the argument which follows it is important to distinguish two separate aspects of the status of helpers:

- There is a range of possible conditions of service, stretching from unpaid volunteers with no safeguards at one extreme to permanent employees with full conditions of service at the other extreme.
- Helpers can be paid either according to the tasks which they perform or at an hourly rate.

Helpers in the intensively managed social care schemes were treated initially as casual employees with poor conditions of service and were paid according to the tasks carried out.

Box 11.1 Tasks undertaken by helpers in the Gateshead Social Care Scheme

Light housework
Shopping for daily or weekly needs
Washing soiled items
Make meals in user's home
Prepare snack or hot drink
Take meal from own home to user
Clear away stale food
Monitor amount user has eaten/drunk
Help with heating system (gas, electric, central heating)
Help with getting up and going to bed
Help with dressing and undressing
Brush or comb hair
Help with washing older person
Help to use toilet or commode
Clean or empty commode, bottle or bedpan
Change/dispose of incontinence pads/sheets
Give/check tablets/medication
Companionship and stimulation
Reality orientation
Provide reassurance if user agitated

4.1 Staffing of community care in intensively managed schemes of the late 1980s

4.1.1 The Kent Home Care Service

In Kent, the original community care project in Thanet had been systematically extended until the care management scheme for older people was part of standard services throughout the county. By this stage, older people were catered for by three core SSD community services:

- the home help service;
- social workers for older people;
- the community care scheme.

The need for an integrated home care service

There was a growing feeling that integration of the care management scheme with both the home help service and the social work for the elderly team to form a new *Home Care Service* (HCS) would be mutually beneficial:

- Care managers saw integration with the home help service as providing them with greater autonomy in arranging home helps for their users.
- The home help service saw integration as a means of assuring the future stability of the service.
- Senior management were looking for a system in which a more integrated approach to assessing older people for services could be followed. Assessment and subsequent care management would eventually be undertaken by separate teams. After the initial assessment, users whose needs satisfied the local authority's eligibility criteria would be allocated to a home care manager with a budget who could purchase a range of in-house and independent sector services.
- Integration of the services would reduce fragmentation and the possibility of a failure of communication.

- There was pressure from the personnel section of the social services department for home helps and helpers to be paid under a common wages system and with comparable conditions of service. This might have been more equitable, though could have led to inflexibility.

Planning a new home care service

The community care working group was asked to design the core features of a new Home Care Service. The resulting proposal would increase the proportion of frail older people receiving a care-managed service with an individually tailored care package; in other words widen the target group. In order to pay for this, two new features would be introduced:

- User charges would be increased to bring them more in line with those for residential care. In order to assist some users to meet these charges, those likely to be eligible for an attendance allowance and not receiving one would be helped to apply.
- Lower need users requiring domestic help would be off-loaded from the social services department and receive independent sector help.

Following union consultation, the form of the new home care service approved by the social services committee had the following characteristics (Kent Social Services Department 1987):

- A comprehensive assessment was to be carried out on all older people referred to the service.
- This assessment was to classify older people deemed as eligible for HCS into three categories of need, each with a flat rate charge:
    1. Highly complex care packages including night cover if necessary. These users would be eligible for an Attendance Allowance at the higher rate (£32.95), and would be charged £21 per week.
    2. Complex care packages without night cover. These users would be eligible for an Attendance Allowance at the lower rate (£22), and would be charged £14 per week.
    3. Packages for users not eligible for Attendance Allowance but whose physical or mental frailty requires support of the HCS to give reasonable quality of life, with a charge of £7 per week.
- Older people who were not sufficiently needy to be assisted by the service might still be eligible for up to three hours of domestic help, provided outside the social services department by independent home helps.
- A user-centred approach would be adopted.
- Resources would be set aside for adequate training of both line managers and front line staff.

Implementing a home care service

Such an integration took place in 1987. Care managers, home help organisers and social workers for the elderly were re-designated as home care managers (HCMs). Each HCM had a budget and carried a caseload of moderate and high dependency older people and cases of high complexity all requiring social work and/or social care. Although caseloads were planned to be in the range 30-60 each, depending upon the experience and expertise of the fieldworkers and the complexity of cases, these were rarely below 60 in practice.

HCMs were responsible for the effective deployment of all helpers and home helps; for their recruitment and training, the monitoring of their activities, and providing them with support, direction and guidance.

Clerical and administrative procedures were changed to effect a major reduction in paperwork through simplifying the system of returns for the various services involved in home care.

Despite pressures from the personnel section, helpers continued to be paid according to the tasks they performed. They still did not have guaranteed hours of service though continued to benefit from being able to work around their family commitments.

Difficulties in the new home care service
The conversion led to excessive workload pressures. To understand how these arose, it is helpful to see how caseloads changed. Before the home care scheme was implemented, a social services office might typically hold the following caseloads of older people in the community:

Two care managers each with a caseload of 30 users;
Two social workers for the elderly each with a caseload of 60;
Two home help organisers each with a caseload of 300;
Total caseload 780.

Following conversion, this caseload might be redistributed as follows:

Two deputy team managers and eight home care managers, with average caseloads of 60;
An independent sector co-ordinator with ten independent domestic care assistants carrying a combined caseload of 180;
Total caseload 780.

Thus, a high proportion of older people in need were being served by the Home Care Scheme instead of just receiving a home help. However, this was at the expense of no longer sufficiently targeting those in greatest need. A slight redistribution of caseloads between home care managers could have ensured that the more experienced and better trained could have carried lower caseloads of the most needy cases, for whom the core tasks of care management could then have been adequately carried out. Although the plan for the new home care service as conceived by the small working group was essentially sound, the subsequent development was carried out largely by people with a home help organiser background who did not appear to understand social work or care management, and existing care managers were not consulted. The subsequent implementation was flawed because the recommended training of line managers had not taken place, and they received no clear guidelines. Users were no longer selected for a specialist care manager on the basis of the importance of care management in particular. Also, the new Home Care Managers tended to deploy just the helpers and home helps for whom they were personally responsible, rather than draw on a wider pool for the whole team. This limited the extent to which they could successfully match helpers or home helps to users.

4.1.2 Subsequent development of Kent Home Care Service

Discussions in 2002 with a current care manager based in Dover helped to clarify how the home care scheme had developed since the withdrawal of PSSRU involvement in the late 1980s and how it operated today. There was overwhelming evidence that although care management principles had been successfully fought for and maintained while the support of the evaluation team was available, these had been rapidly lost since its withdrawal in 1987. Once again, this can be attributed to management weakness and incomprehension.

The role and status of helpers changed. Firstly, the Inland Revenue reported that KCC was acting illegally in employing helpers as agents instead of as employees. Hence, they were given full employee status with improved conditions of service, though were still paid by the task. Subsequently, the personnel department was reluctant to have a separate class of employee, the helper, as well as the traditional home help. Also, an influential principal manager of home care services was unable to appreciate any difference in role between helpers and home helps, and failed to recognise the immense advantages of the much greater flexibility of helpers. These helpers were subsequently offered the option of either becoming home helps or being made redundant. The vast majority left the service. A few attempted to obtain compensation from KCC and two were offered an out of court settlement of £1000 each. The reason the vast majority left appears to be that home helps did not have the flexibility of service, and that ex-helpers would no longer be able to plan their work around their family commitments. Thus, because flexibility was of such great value to helpers, their relatively lower level of pay should not necessarily be viewed as a form of exploitation.

During the 1990s, following the phasing out of the KCC helpers, the role of contracted out agencies had been extended from dealing with just low need cases to covering all levels of disability. Some of these agencies have become sizeable organisations and now supply their own home helps in addition to those provided 'in house'. The agency home helps can make up to three visits per day, though are paid by the hour, making them less flexible than helpers. At difficult times, such as bank holidays, it is the agency's responsibility to provide cover though they do not always respond to this. The user then has to go without. However, if this led to a disaster, the SSD would be responsible. The failure of these agencies to respond as quickly to user needs, coupled with reductions in the numbers of SSD home helps employed, has also meant that setting up a care package to provide support at home following a period in hospital tends to take longer, leading to more bed-blocking.

Agencies find it expensive training their home helps, for example in nursing skills or lifting, by sending them on courses. Under CCS, helpers could be trained directly by a district nurse or the care manager. Additionally, the increasing use of the independent sector, of which agency home helps are an example, has led to the setting up of an SSD contracting department whose workers had no social work training, only an administrative background. This additional layer of bureaucracy adds to the expense of providing care. Thus, the use of agencies has resulted in increasing costs and reduced flexibility and reliability, leading to an inferior quality of service.

Health and Safety regulations have become much more elaborate. Thus, before a home help can visit (even in an emergency) the home has to be inspected for safety.

Although these regulations provide safeguards for staff, they often restrict the flexibility of the care which can be offered the user.

Despite the earlier improvements in conditions of service for SSD based home helps, there has more recently been some deterioration. They no longer receive the full mileage allowance, and now get only 10p per mile. Also they are no longer paid for time spent travelling. Moreover, although ostensibly they are paid by the hour, they are frequently given tasks that take considerably longer than the time scheduled. Consequently, the effective level of pay is now lower than appears, without the accompanying flexibility from which helpers had benefited. At the same time agency home helps are not matched to users, who therefore miss out and no longer receive an individually tailored care package.

Agency home helps, who are paid by the hour for set hours, without the benefits of flexibility, are sometimes difficult to retain by their employers. For example, when a new local supermarket opened, many agency staff left in order to receive better pay. Although Kent SSD personnel department would no longer accommodate their helpers as a separate class of employee, there is apparently no legal reason why they could not have continued to be employed. The fact that they did not take up work as home helps suggests that there is still a potential pool of helpers to be tapped and that helpers could be successfully re-introduced.

4.1.3 The Gateshead social care scheme

In the Gateshead scheme, not only were helpers matched to users: the workload of helpers was balanced so that capable helpers did not just experience the least rewarding older people and become overburdened (Challis *et al.* 2002).

As in the Sheppey and Tonbridge schemes, the Gateshead Social Care Scheme started off by paying helpers according to the tasks they performed. Helpers saw the work as very accessible. Most had family commitments which took priority. Nearly one third found the flexibility over the number of hours they worked each week a major attraction; in weeks when they had more spare time they could if they wished spend extra time visiting. It was sometimes arranged that they worked in small time segments which slotted conveniently into their domestic routine. Helpers valued being able to work so near home, minimising disruption to their domestic routine: in contrast, auxiliary nursing would often involve shift work. The price to helpers was that they could not control whether the scheme offered them work over time periods when they wanted it, and hence no guaranteed income from one week to the next. Work was dependent on the availability of users needing help.

Earning money was seen as important for nearly two-thirds of helpers though not necessarily a prime motive. Over one half of helpers regarded their pay as about right or very good and the vast majority never felt the need to ask for a pay increase, though nearly all helpers preferred being paid:

- For many, they needed the money, otherwise they would not have worked for the scheme.
- Payment provided a formal recognition of the service provided by helpers.
- Being paid by a statutory body gave them the status they needed in the eyes of the older people and their families. This allowed them to insist confidently on doing their job, even in difficult circumstances, because it had the paid status of employment.

This feeling amongst helpers that they should be paid reflects Abram's finding in the Stonegate Warden Scheme: 'Far from being incompatible with paid work, a distinctively working class pattern of care was in fact dependent on it and could flourish on the basis of it' (Bulmer 1986, p. 212).

In the five years leading up to the community care reforms, Gateshead senior managers failed to successfully handle the development of the social care scheme. Care manager budgets were reduced, making the training of helpers less feasible. Also there was no longer a manager dedicated to care management, so that supervision and support were less focussed. At the same time a closer working relationship with the home help service was developed. One consequence of the weakening of the care management role and an increased perception of the scheme in service terms was a growing recognition of the value of the flexible response to needs provided by the helpers. It was not until the community care reforms were being implemented in 1993 that helper payments became more time-oriented. With the increasing awareness of the need to respond in a more user-centred fashion, there was a growing feeling that the home help response should be brought more into line with that for helpers (Challis *et al.* 2002). There are currently plans for the Social Care Scheme to merge with the home help service.

4.2 Staffing of post-reform community care

Following the passing of the 1990 NHS and Community Care Act, the effect of the community care reforms in the early 1990s has been to open up the home care market to a mixed economy. Extra community care funding has allowed local authority home care services to offer a more intensive service. From a fairly representative national sample of the caseloads of care managers working with older people in the period 1994-95, 70 per cent of users received home care provided and financed by the social services department and of these, the average consumption was 6 hours per week. Ten years earlier this had been only 5 hours per week for even the critical interval need cases (Davies *et al.* 1990), which shows how much allocations have increased. Although this service still tended to be limited to office hours on weekdays, it offered a substantial proportion of high cost packages. Only 19 per cent of these users received private or voluntary sector home care at an average level of 5 hours per week. This fulfilled more of a gap-filling role, being more frequently available evenings and weekends (Bauld *et al.* 2000).

There is a strong consensus in post-reform literature that innovative and effective domiciliary services have been developed since 1993 (Audit Commission 1997). Social services departments have increasingly acknowledged the wish of most older people to remain in their own homes and so have made efforts to make this possible. Personal care has become increasingly available at home, mainly through the home care service. Nevertheless, research has shown that overall progress in the development of domiciliary services since 1993 has been slow (Bauld *et al.* 2000). Authorities focussed much of their early attention on processes and systems, rather than on improving and developing services (Henwood *et al.* 1996). One consequence of an increasing emphasis on targeting resources on those most needing assistance has been that low-level support, such as cleaning and shopping, has been withdrawn from a significant proportion of service users (Clark *et al.* 1998). Thus, between 1993 and 1997, the total number of households receiving home care dropped by seven per cent, while the number of hours help provided increased by fifty per cent

(Department of Health 1998b). This targeting is consistent with the aims of the intensively managed schemes in Kent and Gateshead.

There is evidence that some users and carers are continuing to receive inflexible and unreliable services, particularly in relation to the older cognitively impaired (Moriarty and Webb 1997). Boundary disputes between health and social care have exacerbated the process of assessing eligibility for services (Means and Smith 1998a). There is much regional variation in both the levels of service provided and the charges levied (Gostick *et al.* 1997).

4.3 Advantages and disadvantages to helpers of being paid by task

Despite the inferior pay and conditions of service, the extra convenience and job satisfaction for helpers resulted in a strong supply of new applicants and a committed workforce with low turnover in both the Kent and Gateshead schemes. McKie *et al.* 2001 point out the importance to quality of life of the impact that work has on home and that home has on work. The flexibility of being a helper allowed the helper more space for their home life and hence a more relaxed and constructive attitude to the demands of their work. Some of the benefits and problems associated with being paid by task are now summarised.

Advantages of being paid by task:

- Tasks can be scheduled around the helper's family commitments, particularly with a young family.
- Work for helpers can frequently be provided near home.
- The less precise specification of the tasks and when they are performed increases the scope for initiative and leads to greater job satisfaction.

Disadvantages of being paid by task:

- Equivalent weekly rates of pay tended to be worse. Assuming in Kent that a less demanding visit typically took 45 minutes and a more demanding visit 1hour 30 minutes, the equivalent rate of pay of a helper was around £1.60 per hour at 1982 prices, roughly half that for a home help (£3.36 per hour).
- The work tended to be classed as casual, with poor conditions of service. There was no eligibility for sickness benefit and only one week's notice was given for the termination of a contract.
- No guaranteed income was offered.
- There was no incentive of extra pay to reward additional hours worked under a particular contract. This would be less of an issue when helpers were selected as being altruistically motivated.

4.4 Advantages to users when helpers were paid by task

Users appeared to benefit in many ways from this flexible approach to paying helpers, and no disadvantages could be identified:

- Helpers were more likely to be able to call when the user most needed them, which may have been early morning, late evening, weekends or bank holidays.
- The flexibility offered greater scope for users to have contact with the helper's family, which could be very beneficial.
- Because payment by task was cheaper, it was easier to fund a fully care-managed service with reduced caseloads maximising user quality of life.

- Users could benefit from helpers making extra unscheduled visits or longer visits when the user was particularly in need. Indeed this may have sometimes avoided the need for short-term admission to a hospital or care home.
- Users may have preferred the increased informality associated with payment by task, with companionship not being regarded as of only secondary importance.
- Because there was not the necessity of maintaining continuing employment for the whole pool of helpers, there was greater scope for matching the helper's characteristics to the needs of the user.

4.5 Were helpers being exploited?

It is striking that helpers in the care-managed schemes were nearly always female. According to Finch (1984) such schemes tend to involve 'creating new categories of low paid workers who undertake and organise daily caring...They often build upon an extension of domestic virtues believed to be the especial property of women. Moreover the caring envisaged in such schemes implies not just domestic work but a qualitative relationship with the dependent person, of a type characteristically assigned to women in our culture' (pg 10). Community care helpers were attracted by the prospect of accessible paid work which they saw as an opportunity to use the caring skills they had acquired in the home. This gave expression to their sense of a caring identity, fitting a cultural expectation of what women should be (Challis *et al.* 2002).

However, while women are seen as society's 'natural' unpaid carers their bargaining power in the labour market will be weak. Most helpers regarded themselves primarily as wives and mothers and could only contemplate employment which did not interfere with these commitments. Therefore, the option of a convenient factory or service job was generally not available.

Despite the relatively low level of pay of the helpers in Kent and Gateshead, there was greater job satisfaction than could be offered by conventional female manual employment. From this perspective, the schemes provided an additional 'opportunity' (Evers 1994). A substantial proportion of helpers, particularly in Gateshead, were motivated by the chance to do something useful, which would bring emotional rewards as well as material ones. Their work for the scheme, although not challenging women's role as society's carers, offered a more independent and rewarding context in which women could practice their skills and receive recognition for them. Leat and Gay (1987) regard this balancing of objectives by the helpers as making paid carer schemes less exploitative than other forms of caring. Moreover, they do not see payment as invalidating in any way the care they provide.

Dean and Shah (2002) observe that the 'trend to working parenthood may....be experienced rather differently by secure middle-class families than by poor families. It may be that the former will benefit from policies to improve access to formal childcare, career breaks and time off when needed. The latter are more likely to remain dependent on informal childcare from other family members or friends and receive minimal concessions granted by reluctant employers' (pg 61). The flexibility of working as a helper goes some way towards resolving this dilemma. The combination of financial and emotional rewards for work which could be planned around their own family commitments was a major attraction for potential new

helpers to the schemes. However, this made them particularly vulnerable to exploitation. The managers of such schemes therefore had a responsibility to support their helpers (Ungerson 1993), through such means as protecting their rights and offering safeguards in their work. By failing to provide such support, helpers would be more likely to become disillusioned with the work and leave.

The social care schemes in Kent and Gateshead were managed so as to avoid exploitation. Thus, in the Thanet Project the level of fees was negotiated between the care manager and helper, while in the Sheppey and Tonbridge schemes the use of a system of payment bands for different types of task allowed care managers to pay extra depending on the circumstances and helped to ensure that the total fees paid increased in proportion to the total workload.

Nevertheless, there were still circumstances in which exploitation could be apparent. Sometimes helpers were called upon to provide extra support and at inconvenient times. Under such circumstances, flexibility might no longer be seen as a major attraction. In the Lewisham Care Management Scheme for cognitively impaired older people, care managers reported feeling guilty at having to ask helpers to visit frequently and at short notice, which they saw as a form of exploitation (Challis *et al.* 1995).

Moreover, Bagilhole (1996) observes that 'the new rhetoric of the flexibility and adaptability of welfare provided by the voluntary sector hides the increasing use of women volunteers, to offer sophisticated and intensive care' (pg 189). This view can be extended to apply to quasi-informal paid helpers. Some of these, such as qualified nurses, were recruited because of their special skills. Others would spend long hours in providing extra care, such as when a user had fallen sick or suffered from senile dementia. Although the banding of payment levels for particular tasks allowed for some flexibility, payments received in such circumstances were likely to appear as inadequate, since the service provided was of a type normally fulfilled by a professional worker. When helpers have been recruited who possess particularly relevant skills, there is an argument for paying them at a higher rate to take greater account of the professional nature of their work. Such helpers might also be offered better conditions of service. The London Borough of Merton, which, after consultation with the PSSRU, introduced a care-managed scheme for frail older people in the late 1980s, offered such a two-tier system for employing helpers (Chesterman and Challis 1988). A small group of skilled helpers with employee status and full conditions of service were paid by the hour. Remaining helpers were casual employees paid according to the tasks they performed, as in Sheppey and Tonbridge. This system appeared to work well.

4.6 Would a pool of helpers paid by task be feasible today?

Since the 1980s there have been many important changes in the ways that social services departments and health authorities operate and in the supply, demand and conditions of service of the workforce. These changes tend to make it more difficult to employ helpers paid by task:

- As a result of EU and national legislation, including the national minimum wage, rates of pay and conditions of service are much better than in the 1980s.
- Although employers are still able to employ casual staff, it might be more difficult getting union recognition for them.

- Regarding supply and demand in relation to the workforce, the rises in rates of pay in real terms might necessitate a substantial increase in the helper payment bands for different types of task to ensure a sufficient pool of suitable helpers. The greater scope for employment in the independent sector would contribute to this.
- With crèche facilities being more readily available than they were twenty years ago, more potential helpers might prefer the improved pay and conditions of service of regular hourly paid employment.

Nevertheless, the flexibility and job satisfaction of the work are still likely to be powerful motivating factors in recruiting potential new helpers. Moreover, it has been shown in the intensively care-managed schemes that helpers paid by task and hourly paid home helps can successfully work alongside each other.

4.7 Concluding remarks

After reviewing this wide range of material relating to developments in domiciliary support arrangements through time, it is difficult drawing any clear conclusions over whether helpers should be paid by task or by the hour. The total absence of information on any current schemes involving helpers adds to this problem, by offering no direct tests of how feasible the use of helpers would be today. However, the following tentative conclusions might be drawn:

- Despite the much lower helper pay and poor conditions of service associated with schemes which pay helpers by task, the flexibility of such arrangements is a strong attraction to helpers with young families, allowing helpers to work around their family commitments and providing enhanced job satisfaction. It would seem improbable that substantial increases in real terms in rates of pay of the workforce during the last 15 years, and improvements in conditions of service, would be sufficient to completely stifle the attractiveness to helpers of being paid by task.
- The employer has a responsibility to ensure that staff are not being exploited. The flexibility and job satisfaction of the work are considerable attractions which appear to largely offset the disadvantage of the comparatively low level of pay. A system of payment bands for different types of task helped to avoid exploitation. However, when helpers have been recruited who possess particularly relevant skills or are asked to perform particularly onerous tasks, there is an argument for offering them employee status with full conditions of service and paying them at a higher rate to take into account the professional nature of their work.
- One reason why the intensively care-managed schemes were cost-effective was that the use of paid helpers was relatively inexpensive, while the alternative of a care home admission would involve quite high staffing costs.

5. Community care schemes and development of a mixed economy of welfare

5.1 Introduction

Welfare provision had its origins in the family, charities and private organisations (Knapp *et al.* 2001). These continued to be important following the major welfare state legislation of the 1940s. In the decade following this legislation, welfare services were seen as predominantly state funded and state provided. Since then there has been a transition to an attitude in which the state provides a safety net for a minority, with other consumers of welfare services having to rely on the private and voluntary sectors. The operation of these state and independent sector organisations side by side constitutes the *mixed economy of welfare*. Perhaps the main reason for

this change was the great reduction in government spending brought about largely by the hike in oil prices in 1973. Also there has been a move away from socialist ideology, with the emergence of Thatcherism and subsequently New Labour (Pinker 1992). At the same time, welfare organisations have become increasingly motivated by the desire for profit and efficiency.

With the development of the mixed economy of welfare, statutory welfare organisations such as SSDs and the NHS arrange services for their users through purchasing a range of in-house and private or voluntary resources. *Commissioning* is the act of purchasers in securing services from providers in order to meet user needs in a cost effective manner.

5.2 The role of care managers in the early development of a mixed economy

Before the 1980s, social services departments offered welfare services to their users which were nearly always 'in house' and gave little help in putting users in touch with private or voluntary provision.

Care managers for the Thanet Project and the social care schemes that followed in Kent and Gateshead were some of the first workers to draw on a mixed economy of welfare. They offered a radically new means of obtaining services for their users:

- They were provided with a devolved micro-budget to buy in services and had considerable autonomy in the way it was spent, being free to develop innovatory techniques. This purchasing of services by front line staff is termed *micro-commissioning*.
- Although at this time there was no comparative information available on the quality of different services available, care managers acquired knowledge of local resources through experience. From their own observations and those of their users, carers and helpers, they could often make reliable judgements about the quality of these resources, both in-house and in the NHS and independent sector. Their restricted caseloads allow them time for this activity. They were provided with a menu of unit costs of SSD services which enabled them to make more cost efficient decisions.
- The above advantages enabled care managers to effectively 'shop around' in selecting the best ingredients for a care package.

In the social care schemes, helpers with an appropriate attitude to the work were identified by using techniques of community development and drawing on volunteers and voluntary organisations. This generally took the form of advertising for volunteers or paid helpers who were carefully selected so as to have the right attitude to care. As schemes developed, 'word of mouth' usually took over from advertising as the principal means of recruitment. In one of the Kent schemes (Dover), the care manager built up relationships with the local churches which were used as an additional source of helpers. In Thanet, a care manager negotiated with the owner of a local chip shop, who had a flexible attitude, to arrange for meals to be delivered to appropriate users at times when they were needed.

In Thanet, levels of fees for particular types of task were negotiated between user and helper. This suggests that to some extent market forces were allowed to operate, according to levels of supply and demand. However, in order that a good quality service was provided, the primary aim of care managers was to select staff with the right type of motivation, rather than those of least cost. Once the schemes had

become established in several parts of Kent, it was possible to reach a consensus between both care managers and senior management as to what levels of fees might be acceptable across the county for different types of task. Banding of fees allowed for differences in levels of supply and demand and circumstances of helpers across the county. By drawing up countywide payment bands for different tasks, the scheme was both responding to market forces and allowing an equitable policy on payment across the county.

Helpers in Sheppey pressurised the care manager for increased pay: the payment bands allowed some flexibility. If helper fees had become too high, helpers would have to be deployed less frequently. If the fees were too low, this would lead to difficulty in recruiting helpers. Because of the convenience of the employment, enabling helpers to work around family commitments, together with the high level of unemployment in Sheppey, helpers were willing to accept pay which substantially undercut that of a home help and was nearer that for casual labour. In deciding on a suitable level of pay, the local authority needed to take account of the danger of exploitation.

This development by care managers of community resources and the use of the voluntary and (occasionally) private sectors is an early example of operating in a mixed economy of welfare, albeit rather different from the larger scale commissioning found in local authorities today. CCS care managers adopted a user-centred approach, maximising user choice. The range of options available from the mixed economy facilitated this, as is illustrated in the process of matching helpers to users and the selection of a suitable type of day care or lunch club. Their familiarity with the market would help them to know such things as whether a district nurse would be able to respond to a user with assistance in getting them up and toileting them at a time convenient to the user. Care managers were in a position to be able to weigh up the alternative merits of deploying different types of resource selected from the mixed economy in different ways, both for a particular user and between different users.

Some of the main items selected by care managers from the mixed economy for inclusion in care packages included:

- Helpers;
- Home helps;
- Day care and lunch clubs provided by the SSD or voluntary organisations;
- Respite care (SSD- or independent sector-provided);
- Equipment, such as heaters or a washing machine for incontinent laundry;
- Resources negotiated from other agencies – district nursing, GP visits, hospital respite, chiropody, occupational therapists, physiotherapists;
- On case closure, admission to a local authority care home or private or voluntary residential or nursing home;
- Volunteer visits (mainly in Tonbridge), including church volunteers and gardening by those on probation;
- The care manager's own time – an SSD resource;
- Types of innovation such as a community care luncheon club, run by helpers supported by the care manager.

5.3 Influence of the intensively managed schemes on social policy in the 1980s

The importance of the role of micro-commissioning in the intensively managed social care schemes had a subsequent effect on social policy. It influenced the background papers provided by the PSSRU to the Department of Health for the preparation of the care in the community circular of 1983. This emphasised the importance of care management, seen as an essential component of the 24 pilot projects for the discharge of handicapped users from institutional care into the community. It extended micro-commissioning by care managers from the mixed economy to other user groups, such as the younger physically disabled and those with learning disabilities. One of these projects, in Darlington, involved close partnership between the SSD and NHS, using multi-disciplinary assessment of older people from long-term geriatric hospitals with a view to discharging them into the community (Challis *et al.* 1995) and the recruitment of staff who could undertake nursing as well as social care duties. Care managers, employed by the SSD, were again supplied with a budget for micro-commissioning.

The success of the social care schemes, with their cost-effective use of micro-commissioning and drawing on community resources may have also encouraged Conservative governments in their expansion of the mixed economy of welfare during the 1980s. However, although this had been with the intention of reducing public expenditure on statutory welfare services, this remained essentially at the same level. The social care schemes were also influential in the production of the Griffiths Report (Griffiths 1988), which backed the DH over the importance of performing the core tasks of care management, making it a cornerstone of policy. Rather than relying simply on services provided by the local authority, he proposed that care managers set up care packages drawn from services in the public, voluntary and private sectors to encourage choice, flexibility and innovation in a competitive environment.

Many of the report's recommendations appeared subsequently in the government white paper *Caring for People* (Department of Health 1989). This too was heavily influenced by the schemes, and included a direct reference to the Gateshead Social Care Scheme.

5.4 Continuing influence of the social care schemes in the 1990s and beyond

More recently, the rapid expansion of the independent sector continued through the passing of the NHS and Community Care Act of 1990, which had its origins in the Griffiths report and *Caring for People*. Many of the values upheld by the Act may have had their origins in the social care schemes. These included the encouragement of diversity and choice in the welfare provision for older people both in the services offered and their funding, greater co-operation between the statutory, private and voluntary sectors, and improved partnership between formal social services and informal care within the family and the neighbourhood.

Three substantial changes brought about largely by the Act and relating closely to the aims of the social care schemes were:

- the transfer of much funding from central government to social services departments, and with it the responsibility for coordinating care purchasing;
- encouragement of devolved decision making, including care management and

- a reversal in the upward trend of combined public and independent sector care home provision.

Other changes brought about included:

- development and elaboration of regulatory procedures;
- stronger links between local authorities and the independent providers;
- the introduction and rapid development of social care markets.

The challenge for central and local government has been to develop market conditions under which healthy practices and providers thrive at the expense of those which fail to adapt and work efficiently.

While the Conservatives encouraged independent sector provision, the Labour government has given equal weight to both sectors. Under Labour, the economic recovery has provided an environment in which the private and voluntary sectors in the social care market could thrive and expand. In this environment, Labour has encouraged the use of regulation, as described in its social care White Paper *Modernising Social Services* (Department of Health 1998a), in order to maintain standards, particularly in the independent sector. Markets in social care are now as important as ever.

5.5 The purchaser-provider split

Following the Community Care Act, with its emphasis on providing users with a comprehensive assessment, care managers carrying out this assessment tended to specialise in this activity and be different from those setting up care packages and subsequently providing longer term supervision and review. There was therefore a split between the role of the local authority in firstly making a needs assessment and negotiating and paying for the care package, and secondly in the provision of a mixture of 'in house' and independent sector resources that constituted this package. However, this purchaser-provider split was only partial. A complete split can be found in parts of the USA, where the care management role itself can be contracted out to a private organisation. These care management agencies have 5 year rolling contracts and are responsible for buying in services. However, the schemes in England and Wales which were influenced by the PSSRU and which had adopted a purchaser- provider split in the late 1980s did not take such an extreme approach in order to protect the user against commercialisation.

5.6 Development of a more personal service

The growth of social services departments over the past few decades has resulted in their becoming large bureaucratic hierarchies, where tasks previously undertaken largely by informal networks were replaced by a comparatively impersonal service. Pinker (1992) acknowledged the growing evidence from research that the moral basis of formal social services is fundamentally different from that of informal care, and that such organisations often fail to offer assistance in a form which is acceptable to the user. One central aspect of the social care schemes was the personal nature of the support which they offered, with their individually tailored care packages. This personal service was largely a result of using helpers drawn from the local community. These care management schemes may well have been influential in the recent shift towards a more personal service both at a professional level and within caring organisations. Thus there has been an increased emphasis in social work training on respect for persons and self-determination. Moreover, government

white papers and legislation during the 1990s, such as the white paper *Modernising Social Services* (Department of Health 1998a) and the Carers (Recognition and Services) Act 1995 have stressed the importance of the user-centred approach and the consultation with and support of informal carers. Moreover, a greater proportion of uses are now receiving help outside office hours, mainly from the independent sector.

5.7 Macro-commissioning

In parallel with the increased use of care management in social services departments in the 1990s has come a more widespread use of large scale commissioning of services, referred to here as *macro-commissioning*. This is usually carried out by the more recently created, SSD-based, *contracting departments*, which specialise in setting up contracts between the local authority and the provider. Macro-commissioning is very different from the micro-commissioning of the intensively managed community care schemes, as it is not so focussed on the voluntary sector and community development and is not limited to those who are suitably motivated.

In drawing up a contract, it is necessary to specify whether it is short-term or long-term. Three frequently used types of contract are (Knapp *et al.* 2001):

- *Block contracts*, in which the purchaser commissions a block of a particular facility and guarantees the provider that they will be paid for the facility whatever the actual usage;
- *Spot contracts*, basing costs on whether the user actually uses the service. These are more flexible to fluctuating demand but are generally more expensive and involve a centralised purchaser;
- *Call-off contracts*, similar to spot contracts, but involving decentralised purchasers such as care managers, who call off services from the spot contract.

Staff, normally with an administrative background, would specialise in negotiating with private and voluntary organisations to purchase resources from them at an acceptable price. Once a contract has been drawn up, care managers could then call off services from the contract when they were needed. A balance needs to be struck between the discounts achieved through contracts involving bulk buying and the consequent reduced flexibility in the deployment of resources by care managers. Views of commissioners tend to be very commercial, and the resources bought in are not confined to those from suitably motivated staff. Indeed providers are often perceived as alien. Moreover, the contracting department introduces an additional expensive layer to the bureaucracy of the local authority. The use of a contracting department in arranging commissioning from the independent sector reduces the power of the care manager to control the type of care package received by the user.

5.8 Care management today

Care management in the intensively managed social care schemes was intimately bound up with micro-commissioning, which involved drawing on some aspects of a mixed economy of welfare. This is now compared with the ways in which care management today makes use of the mixed economy. Care managers should be well placed to assess needs and preferences and respond through purchasing services. They should also have sufficient knowledge of the local care market to avoid exploitation of their users by providers. However, to achieve this care managers need sufficient time, information and skills, together with autonomy and incentives. Also,

individual care managers are less well placed to spread risk and achieve better price deals than centralised commissioners from a large purchasing organisation. Therefore, even when a number of decision-making powers have been devolved to care managers, it may be preferable to negotiate some contracts centrally, leaving care managers to call off units of service as needed. Budgetary devolution had been introduced in a few English authorities by 1996, but only one in six in a particular sample had care managers who were either sole budget holders or part of a combined team for purchasing external services (Knapp *et al.* 2001). Devolved budgets are only effective when coupled with adequate information and financial monitoring systems (Audit Commission 1997).

Instead of care managers using their own time to set up and support a pool of helpers as in the social care schemes, their contracting department may now commission an outside agency to provide care. Care managers can then call off agency help for individual users from this contract. However, such an arrangement is much more expensive than was the deployment of helpers.

Using data from the ECCEP project on care management of older people in England and Wales, Davies and Fernández (2000) demonstrated the cost effectiveness of providing additional care management time while assessing a user and setting up a care package. Their results suggested that local authorities would benefit from spending more of their resources on care management during this setting up phase rather than on other types of service. This points to the need for more intensive care management with smaller caseloads and also suggests that the micro-commissioning process itself may make an important contribution to the user's quality of life.

It is clear that during the last twenty years care management has played an increasingly important role in the welfare provision for older people. Moreover, the issue of care management is increasingly emphasised as being a central part of government policy. This has tended not to be the case in other parts of Europe. Thus, in the Netherlands and Sweden, although there is a strong interest in care management it is not at the centre of the logic behind national policy. Moreover, they do not have a single assessment policy. Although care management in England and Wales is less intensive than that found in the social care schemes in Kent and Gateshead, its origins can be traced back to these schemes. Indeed, because care management makes use of aspects of the mixed economy of welfare, it follows that the social care schemes have also been influential in the development of this mixed economy.

CHAPTER 12

CONCLUSIONS AND DISCUSSION

The principal aim of this study was to assess whether routine implementation would still show the KCCP model to be cost effective. Another important aim was to obtain insight into how the model would respond to local variations in influences on demand and supply.

The original Thanet Project had benefited from intensive support from the PSSRU evaluation team, at both care manager and senior management levels. The Gateshead scheme also benefited from such help though much less intensively. The schemes being evaluated here did not receive such support (Chesterman, Challis and Davies 1994), relying instead on *mechanisms for promoting good practice* set up jointly by the PSSRU and the authority.

The main findings of the evaluation and the extent to which the objectives of these schemes were achieved forms the first part of this final chapter, preceded by a summary of the methods used in achieving good care management practice. The remainder of the chapter involves a discussion both of the relevance of this study in the context of the time and its implications for the present and the future.

1 Methods used for promoting good care management practice in Kent

The involvement of the PSSRU in developing the schemes in Sheppey and Tonbridge and other parts of Kent was fundamentally different from that in the original Thanet Project. In Thanet, the care managers were offered initial training during a pre-implementation period at the PSSRU. Subsequently, the member of the evaluation team undertaking the interviews with users and carers kept closely in touch with the implementation team on a virtually daily basis, while the evaluation and implementation teams had frequent joint meetings with a local and centrally-based manager. By this means the evaluators played a prominent role in the discussion of issues, and contributed support and guidance to encourage good care management arrangements, policy and practice, both with individual cases and with the more general development of the project, as well as participating in management.

Clearly, with the expansion of the scheme into the remainder of Kent this intensive PSSRU support was no longer feasible or appropriate. Instead the approach adopted was to assist the authority in setting up mechanisms for encouraging good care management practice across the county. These mechanisms took the following forms.

(a) *Monthly whole day meetings of care managers from all Kent schemes* were set up, chaired by a representative from the PSSRU (the evaluator). These offered time for *general discussion of problems and new techniques*. In addition *outside speakers* were invited, to help extend the knowledge base of care managers. A system of *peer review* allowed care managers to present case studies with a view both to sharing techniques, and drawing on the wider skills of the whole group to assist in problem solving.

(b) *Six-monthly meetings of care managers, their immediate line managers and senior managers in Kent*, and the PSSRU evaluation team met under the *chairmanship of the*

assistant director, to allow general issues regarding *community care policy* and the *development of the scheme* to be discussed at all levels of management.

(c) A *small working group* was set up consisting of six experienced care managers, a county development officer and the member of the evaluation team undertaking the detailed collections in Sheppey and Tonbridge (the author), to draw up a Community Care *procedures manual*, covering such issues as suitable wording of job advertisements for care managers, job descriptions, payment levels for helpers and administrative procedures.

(d) A *monitoring system* was set up for each user in the scheme, the data being analysed by the author and regular feedback forms circulated to care managers providing information on their individual caseloads. In addition, feedback forms at different levels of aggregation were provided to line managers and senior managers. By this means, care managers, who carried their own budgets, were made accountable to management.

These techniques, set up jointly with the PSSRU, encouraged the development of good practice amongst care managers and helped to ensure that the aims of schemes in different parts of Kent were broadly the same. They also provided an opportunity for line managers to obtain a greater understanding of the scheme.

There now follows an overview of the results of the evaluation in Sheppey and Tonbridge, two schemes which were being researched at the time that these new techniques for promoting good practice in Kent were first being applied. In Sheppey, the care manager and a part-time assistant supported some 35 users at home. The evaluation of the Tonbridge Community Care Scheme was based on a sample of 33 cases obtained by sampling every fifth case selected by the care manager.

2 Results of the main evaluation

2.1 Outcomes

2.1.1 Locational outcomes

Locational outcomes after one year. Both schemes were successful in maintaining a greater proportion of cases at home than in the matched comparison group through a reduction in the numbers admitted to institutional care. However the results were insignificant at the five per cent level. Although a larger percentage of both groups remained at home in Tonbridge than in Sheppey, the types of case supported were rather different. The greater proportion of cases living with others or having a PIC in Tonbridge may be factors likely to extend the period spent at home. However, the larger proportion of cognitively impaired cases might be expected to have the reverse effect, particularly in view of the stressful effect on informal carers. Comparing the results with those for the earlier schemes in Thanet and Gateshead where the care managers had received more guidance from the evaluation team, the addition to the proportion remaining at home in the Community Care compared with the comparison group in the Sheppey and Tonbridge schemes was not quite as great. Nevertheless Sheppey resembled Thanet in having a much smaller proportion of cases dying in the Community Care group than in the comparison group. Whether this group difference was a direct result of care management intervention was unclear both in Thanet or Sheppey. For instance, in part it could have arisen through group differences in certain medical or personality characteristics whose identification would have been beyond the scope of the social care oriented evaluation. Such case mix effects could have been avoided by having a randomised allocation of cases to the experimental and control groups. However, to avoid statistical fluctuation, sample sizes

would have needed to have been bigger. Also, having experimental and control cases in the same area could have led to contamination between the two groups. No such group differences in death rates occurred in Tonbridge or Gateshead.

Survival in the scheme was also followed up over a *six year period* in Sheppey and Tonbridge. In Tonbridge it was possible to draw on a much bigger sample, taken from the monitoring data base, in charting survival. However, this larger sample differed from the evaluated sample in being slightly (insignificantly) more physically dependent and in having a smaller proportion of cases with a principal informal carer. From the results of a four-year follow up in Thanet it was possible to compare the locational outcomes over this period in Thanet with both Sheppey and Tonbridge.

- After each of the first four years the proportion remaining at home in Sheppey closely resembled that in Thanet. In both these areas a majority of users had no principal informal carer.
- Tonbridge cases showed a quite different survival pattern. While a substantial proportion of users in both Sheppey and Tonbridge remained in the scheme for well over one year when followed up over a six year period, the proportion surviving in Sheppey was much greater than in Tonbridge.
- Thus 50 per cent of cases remained in the Sheppey scheme after two years, compared to 30 per cent of Tonbridge cases and 40 per cent of cases in Sheppey after three years compared to 15 per cent of Tonbridge cases.

The shorter survival time in Tonbridge might well have reflected a greater level of need, particularly a larger proportion of the cognitively impaired, combined with a greater availability of long-term residential and geriatric hospital beds (Table A1.4 of Appendix 1).

2.1.2 Utilisation days outcomes

While locational outcomes after one year offer a snapshot, utilisation days outcomes over that year provide a full picture of the number of days spent in different types of location. The difference in time spent at home by matched groups in Sheppey was then significant at the five per cent level, as was the difference in time spent in institutional care. In Tonbridge the difference in time spent at home was almost significant at the ten per cent level, and although the difference in time spent in institutional care overall was insignificant, that for acute hospital care was significant at the five per cent level.

There is therefore a strong argument for concluding that the Sheppey scheme successfully achieved its aim of allowing frail older people to spend longer at home. The result in Tonbridge was not sufficiently strong to be statistically significant, though this failure reflected in part the smaller sample size.

2.1.3 Quality of life outcomes

In each area, significantly greater improvements of the Community Care groups were demonstrated on a range of key outcome measures relating to quality of life, quality of care and health status of users and their carers. Improvements were found in some of the aspects of quality of life tested for in Sheppey, with more marginal effects in Tonbridge:

- In Sheppey, significant improvements were achieved in *felt capacity to cope*, with significant reductions in *anxiety* and *depression*.
- In Tonbridge, reduction in *depressed mood* and in *dissatisfaction with life development* were almost significant at the five per cent level.

The companionship provided by Community Care helpers may have contributed to these achievements. However, the overall level of improvement in quality of life outcomes in Sheppey and Tonbridge was smaller in magnitude than in Thanet and Gateshead, with cases in Sheppey doing marginally better than in Tonbridge.

2.1.4 Quality of care outcomes

Quality of care outcomes presented the most striking results. The *need for extra help with personal care and housework* was significantly less for three of the four categories in both Sheppey and Tonbridge. The assistance provided by Community Care helpers and additional hours of home help are likely to have been powerful contributory factors. The *need for extra services* was significantly reduced in each area. Both schemes also significantly reduced the user's *social resource impairment*. Taken overall, these levels of improvement in quality of care in both Sheppey and Tonbridge were as good as in Thanet and Gateshead.

The strength of these results in comparison to those for quality of life is unsurprising. In the main, they evaluate whether the intentions of the programme were realised with respect to inputting care resources. Many of the improvements in quality of care were measured as a *reduction in need shortfall* brought about by the appropriate deployment of resources, which would be expected to be closely related to level of need, particularly in the Community Care group. This is well illustrated by the big effect of variations in inputs on an analogous outcome indicator in a study of post-reform community care (Davies and Fernández 2000).

2.1.5 Health needs outcomes

In addition to the relative improvements in quality of life and quality of care of the Community Care group over the comparison group in each area, the health of users deteriorated far less in the schemes than in their comparison groups. For example, on Sheppey the increase in *ADL score* was much reduced and the *ADL impairment rating* was also lower among cases in the scheme. The user's *self-rated degree of ill-health*, which reflects morale as well as health needs, was significantly lower for the care managed group. Moreover the *general health problem index* and *risk of falling* were both significantly reduced relative to the comparison group.

In interpreting these results some caution is needed since the greater deterioration amongst the comparison group might simply reflect additional medical needs of this group at time one which the social care oriented evaluation had failed to identify. However, in view of the levels of disability having been matched by group and the referral routes being similar, this would be rather unlikely. Whatever the cause of the difference, it is probable that the smaller deterioration in health of the Community Care group is associated with their much lower death rate.

It is more likely that the results were largely produced by the scheme. A high priority had been given to improving diet and food intake, particularly in instances of malnutrition and of combating cold and dampness. These could well contribute to the health of users. This, and the provision where necessary of regular check up visits and suitable aids could reduce the risk of falling. Incontinence problems could also be reduced through such means as offering help when needed with toileting and managing fluid intake.

Many of these group differences may have been produced in Tonbridge though none were significant at the five per cent level. For instance, reductions in *ADL score* and *ADL impairment rating* were marginally higher in the Community Care group, being significant at the ten per cent level.

Although many of the health outcomes in Sheppey and Tonbridge did not show significant group differences due to the small sample sizes, the extent of the reduction in deterioration found in health needs outcomes was about the same as in Thanet and Gateshead.

The *close co-operation between care managers and GPs* in Tonbridge could have led to primary health teams taking prompter action when alerted by care managers to health problems in the older person, thus accounting for their superior health needs outcomes. Some years later, full advantage was taken of this type of co-operation in the *Gateshead scheme*, in which the care management team based part of their work in a primary care group. In contrast, GPs in Sheppey were poor in responding to requests for intervention from care managers and this may account for the lower level of health needs outcomes achieved. This theme of co-operation between social and health services is pursued further in section 7.1.

2.1.6 Informal carer outcomes

As well as the benefits experienced by the older person, results also suggest gains for the principal informal carer. However, the extremely low number of cases with a carer, particularly in Sheppey, meant that all results were extremely tentative. There was a suggestion in each area that after one year informal carers were less involved in providing help at times of *getting up and going to bed.* Due to the help which informal carers received, those in Sheppey managed with *less support from others within the household.* Overall they felt under *less strain*, and expressed *more warmth* towards the subject. In Tonbridge, despite the low sample, carers in the scheme reported a significant *reduction in backstrain* compared to the comparison group. Assistance from helpers with lifting may have contributed to this. They also reported a reduction in their experience of *burden*, though this result was not quite significant. However, taken overall, outcomes to informal carers in both Sheppey and Tonbridge attained lower levels than in Thanet and Gateshead.

Thus, although *quality of care* and *health needs outcomes* achieved in Sheppey and Tonbridge were as good as in Thanet and Gateshead, outcomes relating to the older person's *quality of life* and to *informal carers* did not reach the levels found in Thanet and Gateshead. One possible explanation is that outcomes relating to quality of care could be achieved just as effectively in Sheppey and Tonbridge as in Thanet and Gateshead, since they depended mainly on the quantity of resources deployed. However, the achievement of high quality of life outcomes depends much more critically on the particular mix of resources selected for the care package and the way in which the case was co-ordinated, and the lower level of PSSRU involvement in Sheppey and Tonbridge therefore led to the production of outcomes, which although good, were not as striking as in Thanet and Gateshead.

2.2 Costs

The benefits experienced by the Community Care group after one year relative to the comparison group were achieved at no overall additional combined cost to the social services department and National Health Service, though there were major transfers of expenditure between the two agencies in each area. Moreover the balance of expenditure

between the agencies was quite different. In Sheppey, higher costs of the Community Care group to the SSD were associated with reduced costs to the NHS. In Tonbridge, while costs to the SSD were not greater, NHS costs were significantly lower for the scheme.

Although in Sheppey the average weekly opportunity cost to the social services department in the Community Care group was almost double that in the comparison group, the combined weekly opportunity cost to the social services department and National Health Service was slightly less for Community Care cases, the difference being insignificant. This was so because health service opportunity costs in Sheppey were less than half of those for the comparison group. Indeed, if the proportion of cost met by each agency had been maintained at the level for standard provision, it would have been necessary for the health authority to contribute an average of over £900 per case to the Community Care budget during the first year alone.

In Tonbridge, the weekly opportunity cost of the Community Care group to the social services department and health service combined (£43) was substantially less than that of the comparison group (£65), the difference being significant at the 5 per cent level. Although this cost saving was greater than in Sheppey, the group differences in outcomes in Tonbridge were smaller in important respects, showing the importance of adopting the Production of Welfare approach of examining the costs of outcomes. In other words, the Tonbridge scheme spent less and achieved less. Another possible effect is that the goodwill between the care manager and the primary care teams led to improved ADL performance and hence lower cost. A further contributory factor would be that comparison group costs were made artificially high as a result of a relatively heavy usage of the day centre, due to the selection of control group cases via the day centre. However, even if the day centre costs are excluded completely from the cost totals for each group, the annual combined net revenue cost for Community Care was still more than £400 less than for the comparison group, and the corresponding weekly cost was over £11 less for the Community Care group.

Thus cost gains were almost certainly substantial. The weekly opportunity cost to the social services department for Tonbridge Community Care cases was only some 35 per cent higher than for the comparison group, while the corresponding health service cost for Community Care cases was less than one third of that for the comparison group. If the proportion of the cost borne by each agency had remained the same for Community Care as for the comparison group, this would have required a transfer payment of £700 from the National Health Service to the social services department during the first year of each case in the scheme, close to the figure of £900 found for Sheppey.

For the small proportion of the evaluated Tonbridge Community Care cases which had been taken on by the care manager based in Sevenoaks, the National Health Service provided some of this difference through joint funding of the salary of the care manager. However, since the proportion due to the health service fell sharply over the following five years, costing was carried out assuming 100 per cent funding by social services. Even if all care manager and assistant care manager posts had been 50 per cent funded by the health services on a permanent basis, this would have represented a transfer payment of only

£160 per case per year, less than one quarter of that required to maintain unchanged the proportion of funding from each agency.[1]

The benefits to users and their carers were therefore achieved at *no extra cost to the social services department and health service combined*; indeed with a likely cost saving in Tonbridge. However, a large cost saving to the National Health Service was only achieved through greatly increased SSD costs, particularly in Sheppey. Health service savings were brought about mainly through substantial reductions in all types of in-patient hospital treatment in Sheppey, and all types except psychiatric hospital in Tonbridge. Here, again, these results need treating with a little caution.

Firstly, a failure to detect extra health problems amongst comparison cases could have led to groups being inadequately matched in each area according to medical criteria. Secondly, it should be tested whether the lower levels of hospital usage amongst the Community Care group could have been as a result of reduced availability of institutional care provision in the experimental areas. Examination of Table A1.4 in Appendix 1, showing resource availability for both groups in Sheppey and Tonbridge, reveals that in Sheppey the number of hospital beds per thousand of the population over 75 was very similar for the two groups, though a somewhat greater proportion of residential care beds, particularly due to the independent sector, in the comparison area could have slightly relieved pressure on hospital beds in that area. In Tonbridge, residential care beds were evenly balanced between group areas, though the greater availability of hospital beds in Malling would have given the Community Care group better access to them, so could not have accounted for the reduced level of usage amongst the Community Care group. Thus, differences in the availability of institutional beds could not account for the vast group differences in hospital in-patient usage.

If it is assumed that the greatly reduced consumption of hospital in-patient beds amongst Community Care cases was totally or principally as a result of scheme intervention, then large numbers of both hospital and residential care beds would have been made available to others, *reducing problems of bed-blocking* and *freeing more beds for use as respite care.* A reduction in bed-blocking was also reported for post-reform community care in England and Wales by Davies and Fernández (2000), who found that the cost of community care was only some 40 per cent of that which would have been incurred if instead the user had been admitted to hospital. In Thanet, group differences in mean levels of SSD and NHS cost were quite different from those in Sheppey and Tonbridge, with annual and average weekly SSD and NHS costs for the Community Care and comparison groups being similar. When SSD and NHS costs were combined, the group differences in Thanet behaved in a similar fashion to those in Sheppey, with annual costs being insignificantly greater for the Community Care group, while average weekly costs were insignificantly greater for the comparison group. Sheppey differed from Thanet in having much greater SSD costs for Community Care cases, but with correspondingly reduced NHS costs. When SSD and NHS average weekly costs are combined, Tonbridge Community Care cases were cheaper than those in the comparison group by an amount

[1] This substantial transfer of funding for care-managed cases in both Sheppey and Tonbridge from the NHS to the SSD shows that the county's policy of monitoring only SSD costs and not those to the NHS was grossly misleading. If costs to both budgets had been recorded, this process of transfer would have been immediately apparent, providing the SSD with substantial grounds for negotiating extra funding from the NHS. It would also have facilitated the care manager's task of distributing resources equitably according to need, irrespective of who was funding these resources.

which was significant at the five per cent level, so the savings to the combined budget are probably greater than in Thanet.

Community-based costs The overall cost totals just discussed include those due to periods spent in institutional care. It is also helpful to compare the weekly costs of care of the matched groups while the user is living at home. In Sheppey, most SSD resources were used more amongst the Community Care group, the greatest cost differences being due to *care management time*, *helper visits*, *day care* and *home help*.

- The overall net average weekly SSD cost for Community Care cases was more than three times that for the comparison group.
- In contrast, the NHS cost for Community Care was little more than one half of that for the comparison group.
- However, the actual magnitude of the difference was relatively small at £1.85 compared to the group difference for weekly SSD cost of £28.69.

Most of the difference was brought about through the lower level of community nursing costs for care managed cases of £2.24 compared with £3.56 for the comparison group, the difference amounting to £1.32. The observed substantial withdrawal of nurses from cases in Sheppey following admission to the scheme probably accounts for this difference.

In Tonbridge, SSD weekly resource consumption in the community was only slightly more for Community Care cases (£28) than for the comparison group (£21). This appears to have resulted from the particular way in which the comparison group was selected; namely, through a day centre. Thus the weekly cost of day care for the comparison group was a substantial £14.16, more than two-thirds the total SSD community cost for the group. In comparison, the CCS weekly cost for day care was only £4.10. The greater overall cost of the CCS group was brought about mainly through the costs of the care manager and Community Care helpers.

In contrast to Sheppey, average weekly NHS community cost for CCS cases was slightly more, at £5.53, for Community Care than for the comparison group (£4.32). This was brought about mainly through a greater use of community nursing amongst the Community Care group (£3.03) than amongst the comparison group (£1.69). Since the community nursing input in each group showed little overall change between time 1 and time 2, the difference probably arises from the two groups being imperfectly matched.

2.3 Cost-outcomes relationships

Costs and outcomes are not independent. Over a certain range of outcomes it is found that higher costs lead to higher outcomes. Costs and outcomes were brought together in Chapter 9 and related to user and carer characteristics through cost function equations. An attempt was first made to try out the validity of the corresponding equations derived for the Thanet scheme on the Sheppey and Tonbridge data.

2.3.1 Applying the Thanet cost function equations

The Thanet equations were unable to relate costs to needs and outcomes in either Sheppey or Tonbridge in three important respects.

- The mean cost predicted by the Thanet equation for the cases in Sheppey and Tonbridge (after allowing for price inflation) did not approximate to the actual cost except for the health service costs of standard provision in each area. Instead, the SSD

cost of standard provision was grossly underestimated, while Community Care costs to both budgets were greatly overestimated in each area.

- The coefficients of individual terms in the cost function equations took on quite different values.
- The overall fit could be improved by using a different selection of predictor variables from the pool to that adopted in Thanet. Moreover, although the Sheppey and Tonbridge cost function equations resembled each other more than they did those for Thanet, they were still substantially different.

It may therefore be concluded that there are other important factors contributing to the cost-outcomes relationships which had been excluded from these equations. These would include the availability of resources for each scheme, the style of working of the care managers and the type of team and line management structure in which they were located. These factors would be expected to vary both *between areas* and *over time* (once the effects of inflation had been subtracted out).

2.3.2 Developing new cost function equations

From the above argument, one reason why the Thanet cost function equations could not adequately account for the cost-outcomes relationships in Sheppey and Tonbridge was that there was area variation in both the particular selection of case characteristics influencing the relationships and the degree of importance of each of these characteristics. The next stage in this cost-outcomes investigation was therefore to study the cost function equations obtained using the same pool of variables as a source of predictors as in Thanet, but selecting those case characteristics and outputs giving the best fit. Because expenditure to the SSD and NHS budgets was inter-related, *simultaneity between SSD and NHS costs* was allowed by using the technique of two stage least squares.

For costs, the main findings for *Sheppey* were:

- The presence of *confusion* only increased SSD cost for the comparison group. This suggested that the scheme could maintain cognitively impaired cases at home for longer, thus delaying an admission to residential care, at no additional cost to that for other cases.
- CCS cases in dependency group 1 (*long interval need*) cost substantially less to the SSD. This indicated that care managers targeted most of their resources on those in greater need.
- *Depressed cases* in CCS cost less to the SSD but more to the NHS, mainly through a greater use of acute and psychiatric hospital.
- *Total SSD cost acted as a predictor of total NHS cost*, with over three-quarters of SSD expenditure being made up for by a reduction in NHS cost. In practice, this implied that CCS input reduced the need for hospital admissions.
- Initial *ADL score*, which is associated with morbidity, was an important predictor of NHS cost in the Community Care group. This suggests that NHS resource deployment was not distributed uniformly but according to health needs.
- Annual *NHS expenditure was far greater for men*, though this result only held for CCS cases. It suggests a much greater use of hospital care for men. This finding is probably associated with men having a greater likelihood of dying (Anderson *et al.* 1998). Annual NHS expenditure was also much greater for cases who had suffered a bereavement during the past year.

- *Incontinence of urine* was an important predictor of increased NHS expenditure for the comparison group only. This suggests that CCS was able to take on board these problems without significant extra cost to the health service.

For the costs of outputs, the most important results were that, for both CCS and comparison groups, the cost to the SSD of improvements in quality of care was subject to the law of *diminishing returns*. The high level of SSD inputs in the scheme made the average cost for Community Care always more than for the comparison group, particularly for large improvements in morale. The marginal cost of an improvement in quality of care was higher for Community Care than for the comparison group except for cases where the improvement in quality of care and subjective well-being was relatively low. This suggests that the scheme would have been more efficient if resources had been more strictly rationed, through a lower budget cap.

For Tonbridge, some important findings from the cost function equations were:

- Regarding overall levels of need amongst Community Care cases, SSD expenditure was determined largely by *quality of care shortfall*, while NHS expenditure was influenced, as in Sheppey, by initial *ADL score*.
- NHS cost was reduced for CCS cases with *depressed mood*, an opposite finding to that for Sheppey. Their main source of extra support was from CCS helpers, and once this support had eased their depression they became less costly.
- *Females* in CCS incurred higher NHS cost, the reverse effect to that for Sheppey, the Tonbridge females being more socially isolated, receiving more community nursing and spending longer in hospital.
- As in Sheppey, CCS cases who had suffered a *recent bereavement* were more expensive to the health service, through a greater use of hospital and day hospital.
- Although there was no *simultaneity* between SSD and NHS costs for the Community Care group, SSD cost entered the comparison group equation for NHS cost with a negative sign. Every £1 spent on SSD costs corresponded to a £1.25 saving on NHS costs. Thus expenditure on day care and residential care was leading to a reduction in hospital admissions. This result compares with one for post-reform community care in England and Wales, in which expenditure on home care led to a 40 per cent reduction in usage of acute hospital beds (Fernández and Davies 2000).

While expenditure on SSD cost of the comparison group was influenced by *quality of care shortfall* as for the Community Care group, NHS cost for comparison cases was determined largely by *ADL score*, and superimposed on this, belonging to *dependency group 4*, together with a *passive/independent attitude to help*.

For *Tonbridge*, the most important results with respect to *outcomes* were:

- Improvements in *quality of care* and *morale* for CCS cases required increased SSD expenditure though with efficiency savings through joint supply.
- A reduction in the *activities of daily living score* was associated with additional NHS expenditure.
- Amongst comparison group cases, the clearest outcome effect of SSD expenditure was a *reduction in health problems*, this showing smaller improvements the higher the cost level.

A picture therefore emerges in which any increase in expenditure on day care and residential care is associated with both a reduction in health problems and a substantial reduction in NHS expenditure. Just as a negative general health improvement term entered the comparison group equation for Sheppey NHS costs, a similar negative term, squared, entered the corresponding Tonbridge equation, suggesting again that amongst comparison group cases NHS resources are targeted at cases whose general health is deteriorating most rapidly.

2.3.3 Cost function equations for the period spent at home

The cost function equations just described relate to costs over the entire evaluation year, referring to periods spent in institutional care as well as at home. Their objective was evaluative, testing for cost effectiveness. It is also valuable to examine cost outcome relationships for the period spent at home. These have a quite different objective of revealing the causal processes at work in the scheme.

- Community-based service costs (excluding the care manager's own time) would be expected to have a *direct effect* in improving outcomes
- The cost of the care manager's own time will
  (a) directly improve outcomes through activities related to the user
  (b) indirectly reduce other community-based service costs through activities which improve the effectiveness and efficiency of care provision, such as matching resources to needs and interweaving resources so as to achieve the maximum effect.

The next step in the investigation was therefore to focus on just the periods spent at home, and to divide costs into a care management component and other community-based service costs. Because these are likely to be interdependent, *simultaneity* was again allowed for using the technique of two-stage least squares. The results for Sheppey and Tonbridge were considered separately. Some of the main results are now summarised.

Although effective care management should improve the efficiency of resource deployment, the care management input in Sheppey had only a weak and statistically insignificant effect in reducing other community-based service costs, as shown by the *weak negative care management term* entering the equation for other community-based service costs. The apparent reason for this was that this negative effect was masked by a positive effect caused by care managers having to spend more time on those cases consuming most resources. A method for teasing out these separate effects was subsequently discussed.

The only outcome whose level affected care management cost was a *reduction in the carer's lifestyle problems*. This implies that in order to achieve improvements in the carer's daily life, it was necessary for the care manager to spend more of their own time in bringing this about. *Improvements in quality of care and morale* required additional other community-based service costs. In the case of quality of care this entered as a squared term, implying the law of *diminishing returns*; that the cost of achieving an additional improvement in quality of care increased the greater the improvement already achieved. In addition a negative joint supply term entered ($(MQ)^2$), implying that the deployment of other community-based service costs improved both morale and quality of care simultaneously, reducing the cost of each of these two individual outcomes.

In the corresponding cost function equations for the comparison group in Sheppey care management costs referred to those of the area team social worker. While care managed

Community Care input had a weak effect in reducing other community-based service costs, area team social work input had no effect, as seen by the absence of any simultaneity in the comparison group.

In the Tonbridge Community Care group, as in Sheppey, a *reduction in the carer's lifestyle problems* required an increased care management input. Another outcome to enter the care management cost function equation in Tonbridge involved a *reduction in ADL+IADL score*. This probably reflected a recovery following an acute phase. There was no simultaneity between care management costs and other community-based service costs for the Tonbridge Community Care cases.

In the case of the Tonbridge comparison group, no outcomes entered the care management equation significantly, though *morale* entered the equation for other community-based service costs. Since day care was an important feature of this group, increased day care may have been leading to improved morale.

Finally, the Tonbridge comparison group equations were interdependent, with predicted care management cost of the area team social worker being associated with *increased* other community-based service costs. One possible explanation is that any tendency for the social worker's input to improve efficiency was swamped by the high level of resources associated with cases where the social worker was particularly active.

2.3.4 Cost function equations using disaggregated care management costs

Because the cost reductions caused by the indirect effect of *care management* intervention in Sheppey and Tonbridge tended to be also masked by the high level of resources which were associated with cases having a high care management input, an attempt was made to separate out these effects for the two Community Care groups. This was achieved by breaking down the care management input into three components of activity:

- transactional, involving degree of contact with service providers
- volatility and change, arising from the care manager's ability to reduce the needs of some users over limited periods and hence the cost
- relational and attitudinal, in which the care manager was relating to the user or enabling them to accept help

In Sheppey, other community-based service costs were found to increase strongly with transactional activity but decrease weakly with volatility and change activity, while the relational and attitudinal component would not enter. It was this strong transactional component which apparently led to care management input having little effect in reducing other community-based service costs. Because transactional activity measured the degree of involvement of other agencies in caring for the user, it was the need of the care manager to co-ordinate these agencies which led to the association with higher care management costs. In Tonbridge, none of the three components of care management activity entered the equation for other community-based service costs for the Community Care group. The least insignificant component would have been volatility and change, which would have entered with a negative coefficient but a significance of only -0.22. There is therefore a suggestion that this aspect of care management activity may reduce other community-based service costs, though the small sample size renders the effect statistically insignificant.

Overall, then, the *direct* effects of care management appear to be stronger than its indirect effects:

- In Sheppey, transactional activity had no net indirect effect, but instead this time spent in co-ordinating other agencies was associated with *increased* community-based service costs. This does not mean that there were no indirect effects from transactional activity, but rather that any indirect effects were masked by the natural association between this activity and increased expenditure on a greater range of services.
- In Sheppey, volatility and change activity was stronger as an indirect effect than in Tonbridge. This suggests that efforts by the care manager in Sheppey to adjust costs in line with fluctuating needs (such as with users at risk) may be effective in reducing other community-based service costs and hence in improving efficiency.
- In Tonbridge, the three components of care management activity had no net effect on other community-based service costs.
- Despite the apparent weakness of indirect effects in Sheppey and Tonbridge, care management activity offered valuable direct effects. The care management cost function equations show that in Sheppey (Table 9.12) care management activity successfully *reduced carer lifestyle problems*, allowing carers to function more effectively. This was also achieved in Tonbridge (Table 9.14), where care manager activity additionally led to an *improvement in ADL+IADL physical functioning* of users.

The failure of these investigations to detect any strong and significant efficiency savings through indirect effects of care management activity is probably related to the absence of effective rationing of resources in Sheppey and Tonbridge either for individual cases or as an overall budget restriction. Thus *a majority of cases had expenditure levels below the 'two-thirds' limit* so were unaffected by this constraint, while *requests by care managers to exceed the limit were always granted.* Moreover, *the total Community Care budget was always sufficient* for the care manager's requirements. It was only after the evaluation period that the social services department imposed reductions on these budgets, compelling care managers to ration their expenditure. Given the high levels of resources deployed, it has been demonstrated by the cost function equations that the outputs achieved were frequently subject to the law of *diminishing returns*, when the cost of achieving a small improvement was relatively high. Under these circumstances any substantial efficiency savings would be unlikely. Nevertheless, when the whole evaluation year is considered, cost savings to the Community Care group were still considerable, a reflection largely of reduced admissions to long-term institutional care and acute hospital care.

2.4 Overall cost/outcome comparisons between schemes

With regard to outcomes, Sheppey users improved more in relation to their comparison group than in Tonbridge for a majority of measures. However, Tonbridge users achieved an almost significant improvement in ADL functioning, not found for Sheppey. While the combined weekly cost to the SSD and NHS showed no group difference in Sheppey, it was significantly less for the Community Care group in Tonbridge. There was inconclusive evidence that Tonbridge informal carers improved more than in Sheppey. Thus, overall the Sheppey scheme appeared to be achieving more but at a greater cost. Possible mechanisms might be:

- A much greater proportion of Sheppey users had no principal informal carer. This probably provided more scope for improvement in outcomes, since Sheppey users were starting from a lower base.

- In Tonbridge, there was a greater emphasis on supporting the carers. Despite small sample sizes, indicators such as reduction in burden showed an almost significant group difference in Tonbridge but not in Sheppey.
- In Tonbridge there was much stronger evidence for positive exchange between care managers and primary care teams, which could account for the greater improvement in ADL functioning, and hence to the significant reduction in joint agency cost.

2.5 Gender differences in the pattern of service use

In the statistical modelling, the gender of the user has been included as a predictor. Although carer gender is also of interest, the number of users with male carers was too small for it to be included in the predictor pool.

It has already been commented in Chapters 7 and 9 that, amongst the Sheppey Community Care group, male users cost more to the NHS. They were more likely than females to spend time in hospital and to be admitted to long-term institutional care by the end of the evaluation year. The series of cost-outcomes models described in Chapter 9 shows that gender is often a predictor of cost. It is therefore useful to assemble these results, so that they can be compared and contrasted.

Amongst the Tonbridge Community Care group, the gender effect was the reverse of that found in Sheppey, with females costing more to the NHS than males (Table 9.7). Females were more socially isolated, received more community nursing and spent longer in hospital. This reverse effect is likely to be related to the much greater proportion of users with a principal informal carer (frequently the spouse) in Tonbridge. When a user lived alone and was more socially isolated, they were more likely to be female, due to their greater longevity. These female users received more community nursing and spent longer in hospital. In contrast, the males were more likely to have a female carer, such as a spouse, who could nurse them at home.

When care management and area team social worker costs were modelled in Tables 9.12 and 9.13 for Sheppey Community Care and comparison cases respectively, it was found that gender only made a significant difference in the comparison group, with males consuming more area team social work time. This may possibly reflect a policy of the area team for providing additional direct help to older males, whom they perceived as being a particularly vulnerable group.

When care management cost for the experimental group in Sheppey was broken down into three components, the equation for other community-based service costs showed these other costs to be greater for male users (Table 9.19). This is consistent with the earlier finding, already mentioned, that these male users spent longer in hospital, so were a more vulnerable group which also required more support while at home. These findings may also relate to the sexual division of caring. Many writers adopt Walker's view that 'the implicit assumption of policies promoting community care is that.....men are not expected to look after themselves to the same extent that women are' (Walker 1981, p. 550). Moreover, Hunt (1970) and Wenger (1984) both report that older men who receive home help support are considerably less disabled than women.

Finally, the volatility and change component of care management cost in the Tonbridge Community Care group was greater for males (Table 9.21). Because volatility and change activity tended to be associated with less needy cases, such as those whose main problem

was a risk of falling, this result need not be seen as inconsistent with the result described above that females (including those with chronic problems) were overall a more vulnerable group, incurring greater costs to the NHS.

2.6 Results for Sheppey/Tonbridge and post-reform community care compared

It was possible to compare the case characteristics and resource inputs for this study with those reported by Bauld *et al.* (2000) for care-managed community care in a range of local authorities in England and Wales in the 1990s:

- Rather fewer users were living alone (61 per cent) than in Sheppey (91 per cent) and Tonbridge (69 per cent).
- They were much less disabled, with ADL scores of 1.2, compared to 1.9 for Sheppey and 2.4 for Tonbridge.
- Their PGC morale scores were higher (9.7) compared to Sheppey (7.1) and Tonbridge (7.4).
- Frequent loneliness was less common (43 per cent) than in Sheppey (53 per cent) and Tonbridge (46 per cent).

Thus this group of users was *much less dependent* and with a *better quality of life* than those in Sheppey and Tonbridge.

Differences in weekly resource inputs are also revealing:

- Care management input (0.37 hours) was less than one third of that in Sheppey (1.29 hours) and Tonbridge (1.14 hours).
- If expenditure on helper fees in Sheppey and Tonbridge had been used to purchase additional hours of home help, then the home help hours (5.5) was rather bigger than for Sheppey (4.1) and Tonbridge (3.3). However, this tends to underestimate the input to the Kent study, since helpers probably provided better value for money than home helps.
- Day care (0.45 days) was less than for Sheppey (1.16 days) but comparable with Tonbridge (0.45 days).
- Meals on wheels (1.28) were more frequent than for Sheppey (0.45) though comparable with Tonbridge (1.28).
- Turning to health inputs, hospital in-patient days (0.19) were less than for Sheppey (0.34) but comparable with Tonbridge (0.19).
- Finally community nursing (0.15 hours) was only one third of that in Sheppey (0.45) and Tonbridge (0.44).

Thus, although the 1990s study revealed relatively low dependency levels, the service inputs were fairly comparable, though with two important exceptions:

- *Care managers* spent less than one third of the time on each user in Kent.
- *Community nurses* spent only one third of the time spent in Kent, reflecting both the lower dependency and a continued policy of off-loading social care tasks to the social services department.

The implication is that users in post-reform community care would probably benefit from a *reduction in expenditure on services* in order to finance reduced caseloads, hence releasing sufficient time for performing adequately the *key tasks of care management.* This would allow:

- Closer partnership with other agencies
- More direct time with user and carer

- A more efficient and effective deployment of resources

These key tasks are discussed further in the next section.

It is clear that the process of relating the differences in cost/outcomes results between Sheppey and Tonbridge to contrasts in area characteristics and care management practice is a complex one. This illustrates a general issue of current importance. The 1998 White Paper *Modernising Social Services* requires the use of satisfaction surveys in monitoring the performance of different care management schemes. Using the same post-reform data set for England and Wales, Chesterman *et al.* (2001) have shown that levels of satisfaction are related to user characteristics and resource inputs in multi-faceted and subtle ways. Great care is therefore needed in relating differences between authorities in satisfaction levels to the quality of care management practice.

3 Care management process

The care management process in Sheppey and Tonbridge was discussed in Chapter 6. Some of the findings which illustrated particular contrasts between the two areas or new approaches not adopted in earlier schemes are now highlighted.

3.1 Raising referrals

The method of obtaining referrals in Sheppey and Tonbridge was quite different, and it is valuable to compare and contrast them. In Sheppey, the care manager was a member of the area social work team. All potential Community Care referrals were first visited by a social worker experienced with older people to assess their suitability. These workers would have been accustomed to assessing whether an older person was sufficiently needy to be eligible for a place in a care home, and would be readily able to screen out those cases not meeting the Community Care targeting criteria. The shortlist of referrals passed to the care manager was then extremely suitable, hardly any having to be rejected.

In Tonbridge, referrals to the scheme were all screened directly by the care manager. This was a much less efficient process from the point of view of the care manager. The screening process itself was time consuming and frequently led to unsuitable cases being taken on, particularly in the early stages of the scheme. This arrangement improved as referring agencies developed a better understanding of what types of referral were suitable. The time-consuming nature of the screening meant that there was less care management time available for other activities: this could have contributed to the lower levels of outcomes achieved in Tonbridge.

The difficulty with the Sheppey procedure was that the care manager was seen as one of the team and yet the throughput of Community Care cases was much smaller than that of other area team members because:

- There was a need to maintain a reduced caseload in order to be able to perform all the key tasks of care management adequately.
- The success of the scheme in maintaining older people at home for long periods meant that cases were only occasionally closed, so opportunities to take on new referrals were infrequent.

Other team members were unwilling to accept this and the care manager was unable to withstand the pressure they exerted to take on more referrals. As a consequence the care manager was unable to carry out all duties effectively. It would have taken a particularly understanding social work team and principal social worker for the Sheppey model to

operate most effectively. Yet the evaluation results demonstrate that the scheme was successful in many ways.

Thus in both schemes there were pressures leading to difficulties in carrying out effectively all the core tasks of care management. These difficulties were likely to have been most acute at times of crisis, through the care manager having no spare capacity, an effect also found in the Channelling Projects in the US (Davies and Challis 1986).

3.2 Team setting of care manager

In Sheppey, one advantage of operating in the same area as the social services team was that the care manager had to deal with only one set of people, making the process of explaining the principles of the scheme less time consuming and more effective. In Tonbridge, although most referrals came via the specialist team for older people in which the care manager was based, some came via four generic area teams. This meant having to explain the scheme to a large number of social workers, making the process of education as to the types of case suitable for referral more protracted and less effective.

3.3 Nature of the target group

The groups of cases evaluated in Sheppey and Tonbridge had contrasting characteristics at the time of the initial evaluation interview. These contrasts reflected differences in the needs of frail older people in the two areas, combined with differences in the criteria used for selecting cases for the schemes. Some of the main contrasts were as follows:

- *Informal support* was stronger amongst the cases selected for the Tonbridge scheme than those for Sheppey.
- A higher proportion of cases taken on were *living alone* in Sheppey (88 per cent) than in Tonbridge (64 per cent).
- Most of this difference arose from the much greater proportion of selected cases *living with a spouse* in Tonbridge (21 per cent) than in Sheppey (2 per cent).
- The proportion of cases taken on with a *principal informal carer* was much larger in Tonbridge (46 per cent) than in Sheppey (20 per cent).

These differences in informal support reflect in part the Sheppey care manager's policy of taking on a large proportion of cases who were *socially isolated.* In contrast, the Tonbridge care managers saw the *cognitively impaired* as a group who could benefit particularly well from the scheme and whose needs could not normally be adequately met by other agencies. Consequently a much higher proportion of these cases were accepted by the Tonbridge scheme (36 per cent) than by Sheppey (20 per cent). This led in Tonbridge to *cost savings to the health service*, who eventually agreed as a consequence to the joint funding of the posts of care manager and assistant in the Sevenoaks and Tonbridge office[2].

3.4 Financial motivation of helpers

Because of the *high level of unemployment* on Sheppey, the recruiting process required certain safeguards. Many potential applicants were either unemployed themselves or had an unemployed spouse. They would often be seeking any paid work available rather than having any particular aptitude as a helper. This made advertising in local job centres inappropriate as a means of attracting suitable helpers. Even those recruited by other

[2] This was an example of where the Kent monitoring system was used to provide valuable information; in this case, the high proportion of cases being supported in Tonbridge who were cognitively impaired.

means sometimes had strong financial grounds for applying. *A pressure group of helpers*, consisting of some in genuine need and others apparently motivated primarily by material gain, campaigned for more pay. A tension therefore existed between the aim to recruit helpers whose primary motivation was a wish to care and the demands of a group of helpers for more pay even in the absence of financial hardship. This could sometimes distract helpers from the task of providing a user-centred service. It made the *training of helpers* a greater priority. Another means of dealing with the problem was the setting by the small working group of county-wide payment bands, rather than discrete levels, for different types of helper task, allowing care managers in areas of higher unemployment to offer consistently bigger fees.

In Tonbridge *informal community support* was much stronger than in Sheppey and *voluntary organisations* and *church groups* tended to be more active. Unemployment and a need for financial reward were not dominant issues and fees were less frequently an essential part of the weekly income. The helpers recruited were more likely to be primarily interested in supporting their older users.

Once the schemes had become established, it was found in both areas that the most effective means of potential new helpers learning about the scheme and applying for work was by *word of mouth.*

3.5 Case complexity

In both Sheppey and Tonbridge, when care manager activity was classified into basic types, the frequency of occurrence of each type of activity was much greater than in a separate study made of an area team in a different authority (Goldberg and Warburton 1979). This difference may reflect an overall greater level of need of users in the Sheppey and Tonbridge schemes as well as better care management practice. There was some variation between the two areas. Thus while facilitating problem solving was more frequent in Sheppey (43 per cent) than Tonbridge (12 per cent), supporting informal carers was less frequent in Sheppey (21 per cent) than in Tonbridge (55 per cent). The overall number of SSD, NHS and voluntary services consumed during the evaluation year averaged 6.2 in Sheppey and 5.5 in Tonbridge. All these contrasts between areas reflected a combination of differences in the areas and of the care managers and their line management structure, which would also affect the target group.

4 Results of the helper evaluation

A detailed study of helpers was only undertaken in Sheppey. These helpers formed *a much younger group* than those in the Thanet project. Most Sheppey helpers were in the 31-50 age range, while Thanet also had many in the 51-60 and over 60 ranges. Eighty per cent of the helpers were *married*, compared to less than two-thirds in Thanet, and nearly three-quarters had *at least one child under seventeen living at home*, compared to only 30 per cent in Thanet. Despite the large proportion of Sheppey helpers with young families, *the family did not cause a problem* in the caring process. On the contrary, when helpers had a family, three-quarters stated that their family had called on the older person, while for one helper in five the user had visited the helper.

Experience While in Thanet a substantial proportion of helpers had prior experience in nursing or clerical work, in Sheppey a greater proportion had worked as a *care assistant* or had experience as a *housewife with children.* The care manager sometimes provided *individual training* in specific tasks. This was supplemented by *monthly coffee mornings*

for helpers, offering opportunities to socialise, ventilate their feelings over the difficulties involved in caring and meet others involved with the same older person. The second half of these meetings was geared to improving skills through a talk given either by an outside speaker or by one of the care managers.

Motivations The motivations of helpers for joining the Sheppey scheme were distributed rather differently from those for Thanet. There was a greater emphasis on finding *an interest outside the home* (46 per cent) which was understandable in view of the large proportion with children who had recently reached school age. In Thanet, where the helpers included many who were older, the wish to fill up spare time or do something stimulating was more frequently expressed. Also, the wish to repay help received, almost absent in Sheppey, applied to one Thanet helper in five, perhaps reflecting that some of these helpers, who could be classed as young older people, were assisting the older elderly. A much higher proportion of Sheppey helpers (one in four) wanted *experience for a career* than in Thanet. Indeed a number of Sheppey helpers subsequently obtained jobs in the caring professions, such as an assistant housing warden, a day centre staff member or an assistant care manager.

A cluster analysis showed how different motivations tended to be associated in Sheppey. Thus:

- A wish to fill up spare time was closely linked to a wish to take their mind off their own worries.
- A wish to meet people was often accompanied by the motivation to do something stimulating.

Rewards Helpers were also asked about the rewards they experienced in their work for the scheme. Nearly two-thirds were rewarded by their *relationship with the older person*, and over one half by the *sense of usefulness or purpose*. Over one half were rewarded by seeing the *dependence of their users* and by their *liking for the user*. It was found that some rewards clustered together. Thus:

- Having something to do was closely associated with getting out of the house, and more weakly with the hope of a social work or other career.
- A sense of usefulness or purpose was associated with an admiration or liking for the user.

Drop-out The motivations and rewards expressed by helpers influenced the factors which led some helpers to have left the scheme. By the time they were interviewed, typically one year after joining the scheme, 33 per cent had already left. Of these, the most frequent reasons for leaving were *insufficient work*, *alternative employment* and a *change in personal or family circumstances*, each applying for about one helper in three. Only two of these helpers (13 per cent) had dropped out as a result of insufficient pay, suggesting that the bulk of helpers were not experiencing financial hardship as a result of payment levels. Interestingly, a cluster analysis showed that the items most closely associated with *helper dissatisfaction* were *being motivated by wanting experience for a career*, and *being rewarded by the hope of a social work or other career*. This suggests that the 'career' group of helpers derived less overall satisfaction from the work.

5 How this study relates to more recent developments in care management

The schemes in Sheppey and Tonbridge were examples of intensively managed Community Care based on the PSSRU model which had its origins in the Thanet project.

They were characterised by having care managers whose caseloads were approximately 30 persons, and they were targeted at cases who had a substantial probability of entering a care home, had they not been users of care-managed Community Care. To ensure continuity, the care manager making the initial assessment also, whenever possible, set up the care package and was responsible for its implementation and the subsequent support of the case. The teams could recruit and deploy resources with great flexibility using their budgets, and did so in many ways. However, the most general manifestation of this was the recruitment of helpers. Some were paid more than expenses, some expenses only, and some received no payment. The quasi-informal status of helpers meant that their motivations resembled those of volunteers more than of paid employees.

(a) Kent development 1987 onwards

In Kent, this approach changed in 1987 following reorganisation of the county's Community Care scheme. Firstly, assessments were carried out by a specialist assessment team before being referred to a separate implementation team. This had the advantage of assessors being able to develop more expertise, but led to a lack of continuity in the care provided. Older users can feel overwhelmed by a lot of new faces, particularly in their early contact with the scheme. In Sheppey and Tonbridge the assessment and implementation phases were allowed to overlap so as to allow a smooth transition for the older person.

Secondly, care managers and home help organisers joined home care teams. Their roles became much more blurred, though some distinction still remained, with care managers retaining a more restricted caseload of higher need cases. The advantage of this change was to allow a more integrated approach by the two types of worker. In the KCCP, Home Help Organisers were willing to have some of the cost met by the Community Care budget, this arrangement for budget transfer having been sanctioned by the local director. However, in Sheppey and Tonbridge local managers had not taken this initiative, so that care managers had to negotiate separately with a Home Help Organiser for a service financed out of the home help budget. Following reorganisation, care managers could now allocate home help hours directly and pay for them out of their budget, instead of having to negotiate. Nevertheless, the caseloads of care managers were greater than before, preventing them from carrying out effectively all the core tasks of care management. This resulted in *a less intensive form of care management.*

(b) Post-1993

Following the publication of the community care white paper Caring for people in 1989, subsequent legislation allowed a number of community care reforms to be implemented across the entire country. In particular, joint assessment teams were now used to process referrals for local authority and private residential care and community care.

The funds used to subsidise places in private homes were transferred from the Department of Social Security to the local authority. This had the advantage that the assessment process was made more systematic, and that the anomalies in the levels of subsidy for local authority and private residential care were eliminated. Moreover, charges for services made on recipients of community care have been increased by most local authorities to make them more comparable with those for residential care. Nevertheless, this has resulted in some local authorities imposing *punitive levels of charging*, leading to some older people becoming resentful or anxious, particularly when they have no principal informal

carer, and occasionally refusing to pay for services which they are assessed as needing (Bauld *et al.* 2000).

Not only did the cases assessed as suitable for residential care have to meet a certain minimum level of need. Those accepted for community care also had to meet certain *eligibility criteria* decided by the local authority. Although the aim was to ensure that community resources were allocated to those in greatest need, the rather narrow way in which care managers in some authorities interpreted both the criteria and the circumstances considered to be important may have restricted the scope for serving those older people who could benefit most, the aim of the intensively care managed schemes. The criteria themselves did not usually restrict cases just to those who would otherwise have been eligible for residential care. Indeed, the caseloads of post reform care managers across the country are generally much less needy though bigger in size than in the intensive schemes in Sheppey and Tonbridge. Thus intensive care management as it was understood in the Sheppey and Tonbridge schemes is very different to the lower level care management currently practised across the country.

The evaluations have some important implications, both historically and currently. A selection of these are discussed in the following two sections. Care must be taken in suggesting how the results of these evaluations may be applied today, since many aspects of the social policy environment have changed. Topics which had more relevance at the time than today have been discussed first in their historical perspective (section 6) while those more applicable to the current situation are treated in section 7.

6 Historical implications of these evaluations

6.1 Use of quasi-informal helpers

Because in the Sheppey and Tonbridge schemes the care manager's time was restricted and a home help was limited to performing certain tasks over a relatively short period during office hours, there was a need for a flexible source of help, offering in particular assistance with personal care and companionship and available additionally during the early morning, evening and weekend. It was for this reason that quasi-informal helpers were recruited who were not restricted to working at certain times only and whose contract with the user allowed them to offer assistance in a wide variety of ways. It was clear that the role of these helpers was crucial to the success of these schemes. Without them a large proportion of the users would have been unable to continue coping at home. The helpers must also have contributed much to the improved quality of life of users, through building up warm relationships with them and offering regular sustained care.

It is regrettable that this method of support was not used more generally across the nation in the support of frail older people. A plentiful supply of suitable helpers could be found from a wide range of backgrounds throughout Kent. Social workers have always tended to be reluctant to use volunteers to supplement the support they offer their users (Holme and Maizels 1978; Stevenson and Parsloe 1978). Moreover, the use of helpers requires a substantial time input by care managers in recruiting and maintaining a pool of helpers, which is only possible with a restricted caseload.

The feasibility of using helpers today is less clear. While the supply of manpower to provide social care is decreasing, the numbers of frail older people needing support are rising. Moreover, the ability of women to provide care is diminishing, due to the longer hours spent in employment. Also, the motivation to care is decreasing, due to the

increasing market value of time. Labour supply is found to be very responsive to wages offered, particularly for women (Killingsworth 1983). Hence payment levels could have a large effect on the supply of helpers. This might mean that some of those who had been willing to be paid helpers at the time of the evaluations might now expect a regular wage and improved conditions of service. The diminishing availability of potential helpers could therefore require levels of fees to have risen well above the rate of inflation in order to attract sufficient numbers of helpers today. It could also imply that the use of helpers now would be seen as a greater form of exploitation than it was previously. Nevertheless, the flexible times involved in being a helper and the rewarding nature of the work would probably still be an attraction for many today, particularly mothers with young families or the younger retired.

6.2 Supporting the cognitively impaired

At the time that the Sheppey and Tonbridge schemes were implemented, care of the cognitively impaired in the community was seen as highly problematic. Traditional forms of support for frail older people such as home helps, day care and sheltered housing could frequently not cope, and meals on wheels could be of little use if the user needed companionship and encouragement before they would eat. Informal carers frequently reached a stage at which the stress they experienced became intolerable. Residential care was seen as unsatisfactory, its disorientating effect on the cognitively impaired reducing their physical functioning still further as well as their morale and unsettling other residents. Moreover, the supply of care home beds specifically for the elderly mentally infirm was very limited. Also, the NHS was beginning to reduce their supply of long term beds in psychiatric hospitals.

Both schemes proved to be remarkably effective in supporting this user group. This is illustrated in the case studies 1.3 and 2.4 in Appendix 4. Indeed the Tonbridge scheme deliberately took on a large proportion of cognitively impaired users as part of their policy of co-operation with the health service. The success of the schemes was particularly as a result of the intensive support which helpers could offer:

- Frequent check-up visits or longer periods of supervision could reduce the risk of fire or accidents.
- The removal of rotten food and piles of wastepaper also improved safety.
- Some of the techniques of reality orientation were applied by helpers, such as reminding users about the time of day and where they were.
- Time was spent in providing companionship and in assisting some users to relearn forgotten skills such as knitting.

The cost of such care was usually small in comparison to that of a care home bed.

The Lewisham intensively care managed scheme demonstrated how a specialist multi-disciplinary team for the cognitively impaired could successfully develop the techniques for supporting this user group (Challis *et al.* 1997). However, an opportunity was lost in the failure to extend the support at home of the cognitively impaired across the nation. Fortunately, post-reform care management has been able to provide support to a substantial proportion of the cognitively impaired, though the failure to use helpers and to offer sufficiently intensive help has meant that the severely cognitively impaired could not always be adequately catered for (Bauld *et al.* 2000).

7 Current implications of these evaluations

7.1 Co-ordination between social and health services

In the Tonbridge scheme, care managers reported that close links were forged between care managers and primary care teams. This was achieved through much initial negotiation when the scheme was first being set up, and by keeping GPs and community nurses well informed about the progress and problems of their users on an ongoing basis. Primary care teams were willing to reciprocate. They soon became aware of the types of user which were suitable for the scheme, and GPs were willing to use special referral forms devised by care managers. This close co-operation proved extremely beneficial to both agencies. In Sheppey, there was less scope for working together, apparently a result of the GPs' resistance to the idea of supporting frail older people at home, and their reluctance to be called out when users were unwell. Nevertheless, the care manager was still able to build up good working relationships with community nurses, ward sisters and the local consultant geriatrician, which led to some useful reciprocal arrangements including improved hospital discharge planning.

There was evidence for a need for still closer co-operation between the two agencies. These evaluations have shown that intensive care management intervention in both Sheppey and Tonbridge led to considerable savings in NHS expenditure and a substantial reduction in hospital bed-blocking. Yet before the results of this evaluation were known, both health and social services were unaware of the extent of these savings. If they had been known, social services would have had a very strong case for negotiating a considerable transfer of funds from health to social services. As it was, the only payment made was for the joint funding of two care management posts in the Tonbridge area, which was negligible in relation to the total cost savings made to the NHS.

One way of illuminating this would have been for the care managers to have taken into account health services expenditure in their monitoring of costs:

- Their menu of unit costs could have included both hospital and domiciliary NHS services, as well as those to the social services department. This would encourage care managers to think about the costs of their users more holistically, and hence should improve the efficiency and effectiveness of the schemes. Thus, it is absurd for a care manager to be aiming to minimise the SSD costs of a user while ignoring health costs if as a result these health costs rise substantially. It would also lead to more negotiation between care managers and health services personnel over resource deployment.
- Their quarterly costing sheets could have also included these health service costs.

A change over time in the balance of expenditure between the two agencies would then have become apparent. This points to the need for still greater co-operation between social and health services, at both field and managerial levels.

The clear benefits for both schemes of building up good working relationships with the health service, together with the further advantages which joint heath/social service costing would have brought, are highly relevant in suggesting how practice could be improved today. The current tendency for care managers to carry high caseloads may well be a false economy, one result being that there is not sufficient time for adequate liaison between care managers and the health service (Bauld *et al.* 2000). Poor communication between the two agencies over hospital discharge is still widespread (Kerr *et al.* 2000). Joint costing to both agencies would still be very desirable. Moreover, the current government wish to promote partnership and offer funding to help achieve this (Cm 4169,

Department of Health 1998) makes the present time very suitable for trying to develop these closer links. That such partnership is possible at the highest level is illustrated by the recent appointment for Herefordshire Health Authority of the director of social services and housing as its new chief executive (Wellard 2000). However, if both agencies' funds were pooled, there would need to be in place safeguards to prevent medical staff from insisting on expenditure patterns which only reflected their own attitudes, and not those of social care staff.

7.2 The new managerialism

One important recommendation of the Seebohm Report was that social workers in the new social services departments should improve their professional status through such means as a shared knowledge base and improved career structure, to make them more comparable to the medical profession in the NHS. Organisations like the Central Council for the Education and Training of Social Workers (CCETSW) and the National Institute of Social Work were set up, though they had only limited success and failed to improve the influence or standing of social workers to any extent. Their efforts were undermined by some aspects of the Younghusband Committee report (Ministry of Health 1959). This led to a two tier system of courses, both leading to the Certificate of Qualification in Social Work (CQSW). The high standard of this qualification as reflected in the university courses was reduced by its being awarded for some less advanced courses provided by polytechnics and colleges of further education. This reduced the standing of social work generally. Moreover, social workers were overwhelmed by a fear of elitism which led to insufficient hierarchy in the profession. CCETSW provided insufficient control over social work course providers, encouraging a wide range of educational establishments to offer courses, leading to slippage in standards. Today, the social work profession has become stronger. The overall standard of social work courses is higher and the career structure has improved. Initiatives to improve their professional standing include offering field social workers expensive research opportunities at Exeter University.

Nevertheless, there are still many ways in which the social work profession could learn from the care management experience of the Sheppey and Tonbridge schemes. These took on board the Seebohm view of strengthening the social work profession:

- The *working group* of experienced care managers played an important role in improving the quality of care management. As well as setting out in a procedures manual county-wide methods for tackling various aspects of care management, they laid down guidelines for advertising for care managers and job descriptions. This was crucial in attracting suitable personnel with a social work or equivalent background who would be active in the field, and avoid appointing those with a more administrative approach.
- *Monthly county-wide meetings* of fieldworkers offered care managers an opportunity to discuss and share practice issues and problems. Talks by outside speakers and presentations by care managers on individual cases as a peer review also helped to add to the knowledge base.
- *A strong and supportive assistant director* of field services encouraged two way communication between field staff and senior management, which also included line managers. Six-monthly meetings of care managers, line managers and senior managers, chaired by the assistant director, allowed a range of policy issues to be aired, as well as allowing the author to present individualised feedback forms to all field staff, their line managers and senior managers for general discussion.

These activities for improving practice required the investment of time which again required maintaining caseloads at manageable levels.

7.3 The support of informal carers

A central feature of both schemes was the involvement of informal carers in both the assessment process and the provision of care. Thus the Sheppey care manager would sometimes use family techniques in making a group assessment of user and carers so that their interaction and interplay of ideas could be observed. Carers were recognised as being central in providing much of the care for a substantial proportion of cases, particularly in Tonbridge. Pains were taken not to dislodge carers from helping the user, but instead to provide them with support and relief to enable them to continue in their caring roles. However, it was sometimes necessary for the care manager to examine with the carer alternative ways for them to provide assistance if this was in the user's best interests. For example, the first case study in Appendix 3 illustrates how it was desirable for the care manager to encourage the carer to be less over-protective towards her husband following his strokes. It was frequently found that the knowledge that a care manager was taking overall case responsibility encouraged carers who had partly withdrawn to become fully re-involved in providing care.

The much larger caseloads of care managers in post-reform community care has meant that there has more recently been less scope for working with informal carers (Bauld et al. 2000). However, the government have recognised the importance of supporting informal carers. The White Paper *Caring for People* (Department of Health 1989) acknowledged that the informal sector provided the bulk of care and viewed carers as a resource along with statutory, private and voluntary provision (Twigg 1989). Although the White Paper viewed carers as taking on this role willingly, it recognised their need for relief from stress. Following the community care reforms, the Carers (Recognition and Services) Act laid down their right for a separate assessment. Although there is evidence from the Social Services Inspectorate that the number of carer assessments is increasing, the report *With Respect to Old Age* of the Royal Commission on long term care (1999) stated that the quality of support which carers receive remained a matter of chance and that the response to their needs was generally inadequate. Parker (1999) has attributed this to inadequate financing to support the implementation of the reforms. Improved funding of care management in social services departments could allow the appointment of more staff carrying smaller caseloads. Some of the techniques used in Sheppey and Tonbridge to support informal carers could then be beneficially applied in current care management.

7.4 Care managers and continuity of care

The Sheppey and Tonbridge schemes benefited from care managers who took on full case responsibility from referral through assessment to case closure. Their hands on approach kept them in regular contact with their users and informal carers, and helpers could provide instant feedback should circumstances change. This provided a feeling of stability to users, who frequently find it difficult to adjust to staff changes.

One unsatisfactory consequence of the community care reforms has been to reduce the extent to which care managers can provided sustained support of their users. The initial assessments are now carried out by specialist teams which disrupts the user's experience of continuity of care during the early stages when they are often most vulnerable. The current need to screen and assess users for entry to residential care as well as for community care, taking into account the authority's eligibility criteria, points to some

advantages in having a specialist assessment team. However, to be most effective and acceptable to the user, the initial assessment in Sheppey and Tonbridge was spread over several visits. Hence the assessment process overlapped with the planning and deployment of care packages, providing a smooth transition for the user.

The regular contact with the care manager which continued while a case was open allowed the situation to be regularly *reassessed* as circumstances changed. In post-reform community care, this activity appears to be normally restricted to infrequent reviews (Bauld *et al.* 2000). It is therefore likely that care packages today frequently fail to respond to the changing needs of the user.

The current purchaser-provider split in resource allocation has meant that users must often rely on some of their support from the independent sector, such as the provision of home care during out of office hours. This leads to a greater range of care staff being involved with individual users, who can find this unsettling.

This evidence suggests there might be some advantages in returning to a two-tier system, in which the most needy users are supported by care managers who are qualified and experienced social workers and carry a restricted caseload of some 30 cases. There could then be opportunities to recruit and deploy helpers, maintain regular contact with users and carry out periodic reassessments. Indeed, the cost of employing care managers with low caseloads would be small in comparison with the total package costs (Challis *et al.* 1989).

APPENDICES, REFERENCES AND GLOSSARY

APPENDIX 1

DETAILS ON METHODOLOGY

1 Details of the process for selecting a control group

Sheppey

Control cases not receiving Community Care were drawn from Faversham, situated near the North Kent coast opposite Sheppey. Faversham was covered by one of the three social work teams in the social services division which included Sheppey. Just as the care manager in Sheppey had made use of the area team social workers to screen referrals, the evaluator obtained Faversham control cases through the social workers. The evaluator found these cases, like the Community Care cases, to be well targeted. Sixty cases were given initial interviews of which only two were judged to be unsuitable. Of the remaining 58 cases, 27 (47 per cent) had informal carers who were interviewed, a much higher proportion than in Sheppey. Further details on the screening process in the Community Care and comparison groups are given in the next section.

Tonbridge

There were important differences from Sheppey in the method by which a control group for the Tonbridge and Malling Community Care cases was obtained. Firstly the area from which the control cases were drawn was Tonbridge, which was also part of the area from which Community Care cases were obtained. There was therefore a danger that the scheme might have already 'creamed off' the most suitable cases for Community Care, leaving less well targeted cases for the control group. It was therefore incumbent on the analysis to demonstrate that this was not the case. It was also possible that control cases which had already received an initial assessment interview were subsequently taken on as Community Care cases before the follow-up interview was due. Such 'contaminated' cases would have to be excluded as control cases. In practice, this only happened on one occasion.

Secondly, it was not possible to negotiate for control cases to be selected via an area social services office. Instead, referrals to a particular day centre were used as source of comparison cases, the procedure also followed in the Darlington Community Care Project (Challis *et al.* 1996). Because some of these referrals were unsuitable for day care but would have been appropriate for Community Care, it was possible to make the control group more representative of the type of cases encountered through a resources team for older people. As with Sheppey, it was necessary to demonstrate the degree to which the control group had similar characteristics to the Community Care group. Later in this appendix it is demonstrated that after matching the majority of user and informal carer needs were not significantly greater for the control group. In other words, both factors causing Tonbridge controls to have different characteristics from the experimental group had been substantially overcome. Out of 46 cases interviewed, 9 were considered by the evaluator to be inappropriate as potential recipients of Community Care, while a further case had to be rejected through dying within a fortnight of the initial interview. This left 36 cases suitable for evaluation.

2 The screening of cases for each group

Sheppey

The details of the screening process for both the experimental and control groups are summarised in Table A1.1. The list of cases which were seen by the evaluator was obtained after an initial process of screening by the area social work team which normally included a visit, followed by discussions with the care manager regarding suitability. This initial process was not logged and resulted in a short-list of 53 cases seen by the evaluator, who regarded them all as potentially suitable. Apart from one case who was admitted to long-term hospital care a few days after the evaluator's visit, all remaining cases were assessed by the care manager. Of those interviewed in residential care with the prospect of returning home to Community Care, three decided on further reflection to remain where they were so withdrew. Eight of the cases interviewed at home were sufficiently needy but would not accept the help offered by the care manager. Some of these continued to be monitored by the care manager and three later accepted help from the scheme, though this did not occur until after the evaluation period. After excluding these cases, a group of 41 remained prior to matching.

Because the evaluator was directly involved in the selection process of the control group from an early stage, more details of the screening could be made available. The evaluator made regular visits to the area team at approximately monthly intervals, and recent referral sheets were studied, together with any accompanying case notes.

Table A1.1 The screening of Sheppey and Tonbridge cases for each group[1]

	Sheppey		Tonbridge	
	E N	C N	E N	C N
Original shortlist of cases	-	76	-	52
Users lost to external events:				
1. Long-term residential care	-	6	-	
2. Long-term hospital care	-	5	-	
3. Death	-	3	-	3
User too unwell/confused to be visited	-	1	-	1
User too independent	-		-	3
Informal carer too independent	-	1	-	
Seen by evaluator	53[2]	60		
User lost to external events:				
Long-term hospital care	1			
Seen and approved by care manager	52	-	36	-
Seen by evaluator			36[3]	45
Insufficiently needy		2		9
User lost to external events:				
1. Long-term residential care	3		1	
2. Long-term hospital care			2	
Unsuitable for Community Care				
- refused offer of help	8			
Final groups before matching	41	58	33	36

Notes:

1. E: Experimental group C: Control group
2. The Sheppey experimental cases were seen by the evaluator before the care manager's first visit. Details of loss of experimental cases before being seen by the evaluator were not logged.
3. The Tonbridge experimental cases were seen by the evaluator after the care manager's first visit. Details of loss of experimental cases before being seen by the care manager were not logged.

Potentially suitable referrals were subsequently discussed with the social worker regarding their appropriateness. This procedure resembled that adopted by the care manager in obtaining referrals in Sheppey, and resulted in a shortlist of 76 cases. The main difference from Sheppey was that there was frequently a longer time interval between the older person having been seen by the social worker and subsequently visited by the evaluator. Consequently 14 cases were found to have been lost to external events, 6 to long-term residential care, 5 to long-term hospital care and 3 having died. These lost cases were likely to have been rather more needy than those remaining. This would have the effect of making the comparison group as a whole less needy than the Community Care group. Later in this appendix it is shown that while the unmatched experimental group was indeed more needy than the control group with respect to a few indicators, these differences were largely eliminated by the matching process. A further 2 comparison cases were lost, one because the older person was too unwell to be interviewed, and the other because the informal carer was found to be unwilling to accept help. The remaining 60 cases were seen by the evaluator. Of these, only 2 were felt to be insufficiently needy, leaving 58 cases suitable for evaluation.

Tonbridge

Details of the process by which community case and comparison group cases were screened are shown in Table A1.1. The large number of referrals for Community Care were made directly to the care manager, though, of these, referrals from social workers for older people from the resources team or from social workers in other area teams would have already undergone some screening, though not as rigorously as was the case in Sheppey. By a gradual process of education, the cases from outside referring agencies such as GPs and community nurses became progressively more appropriate, though a number still remained unsuitable. No record is available of the referrals which were rejected by the care manager. Many of these would have been re-referred. Of those cases which had been approved by the care manager and received an initial assessment interview, every fifth case (starting at case 20) was selected for evaluation, this resulting in 36 cases. After the evaluator had visited, a further 3 cases were lost to external events before they had been significantly helped, leaving 33 evaluated Community Care cases.

In selecting control group cases, the source used was referrals to a social services department day centre in Tonbridge. This had the advantage that, as in the experimental group, referrals arrived from a range of agencies from both within and outside the social services department. The disadvantage was that those cases referred for day care which were also suitable for Community Care tended to form a more specialised sub-set of the type of cases selected by the care manager as well as receiving a disproportionate amount of day care. Referrals were scrutinised which had been made over a period of years, and included those cases which were classed as unsuitable for day care, as well as those who subsequently attended. The screening process is again summarised in Table A1.1. With the assistance of the superintendent of the day centre an original shortlist of 55 cases was obtained. Of these, 3 were lost through death before the evaluator could visit, another was regarded by the social worker as too disorientated to be interviewed and in a further 3 cases the users turned out to be too independent to have been suitable for Community Care. This left 45 cases which were seen by the evaluator. As anticipated, the screening process had been less efficient than in Sheppey, and the evaluator eliminated a further 9 cases as being insufficiently needy, leaving 36 comparison cases for analysis.

Table A1.2 Significant differences at the 5% level by group and mean values before matching in Sheppey

	Mean values		Significance level
	Experimental	Control	
(A) User characteristics			
Environmental conditions			
Unsuitability of housing	0.88	1.19	<0.01
Informal support			
Whether living alone	88%	67%	<0.05
Whether living with spouse	2%	16%	<0.05
Whether has principal informal carer	20%	47%	0.01
Whether going out at least once weekly	44%	66%	0.05
Social resource impairment (OARS)	3.98	3.21	<0.001
Activities of daily living			
Help needed getting into bed	2.00	1.60	<0.05
Help needed washing soiled linen	2.22	1.52	<0.01
Adl score	2.37	1.71	<0.05
Self-rated ability to cope	5.39	6.76	0.01
Health status			
Depression	1.32	0.95	<0.05
Anxiety	1.32	0.71	0.001
Cognitive impairment	0.61	1.05	<0.05
Sample size	41	58	
(B) Informal carer characteristics			
Ways in which informal carer helps			
Help for user with light housework	2.63	3.56	0.01
Help for user away from house	2.75	3.19	0.05
Behaviour causing problems			
Incontinence of faeces	0.63	0.15	<0.05
Physical and mental health			
Extent of effect on physical health	0.38	1.11	0.01
Sample size where informal carer interviewed	8	27	

Notes:

1. Where means have been expressed as percentages, chi-square tests with a continuity correction have been used, as the variables were dichotomous. Otherwise analysis of variance was used to determine significance levels.

3 Group differences

In order to be able to proceed with subsequent analysis, it was necessary to apply significance tests to identify any differences between both the unmatched and the matched groups at the time of the initial assessment. The wide range of user criteria tested covered basic characteristics (age and sex), housing problems, financial difficulties, informal support and loneliness, activities of daily living, the need for extra help, physical and

mental health (including morale, depression and cognitive impairment), recent bereavement and attitude to help. These amounted to 67 user criteria in all. Informal carer characteristics, based on smaller numbers of cases, covered basic descriptors, layout of home, the ways in which the informal carer helped, the types of user problem behaviour encountered, help received from others, effects on the carer's lifestyle, the carer's physical and mental health, attitude to caring and the user-carer relationship, resulting in 47 informal carer characteristics in all.

Sheppey

Unmatched groups are compared in Table A1.2. Although most indicators (54 out of 67 user criteria and 43 out of 47 informal carer characteristics) showed no significant group effects so were excluded from the table, some important differences nevertheless remained. Thus, the Community Care group appeared more isolated, with significantly greater numbers living alone, having no informal carer or not getting out in the week. The Community Care group was also more dependent, with a significantly higher mean activities of daily living score, based on the need for help with feeding, toileting, dressing, washing or bathing, transfer from bed or chair and the presence of incontinence. Although the Community Care group were significantly more depressed and anxious, the control group were more cognitively impaired. Regarding informal carer characteristics, the control group carers appeared to offer more help with household tasks, while those from the Community Care group found incontinence of faeces to be more frequently a problem. The physical health of informal carers was affected much more amongst the control group.

After matching, it can be seen from Table A1.3 that most of these differences became no longer significant, as expected. However housing problems, which had been significantly greater for the control group before matching, now showed an even greater contrast. The control group also exhibited a greater need shortfall with respect to weekly household tasks. Turning now to the informal carer, the effects on the carer's physical health was still much greater amongst the control group. However, in view of the large number of test variables used, the agreement between matched groups may be regarded as satisfactory.

In addition to these differences between users and their informal carers in the two areas, the areas themselves showed some differences regarding the availability of resources. A comparison of the availability of some important resources between experimental and control cases in Sheppey and Tonbridge is shown in Table A1.4. Measures of resource availability have been expressed for every one thousand of the population aged seventy-five or over during the evaluation period.

Firstly, although Sheppey and Faversham were both located in the same social services division, the social service resources available were not normally shared. Thus although the availability of care home accommodation in Sheppey was poor (35 beds/1000 75+) the corresponding figure in Faversham was still smaller at 27 beds/1000 75+. However, a compensating factor was the greater availability of private or voluntary registered home places in Faversham (18/1000 75+) compared with only 4/1000 75+ in Sheppey. This might have led to slightly more control cases entering residential care than would have been the case if the control group had all been drawn from Faversham. The day centre in Sheppey provided 14 places/1000 75+ daily compared with none in Faversham. Moreover, the Age Concern day centre places in Sheppey (49/1000 75+) greatly outnumbered those in Faversham (19/1000 75+).

Table A1.3 Significant differences at the 5 per cent level and mean values by matched group in Sheppey

	Mean values		Significance Level[1]
	Experimental	Control	
(0) **User characteristics**			
Environmental conditions			
Unsuitability of housing	0.78	1.28	<0.001
Activities of daily living			
Help needed with gardening	2.72	3.53	0.01
Self-rated ability to cope	5.22	6.56	0.05
Need for extra help			
Need for extra help with weekly housework	2.47	3.59	<0.05
Sample size	32	32	
(B) Informal carer characteristics			
Housing/accommodation			
Access difficulties	1.00	2.00	0.01
Physical and mental health			
Extent of effect on physical health	0.38	1.44	0.001
Overall ratings of interviewer			
Warmth expressed towards older person	1.75	2.56	<0.05
Sample size	8	9	

Note:

1. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. An analysis of variance could then be used in determining significance levels.

Secondly, Sheppey and Faversham were located in different health authorities, with Sheppey being attached to Medway, while Faversham was attached to Canterbury and Thanet. This led to differences in NHS resource availability between areas. Although the supply of geriatric hospital beds and acute beds was roughly the same in each area, the number of day hospital places per day was only 6/1000 75+ in Sheppey compared to 16/1000 75+ in Faversham. However, since the day centre in Sheppey (14 places/1000 75+) offered some of the facilities of a day hospital, such as physiotherapy and chiropody, the overall day care provision in the two areas roughly balanced. The greater supply of psycho-geriatric hospital beds in Sheppey is roughly balanced by the smaller number of geriatric hospital beds. The likely effect on costs of the greater availability of geriatricians in the control area is unclear.

Table A1.4 A comparison of the availability of resources in the Sheppey and Tonbridge experimental and control areas during the evaluation period

	Sheppey		Tonbridge	
	Experimental	Faversham Control	Malling Experimental	Tonbridge Experimental and Control
Social service department				
Residential care beds/1000 75+	35	27	44	44
Day care centre places/1000 75+	14	0	0	13
Private/voluntary sector				
Registered residential home beds/1000 75+	4	18	11	11
Age Concern day centre places/1000 75+	49	19	0	0
National Health Service				
Geriatric hospital beds/1000 pop 75+	15	20	21	14
Psycho-geriatric hospital beds/1000 pop 75+	10	3	17	8
Acute hospital beds/1000 pop 75+	10	12	14	15
Orthopaedic hospital beds/1000 pop 75+	6	6	4	7
Day hospital places/1000 pop 75+	6	16	13	9
Community nursing staff/1000 pop 75+	6	5	6	4
Geriatrician sessions per week/1000 pop 75+	1.3	3.3	1.2	1.6

Source of information: Kent County Council Planning Department figures for 1982.

It may therefore be concluded that while there appear to be no substantial differences in the overall availability of resources between areas, Faversham cases had to rely more heavily on residential care in the private/voluntary sector as a substitute for local authority care, while in Sheppey cases relied more on the joint funded day centre in place of a day hospital.

Thirdly, 5 of the 32 control cases were drawn from Tonbridge and not Faversham, leading to further possible differences in the availability of resources. There was a slightly greater supply of local authority residential care beds in Tonbridge (43/1000 75+) than in Sheppey (35/1000 75+). Moreover there were more registered private and voluntary home beds in Tonbridge (11/1000 75+) than in Sheppey (4/1000 75+). This might have led to slightly more control cases entering residential care than would have been the case if the control group had all been drawn from Faversham. However, the availability of geriatric hospital beds in the two areas was similar. Also the supply of day centre and day hospital places was equally balanced between Sheppey and Tonbridge. However there did appear to be more community nursing activity in Sheppey (6.2/1000 75+ whole time equivalent staff) than in Tonbridge (3.5/1000 75+). Nevertheless the overall balance between resources in Sheppey and Tonbridge is tolerably good.

Tonbridge

As in Sheppey, significance tests were used to identify any difference between unmatched and matched groups regarding characteristics relating to both the older people and their informal carers. From Table A1.5 for unmatched groups it can be seen that seven factors relating to the older people and a further seven relating to their informal carers showed significant differences. The Community Care group appeared more socially isolated. Regarding health problems they suffered more from deafness, but less from giddiness than the comparison group. Of greater importance was the fact that cognitive impairment amongst the Community Care group was almost twice that of the comparison group. Although the need shortfall amongst Community Care cases was significantly greater for tasks involving rising and retiring or daily housework, the overall number of additional resources required was less than for the comparison group.

Problems for informal carers appeared systematically worse in the comparison group, with more access problems to housing and night disturbance. The physical health of informal carers in the comparison group was affected more severely, as was the Malaise score of stress symptoms and the mental health rating. All these problems were associated with more tension in the home and greater hostility expressed towards the older person amongst comparison group informal carers.

After matching, the number of characteristics for which there was still a significant group difference fell to four relating to the older person and four to their informal carers, as shown in Table A1.6. Community Care cases now appeared significantly less impoverished than their matched comparison cases and still had fewer problems of giddiness, while needing more extra help with tasks involving both rising and retiring and daily housework. After matching, informal carers in the comparison group were no longer systematically worse over a range of characteristics. Community Care cases were now more frequently a danger to themselves or others than comparison cases, though there was more evidence of uncooperative behaviour from the older person amongst informal carers in the comparison group. Also although the frequency of mental health problems showed less group divergence, they were still twice as frequent amongst carers of comparison

group cases. Nevertheless, considering the large number of aspects of the older person and informal carer for which significance tests had been made, the small number of differences remaining suggests that overall the characteristics of the user groups and their informal carers had been successfully matched. This had been achieved in spite of the comparison group cases having been identified through the day centre.

As in Sheppey, there were some differences between the Tonbridge experimental and control group areas in the availability of services. These differences could only arise between Community Care cases in Malling and the control cases in Tonbridge, since experimental cases in Tonbridge itself would have access to the same resources as the control group.

Table A1.5 Significant differences at the 5% level by group and mean values before matching in Tonbridge

	Mean values		Significance level[1]
	Experimental	Control	
(A) User characteristics			
Informal support			
Social resource impairment (OARS)	3.39	3.00	0.05
Health status			
Problems with hearing	1.61	1.31	0.01
Problems with giddiness	1.39	1.69	<0.05
Cognitive impairment	1.00	0.53	<0.05
Need for extra help			
Need for extra help when raising and retiring	3.67	2.42	<0.05
Need for extra help with daily housework	3.27	2.00	<0.01
Number of additional resources required	5.88	7.75	<0.01
Sample size	33	36	
(B) Informal carer characteristics			
Housing/accommodation			0.05
Difficulties in access	1.36	1.94	
Behaviour causing problems			0.05
User noisy/wandering at night	0.36	0.94	
Physical and mental health			<0.05
Extent of effect on physical health	0.50	1.22	<0.01
Malaise score	4.07	8.33	<0.001
Effect upon carer's mental health	0.50	1.61	
Overall ratings of interviewer			<0.05
Tension in home	0.79	1.17	<0.05
Hostility expressed towards user	1.07	1.67	
Sample size	14	18	

Note:
1. Analysis of variance was used to determine significance levels.

Table A1.6 significant differences at the 5 per cent level and mean values by matched group in Tonbridge

	Mean values		Significance
	Experimental	Control	Level[1]
(A) User characteristics			
Financial circumstances			
Economic resource impairment (OARS)	2.09	2.70	<0.05
Health status			
Problems with giddiness	1.30	1.70	<0.05
Need for extra help			
Need for extra help when rising and retiring	3.35	2.09	0.05
Need for extra help with daily housework	3.22	2.00	<0.05
Sample size	23	23	
(B) Informal carer characteristics			
Ways in which informal carer helps			
Time spent with user for company	4.00	3.27	<0.01
Behaviour causing problems			
Older person a danger to self or others	0.90	0.07	<0.01
Uncooperative/personality conflicts	1.10	1.73	0.05
Physical and mental health			
Effect upon carer's mental health	0.60	1.18	<0.05
Sample size when informal carer interviewed	10	11	

Note:

1. Since most characteristics were matched on a group rather than an individual basis, it was assumed that cases were independently selected. An analysis of variance could then be used in determining significance levels.

The availability of some key resources, measured for every one thousand of the population aged 75 and over in the two areas of Tonbridge and Malling, is shown in Table A1.4. The availability of local authority care home accommodation was well balanced, having the same value of 44 in each area. This was hardly surprising, since before the administrative reorganisation of social services both Tonbridge and Malling had been part of the same social services division. The supply of private registered home beds was also similar in each area at around eleven. Although this number increased rapidly during the period spanning the evaluations, the experimental and control cases were interviewed over similar time intervals, so effects of the increase should have cancelled out. However, health service provision for older people was rather better in Malling than in Tonbridge, these two areas lying in different area health authorities. Thus, the availability of geriatric hospital beds was somewhat greater in Malling (21) than in Tonbridge (14), where the district general hospital was catering for many of the medium-term geriatric patients, and where the considerable number of private nursing homes provided some of the long-term geriatric care. The supply of psycho-geriatric beds in Malling (18) was also much better than in Tonbridge (8). These differences could have led to more experimental cases entering geriatric hospital. On a short-term basis this could have increased the overall time spent at home, though if received long-term it could have had the reverse effect and also

reduced numbers entering private nursing homes. Experimental group costs to the NHS would appear artificially high, biasing the experiment against the Community Care group. There was in addition a surprising difference in the availability of Community Nursing staff, with 6.1 in Malling compared to only 3.5 in Tonbridge, and this was likely to have increased further the NHS cost to the experimental group.

Although the availability of day hospital in the two areas was very similar, day care places provided by the social services department were completely lacking in Malling, but amounted to 13 in Tonbridge. This fact, combined with the use of day centre referrals as a source of control group cases, meant that, although the characteristics of matched Community Care and comparison group cases were fairly similar, the latter tended to consume rather more day care. Because the daily cost of day care was fairly high at £15.61 net, this had the effect of substantially increasing the comparison group costs to the SSD compared to those of the Community Care group. The overall effect, then, of these area differences in resource availability was that Tonbridge control cases had NHS costs which were too low but SSD costs which were too high. Thus the actual cost saving of the scheme to the NHS is likely to have been even greater than that measured.

Finally there were differences in the resources available to the experimental and control group members of matched pairs drawn from Tonbridge or Malling and Faversham. Firstly the availability of local authority care home accommodation was less in Faversham (27) than in Tonbridge and Malling (44). Secondly the supply of psycho-geriatric beds was smaller in Faversham (3.2) than in Malling (18) and Tonbridge (8). These differences could have led to a greater use of private sector residential care amongst the Faversham comparison group, though only a few cases would have been affected. Costs to the SSD and NHS in the control area could then have been slightly depressed, while corresponding private residential care costs would have increased.

To summarise, differences between matched groups regarding the availability of resources could lead, as in Sheppey, to a slightly greater use of private sector residential care in the control group, though this time mainly as a substitute for a reduced supply of some National Health Service resources. However, the main factor affecting resources was likely to have been the method by which control cases were raised; namely, through the day centre. Because a relatively high proportion of these cases already received day care, they were more likely to continue doing so. This effect will be referred to later in interpreting cost results.

4 Correcting for initial group differences in comparing outcomes by group

In measuring outcomes, changes were only available for those cases who were either living at home or in residential care at the end of the evaluation year, for which follow up assessment interviews were made. Consequently a selection of such cases from matched groups would no longer be matched, due to the loss of cases who had died, moved away or entered long-term hospital. The approach therefore adopted in group comparisons of outcomes was to use unmatched groups. In determining the significance levels of group differences in outcomes, corrections for differences in initial group characteristics were made, by testing the effect of introducing the variables shown in Tables A1.2 or A1.5 as covariates in an analysis of variance.

APPENDIX 2

TIME ONE USER AND CARER INTERVIEW SCHEDULES

TIME ONE USER INTERVIEW SCHEDULE

ELDERLY CLIENT INTERVIEW.

a. Name _____

b. Address _____

_____

c. Social Worker _____

d. Interview Number ☐☐☐ (1)(2)(3)

e. Scheme ☐ (4)

f. Test 1 2 3 4 (6)

g. Card Number ☐☐ (7)(8)

h. Area (9)

EXPERIMENTAL	CONTROL
2 Sheppey	5 Faversham
3 Tonbridge	6 Tonbridge

i. SW's reasons for need of residential care

j. CCS Social Worker ☐ (10)

k. Interviewer ☐ (11)

l. Date of Interview ☐☐/☐☐/☐☐ (12) (13) (14) (15) (16) (17)

ELDERLY PERSON INTERVIEW.

Introduction: An enquiry on behalf of the Social Services Department into the difficulties of old people living in Sheppey and Faversham/Folkestone and Hythe. The information given will be treated as private and confidential.

1. Sex M 1 (18)
F 2

2. I should like to start by asking about your household.

Domestic Details.

Record living group: If living with family/friend
Are you the householder?

	Living alone	0	(19)
	With spouse	1	
(Client householder)	With family	2	
(Not householder)	With family	3	

3. Who are the people living with you?

Relationship to subject	Sex	Age
1.	M [1] F [2] (20)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (21)
2.	M [1] F [2] (22)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (23)
3.	M [1] F [2] (24)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (25)
4.	M [1] F [2] (26)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (27)
5.	M [1] F [2] (28)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (29)
6.	M [1] F [2] (31)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (32)
7.	M [1] F [2] (33)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (34)
8.	M [1] F [2] (36)	< 18 [1] 19-65 [2] 65-75 [3] 75+ [4] (37)

Check: So there are [ ][ ] of you altogether? (38)(39)

Housing and Background.

4. Can you tell me about your house/flat?

Type of accommodation:

0 One storey bungalow/cottage
1 House/cottage more than one storey
2 Farm
3 OAP Housing (without warden)
4 Sheltered Housing (with warden) (41)
5 Ground floor flat/bedsit
6 Upper floor flat/bedsit
7 Caravan
8 Multi-storey flat (no warden)
9 Other (specify).....

5. How many rooms have you for the household?.....
(Living rooms + bedrooms; + kitchen if eating area [ ][ ] (42)(43)

Comments: (44)

6. Do you own the home or rent it?
If rented: from whom?

Owner-Occupier - owned outright	0	
Owner-Occupier - mortgage	1	
Council rented	2	
Private rented - furnished	3	(46)
Private rented - unfurnished	4	
Housing association	5	

7. How long have you lived in this house?

0 - 3	1	
4 - 5	2	
6 -10	3	(47)
11 -20	4	
21 -30	5	
31+ years	6	

8a. Can you tell me where you were born? _____ place

_____ country

Within 5 miles of here	1	
More than 5 but less than 15 miles	2	
More than 15 but less than 50	3	(48)
More than 50 miles away	4	

b. And where was your husband/wife born? (If appropriate)

_____ place

_____ country

Within 5 miles of here	1	
More than 5 but less than 15 miles	2	
More than 15 but less than 50	3	
More than 50 miles away	4	(49)

9a. How long have you lived in this area [ ][ ] years

(if not born there) (51)(52)

b. Where did you live before? Record _____ BLANK (53)

BLANK (54)

BLANK (56)

BLANK (57)

10. If interviewee has lived elsewhere, ask:

What was the main reason for your coming to live in this community?

	NA	Yes	No	
Return to home area	0	1	2	(58)
Near relatives/children	0	1	2	(59)
Connections with area	0	1	2	(61)
Job	0	1	2	(62)
Country/environment/seaside	0	1	2	(63)
Small town	0	1	2	(64)
Available housing	0	1	2	(66)
Retirement	0	1	2	(67)
Other	0	1	2	(68)

11. Basic Amenities:

Now a few questions about the facilities you have:

Amenity	Sole use of household	Shared	None	
Hot water tap	2	1	0	(69)
Indoor W.C.	2	1	0	(71)
Fixed bath	2	1	0	(72)
Cooking facilities	2	1	0	(73)

12. How do you heat the room?

(Record only main source of heating actually used).

	(74) Bedroom	(76) Living room
Central heating	0	0
Gas	1	1
Electricity	2	2
Coal	3	3
Oil	4	4
Paraffin	5	5
Other	6	6
Storage heater	7	7
None	8	8
Calogas	9	9

13. Do you find the house warm enough in the Winter period?

Yes	0	
No	1	(77)
Not sure	2	

14. Adequacy of heating (interviewer rating)

a. Are heating systems apparently potentially adequate?

Yes	0	(78)
No	1	

b. Adequacy of heating during interview

Adequate	0	
Less than adequate	1	(79)
Very inadequate ;at risk	2	
Summer - not applicable	3	

15. Standard of housing.

a. What is the structure of the house like?

(Probe: damp, dry rot, loose plaster, defective roof)

(Interviewer rating)

Very good	0	
Adequate	1	(CARD 2) (11)
Less than adequate	2	
Very inadequate	3	

Comments: BLANK (12)

b. Furnishing (interviewer impression)

(Note presence/absence of essential furnishings, e.g. floor covering, also additional items - lampshades, curtains, easy chairs)

Very good	0	
Adequate	1	(13)
Less than adequate	2	
Very inadequate	3	

16a. In general, do you feel satisfied with your home

Yes	0	
Yes with doubt	1	(14)
No	2	
Not sure	3	

b. If evidence of dissatisfaction:

What don't you like about it? (Probe)

Problems	Yes	N/A.	
Poor condition	0	1	(16)
Lack of privacy	0	1	(17)
W.C. outdoors/ inconvenient	0	1	(18)
Too small	0	1	(19)
Too large	0	1	(21)
Unpleasant memories	0	1	(22)
Heating costs	0	1	(23)
Access difficulties	0	1	(24)
Distance from shops	0	1	(26)
Isolation/transport problems	0	1	(27)
Stairs	0	1	(28)
Distance from family	0	1	(29)
Area	0	1	(31)
Noise/nuisance	0	1	(32)
Heating/dampness	0	1	(33)
Other	0	1	(34)
Risk of flooding	0	1	(35)

c. Standard of cleanliness of home (Interviewer impression)

Very clean	0	
Clean	1	
Barely clean (dusty etc).	2	(36)
Dirty	3	
Extreme filth	4	

17. How many children have you?

a. Ask individually:

	CCS Worker Yes	CCS Worker No		Living less than ½ hour journey. Yes	Living less than ½ hour journey. No		See you reg. 1 x month at least. Yes	See you reg. 1 x month at least. No		How many days seen in last week?	
Eldest child	0	1	(37)	0	1	(38)	0	1	(39)	☐	(41)
Spouse	0	1	(42)	0	1	(43)	0	1	(44)	☐	(46)
2nd child	0	1	(47)	0	1	(48)	0	1	(49)	☐	(51)
Spouse	0	1	(52)	0	1	(53)	0	1	(54)	☐	(56)
3rd child	0	1	(57)	0	1	(58)	0	1	(59)	☐	(61)
Spouse	0	1	(62)	0	1	(63)	0	1	(64)	☐	(66)
4th child	0	1	(67)	0	1	(68)	0	1	(69)	☐	(71)
Spouse	0	1	(72)	0	1	(73)	0	1	(74)	☐	(76)
5th child	0	1	(77)	0	1	(78)	0	1	(79)	☐	(CARD 3)(11)
Spouse	0	1	(12)	0	1	(13)	0	1	(14)	☐	(16)

b. Do they help you in any way?

Yes considerably 0
A little help 1 (17)
Unsure/ambivalent 2
No help 3

Comments: BLANK (18)

c. If help given: Do they help with.....? If unsure: Do they ever help with?

		Yes	No	
(i)	Household jobs?			
	Gardening	0	1	(19)
	Cleaning	0	1	(21)
	Shopping/getting pension	0	1	(22)
	Laundry	0	1	(23)
	Exchanging prescriptions	0	1	(24)
	Bringing in meals/cooking	0	1	(26)
	Making fire/getting coal	0	1	(27)
	Handyman/odd jobs.	0	1	(28)
	Form filling - clerical	0	1	(29)
	Other (state).....	0	1	(31)
(ii)	Personal needs?			
	Getting up and going to bed	0	1	(32)
	Bathing	0	1	(33)
	Toileting	0	1	(34)
	Feet/toenails	0	1	(36)
	Hair care	0	1	(37)
	Checking up/supervision	0	1	(38)
	Other (state)	0	1	(39)
(iii)	Financially with:			
	Regular allowance	0	1	(41)
	T.V.Rental/licence	0	1	(42)
	Telephone	0	1	(43)
	Clothing	0	1	(44)
	Household goods	0	1	(46)
	Repairs/decorating	0	1	(47)
	Fuel bills	0	1	(48)
	Other (state)	0	1	(49)
(iv)	Social needs?			
	Taking you out/ to their own home	0	1	(51)
	Visiting you socially	0	1	(52)
	Phoning up for chat	0	1	(53)
	Other (state)	0	1	(54)

18. In general - how do you and your children get on?

(Note both verbal and non-verbal cues using previous information).

Interviewer Rating:

a.

Good relationship - most	0	
Good relationship - some	1	
Some difficulty	2	(56)
Little contact	3	
Not sure/ambivalent	4	
No children	5	

b. (If applicable) What kinds of difficulty are there?

	Yes	No	
Problems with grandchildren	0	1	(57)
Overcrowding	0	1	(58)
Client feels unwanted	0	1	(59)
Physical ill-treatment	0	1	(61)
Other (record)	0	1	(62)

Comments: (Note whether of recent origin). (63)

19. Would you like more contact with your children or is it about right?

More	1	
About right	2	(64)
Less	3	
Unsure/ambivalent	4	(Note comments).
		BLANK (66)

Comments:

20a. Have you any other relatives (other than children and their spouses) whom you see? (e.g. brothers, sisters, grandchildren).

Relationship	CCS Worker Yes	CCS Worker No		Do they live less than ½ hr. Yes	Do they live less than ½ hr. No		Do they see you regularly? (1 x month +) Yes	Do they see you regularly? (1 x month +) No		How many days seen last week		
1.	0	1	(67)	0	1	(68)	0	1	(69)	☐		(71)
2.	0	1	(72)	0	1	(73)	0	1	(74)	☐		(76)
3.	0	1	(77)	0	1	(78)	0	1	(79)	☐	(CARD 4)	(11)
4.	0	1	(12)	0	1	(13)	0	1	(14)	☐		(16)
5.	0	1	(17)	0	1	(18)	0	1	(19)	☐		(21)
6.	0	1	(22)	0	1	(23)	0	1	(24)	☐		(26)
7.	0	1	(27)	0	1	(28)	0	1	(29)	☐		(31)

b. Do they help you at all?

Yes considerably	0	
Yes - a little	1	
Unsure/ambivalent	2	(32)
No help	3	

Comments: BLANK(33)

If Yes: c. Do they ever help with:		If No: Do they never help with: Yes	No	
(i) Household jobs:				
	Gardening	0	1	(34)
	Cleaning	0	1	(36)
	Shopping/pension	0	1	(37)
	Laundry	0	1	(38)
	Bringing in meals/cooking	0	1	(39)
	Making fire/coal/fuel	0	1	(41)
	Odd jobs/handyman	0	1	(42)
	Other	0	1	(43)
	Clerical - form filling	0	1	(44)
	Exchanging prescriptions	0	1	(46)
(ii) Personal Needs:				
	Getting up and going to bed	0	1	(47)
	Bathing	0	1	(48)
	Feet/toenails	0	1	(49)
	Other	0	1	(51)
	Check up/supervision	0	1	(52)
	Toileting	0	1	(53)
	Hair care	0	1	(54)
(iii) Financial help:				
	Regular allowance	0	1	(56)
	T.V. Rental/licence	0	1	(57)
	Telephone	0	1	(58)
	Household articles	0	1	(59)
	Repairs/decorating	0	1	(61)
	Fuel bills	0	1	(62)
	Other	0	1	(63)
(iv) Social Needs:				
	Taking you out /to own home	0	1	(64)
	Visiting you socially	0	1	(66)
	Phoning up for chat	0	1	(67)
	Other (state).....	0	1	(68)

21. In general - how do you and your family get on?
(Note both verbal and non-verbal cues using previous information).

Interviewer rating: (Family are those of relations in closest contact).

a.

Good relationship - most	0	
Good relationship - some	1	
Some difficulty	2	
Little contact	3	(69)
Not sure/ambivalent	4	
No family	5	

b. (If applicable) What kinds of difficulty are there?

	Yes	No	
Problems with other generations	0	1	(71)
Overcrowding	0	1	(72)
Client feels unwanted	0	1	(73)
Ill-treatment	0	1	(74)
Other (record).....	0	1	(76)

Comments: (Note whether of recent origin). BLANK (77)

22. Would you like more contact with your relatives or is it about right?

More	1	
About right	2	(78)
Less	3	
Unsure/ambivalent	4	(note comments)
	BLANK	(79)

Comments:

23. Can you tell me about the neighbours you know well enough to speak to or visit? And your friends?

How many are there? Prompt: Same house/flats:
Next door
Further away

Check: So there are ..... altogether?
Will you tell me about them individually?

Person named	CCS Worker Yes	CCS Worker No	Do they see you regularly (1 x month+) Yes	Do they see you regularly (1 x month+) No	Times seen last week
	(CARD 5)				
1.	0	1 (11)	0	1 (12)	☐ (13)
2.	0	1 (14)	0	1 (16)	☐ (17)
3.	0	1 (18)	0	1 (19)	☐ (21)
4.	0	1 (22)	0	1 (23)	☐ (24)
5.	0	1 (26)	0	1 (27)	☐ (28)
6.	0	1 (29)	0	1 (31)	☐ (32)
7.	0	1 (33)	0	1 (34)	☐ (36)
8.	0	1 (37)	0	1 (38)	☐ (39)

b. (If applicable) Do they help you in any way?

Yes - considerably	0	
Yes - a little	1	
Unsure/ambivalent	2	(41)
No help	3	

c. What do they do for you?

	Yes	No	
Cleaning	0	1	(42)
Shopping/pension	0	1	(43)
Laundry	0	1	(44)
Bringing in meals/cooking	0	1	(46)
Making fire/coal/fuel	0	1	(47)
Getting up and going to bed	0	1	(48)
Bathing	0	1	(49)
Toileting	0	1	(51)
Do feet, toenails	0	1	(52)
Hair care	0	1	(53)
Garden	0	1	(54)
Checking up/supervision	0	1	(56)
Exchange prescriptions	0	1	(57)
Handyman/odd jobs	0	1	(58)
Financial help	0	1	(59)
Taking you out/to own home	0	1	(61)
Visiting you socially	0	1	(62)
Phoning up for chat	0	1	(63)
Other	0	1	(64)
Clerical/form filling	0	1	(66)

Comments:

24. And how do you get on with the people around here? (I mean the neighbours) (Note verbal and non-verbal cues).

Interviewer rating	Good relationship	0	
	Some difficulty	1	
	Little contact	2	(67)
	Unsure/ambivalent	3	

Comments: (Note whether any problems are of recent origin). BLANK (68)

25. Would you like more contact with neighbours/friends or is about right?

More	1	
About right	2	(69)
Less	3	
Unsure/ambivalent	4 (note comments)	
	BLANK	(71)

Comments:

26. Can I ask you about the other people you see?

Visitor	Times in last week	If <1 x week Times in last month	If< 1 x month Times in last 3 months	Is that usual? Yes	No	
Home Help	☐☐ (72)(73)	☐ (74)	☐ (76)	0	1	(77)
Health Visitor	☐ (78)	☐ (79)	(CARD 6) ☐ (11)	0	1	(12)
District Nurse	☐☐ (13)(14)	☐ (16)	☐ (17)	0	1	(18)
Meals on Wheels	☐ (19)	☐ (21)	☐ (22)	0	1	(23)
Social Worker	☐ (24)	☐ (26)	☐ (27)	0	1	(28)
Doctor	☐ (29)	☐ (31)	☐ (32)	0	1	(33)
Home teacher	☐ (34)	☐ (36)	☐ (37)	0	1	(38)
Vicar/minister	☐ (39)	☐ (41)	☐ (42)	0	1	(43)
	☐☐				BLANK	(44)
Warden of shelt.accom.	(46)(47)	☐ (48)	☐ (49)	0	1	(51)
Street warden	☐☐ (52)(53)	☐ (54)	☐ (56)	0	1	(57)
Chiropodist	☐ (58)	☐ (59)	☐ (61)	0	1	(62)
Private help	☐ (63)	☐ (64)	☐ (65)	0	1	(67)
Private Nurse	☐ (68)	☐ (69)	☐ (71)	0	1	(72)
CCS Visitor	☐☐ (73)(74)	☐ (76)	☐ (77)	0	1	(78)
	☐☐				BLANK	(79)
Emerg.telephone	(CARD 7)(11)(12)	☐ (13)	☐ (14)	0	1	(16)
Night sitter	☐ (17)	☐ (18)	☐ (19)	0	1	(21)
Community worker	☐ (22)	☐ (23)	☐ (24)	0	1	(26)
Voluntary visitor. Specify:	☐ (27)	☐ (28)	☐ (29)	0	1	(31)
	BLANK (32)	BLANK (33)	BLANK (34)		BLANK	(36)
Other	☐ (37)	☐ (38)	☐ (39)	0	1	(41)
Other	☐ (42)	☐ (43)	☐ (44)	0	1	(46)

Comments: BLANK (47)

27. Have you received any aids or adaptations to help you manage at home? If Y who provided them?

		No	SSD	CCS	NHS	Vol.Agy.	Fam/Self	Other	
(i)	Walking aid	0	1	2	3	4	5	6	(48)
(ii)	Wheel chair	0	1	2	3	4	5	6	(49)
(iii)	Special chair	0	1	2	3	4	5	6	(51)
(iv)	Extension arm to pick things up	0	1	2	3	4	5	6	(52)
(v)	Handrail	0	1	2	3	4	5	6	(53)
(vi)	Aids for toileting	0	1	2	3	4	5	6	(54)
(vii)	Aids for bathing/washing	0	1	2	3	4	5	6	(56)
(viii)	Household aids	0	1	2	3	4	5	6	(57)
(ix)	Aids for blind/partial sight	0	1	2	3	4	5	6	(58)
(x)	Aids for deaf/hard of hearing	0	1	2	3	4	5	6	(59)
(xi)	Other aid	0	1	2	3	4	5	6	(60)
	Other aid	0	1	2	3	4	5	6	(61)
(xii)	Ramp	0	1	2	3	4	5	6	(62)
(xiii)	Lift	0	1	2	3	4	5	6	(63)
(xiv)	Hospital bed	0	1	2	3	4	5	6	(64)
(xv)	Ripple bed	0	1	2	3	4	5	6	(66)
(xvi)	Hoist	0	1	2	3	4	5	6	(67)
(xvii)	Alarm system	0	1	2	3	4	5	6	(68)
(xviii)	Other adaptation	0	1	2	3	4	5	6	(69)
(xix)	Other adaptation	0	1	2	3	4	5	6	(71)

Comments (including whether aids/adaptations used appropriately or not):

28. a. Do you eat your meals alone or with others?

Alone 0
With others 1 (72)

b. During the last week how many meals have you eaten with others?

.....Mid-day meals with ..... others (73) (74)

.....tea/evening meals with..... others (76) (77)

c. Is that usual Yes 0 (78)
No 1

29. Do you find that you get lonely?

a.

Most of the time	0	
Often lonely	1	
Sometimes	2	(79)
Rarely	3	
Never	4	

b. If loneliness is expressed: Does this upset you?

Yes	0	
No	1	
Unsure	2	(CARD 8)(11)

c. If loneliness is expressed: What is it that might stop you feeling that way?

Record: BLANK (12)

30. On average, how often do you go out?

a.

Daily	0	
More than 3 times a week	1	
" " twice " "	2	(13)
" " once " "	3	
Less frequently	4	
Never	5	

b. If not going out: Why is that?

Disability/access problems	0	Lack of confidence	5	
Winter months	1	Fear of falling	6	
Lack of help	2	Environmental (traffic/vandals/ mugging)	7	(14)
No wish to	3			
Nowhere to go	4	Other (record).....	8	

c. If going out: Can you tell me the kind of place you go out to?

		Times last week.	MEANS OF TRANSPORT. Public Trnspt./self	Social Services	Area Health	Family	Friends	CCS	Vol. Transport	
1.	Church	(16)☐	0	1	2	3	4	5	6	(17)
2.	Lunch Club	(18)☐	0	1	2	3	4	5	6	(19)
3.	Club (L.A.)	(21)☐	0	1	2	3	4	5	6	(22)
4.	Day Centre (Hospital)	(23)☐	0	1	2	3	4	5	6	(24)
5.	Day Centre (L.A)	(26)☐	0	1	2	3	4	5	6	(27)
6.	Club (Vol.)	(28)☐	0	1	2	3	4	5	6	(29)
7.	Visiting friends & relations	(31)☐	0	1	2	3	4	5	6	(32)
8.	Pub	(33)☐	0	1	2	3	4	5	6	(34)
9.	Bingo/betting shop	(36)☐	0	1	2	3	4	5	6	(37)
10.	Shopping/walk/going out indep.(public transport/ invacar)	(38)☐	0	1	2	3	4	5	6	(39)
11.	Other: e.g. med. appointments	(41)☐	0	1	2	3	4	5	6	(42)

31. Do you feel that you see enough of people?

(If necessary expand - would you like to see more/less?)

Rate degree of satisfaction with amount of social contacts.

Very satisfied	0
Satisfied	1
A little dissatisfied (too little)	2
Very dissatisfied (too little	3
A little disatisfied (too much)	4
Very dissatisfied (too much)	5

(43)

Social contact score:

Q17 .....

20 .....

23 .....

26 .....

28 .....

30 .....

BLANK (44) ☐☐ (46) (47)

32. a. Have you recently lost someone whom you miss? (suffered a bereavement)

Yes	0
No	1

(48)

b. If yes. Who was that .....?

c. How long ago was it?

<6 months	0
6-12 months	1
1-2 years	2
3 years +	3
Unsure	4

(49)

33. Are there people around from whom you can ask small favours?

Yes	0
No	1

(51)

34. Are there people in this area whom you can call real friends?

Yes	0
No	1

(52)

35. Help with common problems and crises.

One of the things we are interested in is the kinds of local help available to people. Is there anyone you could turn to .....?

If you needed someone to confide in, i.e. discuss a really personal problem. ☐☐

(53)(54)

Code frame	
CCS helper	13
No one	00
Spouse	01
Other household member	02
Children	03
Other relative (not in household	04
Friend/neighbour	05
Home help	06
CCS worker	07
Social Worker	08
District Nurse	09
Voluntary visitor	10
Minister/vicar	11
Other	12

Social Activities

36. Do you have a wireless? Yes 0 (56)
No 1

If Yes - was this provided by the LA? Yes 0 (57)
No 1

37. Have you got a TV? Yes 0 (58)
No 1

If Yes - was this provided by the LA? Yes 0 (59)
No 1

38. Have you a telephone? Yes ordinary 0
Yes emergency 1 (61)
No 2

If Yes - was this provided by the LA? Yes 0 (62)
No 1

39. Do you belong to a club? Yes 0 (63)
No 1
If not attending club:-
- Why not? Record: BLANK (64)
- would you join one if transport were available? Yes 0 (66)
No 1

40. Do you receive the Mobile Library Yes 0 (67)
No 1

If No - would you like to? Yes 0 (68)
No 1
Other access to books 2

41.(i) Do you have plenty to do most days? Yes 0 (69)
No 1

Comments: BLANK (71)

(ii) Do you ever find yourself suffering from boredom?
Frequently 0
Occasionally 1 (72)
Never 2

(iii) And in general, do you find that the days pass quickly or slowly for you? Quickly 0 (73)
Slowly 1

42 Night and Morning.

Let us talk about getting up and going to bed.

Do you have any difficulty with.....
(Prompt: Could you if you had to?

		Done Unaided	Unaided but difficult/ fragile	Some help needed.	Totally dependent bedridden	
(i)	Getting into bed	1	2	3	4	(74)
(ii)	Getting up	1	2	3	4	(76)
(iii)	Washing hands and face	1	2	3	4	(77)
(iv)	Dressing (including buttons and shoes)/undressing	1	2	3	4	(78)
(v)	Shaving(if applicable)	1	2	3	4	(79)

43. Is there anyone who regularly gives you help (with these things) when you get up or go to bed?

Yes 1 (60)
No 2 ——→ to Q.45

(i) Who helps you?

(ii) How often do they give you help?

(After each person ask: "Anyone else?"
Code only helpers coming at least 1 x week The total, summed over all those helping, must not exceed 14)

	CCS Helper. Yes	No (CARD 9)		No. of times weekly.	
Spouse	1	2	(11)	☐	(14)
Other person in household	1	2	(16)	☐	(19)
Relative outside	1	2	(21)	☐	(24)
Friend or neighbour	1	2	(26)	☐	(29)
Help from SSD	1	2	(31)	☐☐	(33)(34)
Help from NHS	1	2	(36)	☐☐	(38)(39)
Private paid help	1	2	(41)	☐☐	(43)(44)
Voluntary agency	1	2	(46)	☐☐	(48)(49)
CCS Helpers	(BLANK)		(51)	☐☐	(53)(54)
Other (specify).....	1	2	(56)	☐☐	(58)(59)

44. (i) Are you getting enough help when you get up and go to bed?

(Code nearest applicable).

Prompt: (a) Can you rely on someone being there to help you?

(b) Are they really helpful?
(I mean do they do things as you would like when helping?)

(c) Are you getting as much help as you need?

(ii) What about at weekends? (Code nearest applicable).

		(i)	(ii)		
(a). Reliable	Reliable	1	1	(61)	(62)
	Doubtful/mixed	2	2		
	Unreliable	3	3		
	No, but client not reliant on help	4	4		
	No answer	5	5		
(b) Effective		(i)	(ii)		
	Yes	1	1	(63)	(64)
	Doubtful/mixed	2	2		
	Ineffective	3	3		
	No answer	4	4		
(c) Sufficiency		(i)	(ii)		
	Yes	1	1	(66)	(67)
	Would like more	2	2		
	Extra essential	3	3		
	No answer	4	4		

45.

		No additional help.	Extra help needed.	
(i)	Getting into bed	1	2	(68)
(ii)	Getting up	1	2	(69)
(iii)	Washing	1	2	(70)
(iv)	Dressing	1	2	(71)
(v)	Shaving	1	2	(72)
(vi)	Other	1	2	(73)

46. (Interviewer assessment of the Client Welfare Shortfall at the time of rising and retiring. Code nearest that applies).

	Mon-Fri	Sat-Sun		
No shortfall	1	1	(74)	(76)
No shortfall obvious, but vulnerable (occasionally falls)	2	2		
Inadequate help at least one occasion in week or per weekend	3	3		
Inadequate help on majority of occasions (5+ times per week)	4	4		
Grossly inadequate help seriously diminishing quality of life	5	5		

Comments. BLANK (77)

Personal Care.

47. Let us talk about the things you have to do to look after yourself during the day. Do you have any difficulty with them?

(Prompt: Could you if you had to?)

		Done Unaided.	Unaided but difficulty/ fragile.	Some help needed.	Totally dependent/ bedridden	
(i)	Feeding yourself (mechanical).	1	2	3	4	(78)
(ii)	Getting to/using toilet	1	2	3	4	(79)
(iii)	Getting around indoors (room to room on level)	1	2	3	4	(CARD 10)(11)
(iv)	Getting around outside (200 yards; not garden).	1	2	3	4	(12)
(v)	Rise from chair	1	2	3	4	(13)
(vi)	(Rating) Avoid risk of self neglect/care for self adequately.	1	2	3	4	(14)
(vii)	Managing medication.	1	2	3	4	(16)

48. Is there anyone who regularly gives you help to look after yourself during the day? (Exclude provision of transport for outside activities).

Yes 1 . No 2 - - > To Q. 50. (17)

a. Who helps you?

b. How much of the time are they around to give you help - (i.e. within normal calling distance?) (After each person ask: "Anyone else?")

BLANK (18)

	Whether CCS helper. Yes	No	Help some days. Hrs per week	Every day 8.am - 8.pm. Yes	No	Every night 8.pm - 8.am. Yes	No	
(i) Spouse	1	2	(19) (21)(22)	1	2(23)	1	2 (24)	
(ii) Other person in household	1	2	(26) (27)(28)	1	2(29)	1	2 (31)	
(iii) Relative outside	1	2	(32) (33)(34)	1	2(36)	1	2 (37)	BLANK(38)
(iv) Friend or neighbour	1	2	(39) (41)(42)	1	2(43)	1	2 (44)	
(v) Help provided by SSD	1	2	(46) (47)(48)	1	2(49)	1	2 (51)	
(vi) Help provided by NHS	1	2	(52) (53)(54)	1	2(56)	1	2 (57)	BLANK(58)
(vii) Private paid help	1	2	(59) (61)(62)	1	2(63)	1	2 (64)	
(viii) Vol.Agency	1	2	(66) (67)(68)	1	2(69)	1	2 (70)	
(ix) Other(specify)	1	2	(71) (72)(73)	1	2(74)	1	2 (75)	
(x) CCS Helper			(76)(77)	1	2(78)	1	2(79)	

Comments:

49 a. Are you getting enough help to look after yourself?

(Code nearest applicable, exclude the provision of transport for ourside activities).

(Prompt: (i) Can you rely on someone being available to help you?

(ii) Are they really helpful (Do they help in the way that you find useful?)

(iii) Are you getting as much help as you need?

b. What about at weekends?

(80)(CARD 11)(11)(12)

		Mon-Fri	Sat-Sun	Evenings/Nights
(i)	Reliable			
	Yes	1	1	1
	Doubtful/mixed	2	2	2
	Unreliable	3	3	3
	No, but not reliant on help	4	4	4
	No answer	5	5	5

(13)(14)(16)

		Mon-Fri	Sat-Sun	Evenings/Nights
(ii)	Effective			
	Yes	1	1	1
	Doubtful/mixed	2	2	2
	Ineffective	3	3	3
	No answer	4	4	4

(17)(18)(19)

		Mon-Fri	Sat-Sun	Evenings/Nights
(iii)	Sufficient			
	Yes	1	1	1
	Would like some extra	2	2	2
	Extra essential	3	3	3
	No answer	4	4	4

Comments/Special Problems:

50.

		No additional help	Extra help needed	
(i)	Feeding self	1	2	(21)
(ii)	Getting to/using toilet	1	2	(22)
(iii)	Mobility in home	1	2	(23)
(iv)	Mobility outside home	1	2	(24)
(v)	Rising from chair	1	2	(25)
(vi)	Avoiding neglect	1	2	(27)
(vii)	Managing medication	1	2	(28)
(viii)	Companionship	1	2	(29)
(ix)	Supervision/check up	1	2	(31)
(x)	Other.....	1	2	(32)

51. Interviewer assessment of the welfare shortfall in looking after self during the day.

a. Extra amount of help required ☐☐ hours/week (32)(33)

b. Anticipated effect of additional help in reducing need for residential care and/or improving quality of life

Great improvement	1	
Considerable improvement	2	(34)
Probable improvement	3	
Little significant improvement	4	

Comments:

Less frequent Personal Care.

52. How do you manage with less regular tasks?

Do you have any difficulty with.....?

	Done Unaided	Unaided but diff. fragile indep.	Some help needed.	Totally dependent/ bedridden	
(i) Bathing/showering	1	2	3	4	(35)
(ii) Cutting toenails	1	2	3	4	(36)

53. Do you have any help with them? Yes 1 No 2 (37)

a. Who helps you?	(i)	(ii)	
Spouse	1	1	
Another member of household /Relats	2	2	
Friend or neighbour	3	3	
Help from SSD	4	4	(38)(39)
Help from NHS	5	5	
Private paid help	6	6	
Voluntary agency	7	7	
Other (specify).....	8	8	
CCS Helper	9	9	

54. Shortfall on long-term personal care:

	No additional help	Extra help needed	
(i) Bathing/showering	1	2	(40)
(ii) Cutting toenails	1	2	(41)

Daily Household Chores

55. Can we talk about daily household chores?

Do you have any difficulty with .....?
(Prompt: Could you if you had to?)

	Done unaided	Unaided but diff. fragile indep.	Some help needed.	Totally dependent/ bedridden.	
(i) Light housework (e.g.washing up, dusting, tidying bed).	1	2	3	4	(42)
(ii) Make hot drink or snack.	1	2	3	4	(43)
(iii) Cook hot meal.	1	2	3	4	(44)
(iv) Manage coal fire/ fuel heater/	1	2	3	4	(45)

56. Is there anyone who regularly gives you help (with these things) during the day?

Yes 1 (46)
No 2 → to Q.58

a. Who helps you?

b. How often do they help?

		CC helper Yes	No		Hours per week	
(i)	Spouse	1	2	(47)	☐☐	(48)(49)
(ii)	Other person in household	1	2	(50)	☐☐	(51)(52)
(iii)	Relative outside	1	2	(53)	☐☐	(54)(55)
(iv)	Friend or neighbour	1	2	(56)	☐☐	(57)(58)
(v)	Help from SSD	1	2	(59)	☐☐	(60)(61)
(vi)	Help from NHS	1	2	(62)	☐☐	(63)(64)
(vii)	Private paid help	1	2	(65)	☐☐	(66)(67)
(viii)	Voluntary Agency	1	2	(68)	☐☐	(69)(70)
(ix)	Other (Specify).....	1	2	(71)	☐☐	(72)(73)
(x)	CCS Helper	1	2	(71)	☐☐	(74)(75)

Comments

57. a. Are you getting enough help with domestic chores during the day? (Code nearest applicable)

Prompt:

(i) Can you rely on someone being available to help you?

(ii) Are they really helpful?
(I mean do they do things as you would like?)

(iii) Are you getting as much help as you need?

b. What about weekends?

(i) Reliable

	(a)	(b)	
Yes	1	1	
Doubtful/mixed	2	2	
Unreliables	3	3	(74)(76)
No - but not reliant on help	4	4	
No answer	5	5	

(ii) Effective

	(a)	(b)	
Yes	1	1	
Doubtful/mixed	2	2	
Ineffective	3	3	(77)(78)
No answer	4	4	

(iii) Sufficient

	(a)	(b)	
Yes	1	1	
Would like extra	2	2	
Extra essential	3	3	(79)CARD 12 (11)
No answer	4	4	

Special problems/comments:

58.

		No additional help	Extra help needed	
(i)	Light housework	1	2	(12)
(ii)	Snack/hot drink	1	2	(13)
(iii)	Cook hot meal	1	2	(14)
(iv)	Fire/heater	1	2	(16)
(v)	Other	1	2	(17)

59. Interviewer assessment of the welfare shortfall in looking after home during the day.

a. Extra amount of help required

Hours per week ☐☐ (18)(19)

b. Anticipated effect of additional help in reducing need for residential care and/or improving quality of life

Great improvement	1	(21)
Considerable improvement	2	
Probable improvement	3	
Little significant improvement	4	

Comments: BLANK (22)

Weekly Household Tasks.

60. Let us talk about the domestic jobs you have to do during the week?

Do you have any difficulty with .....?
(Prompt: Could you if you had to?)

		Done Unaided	Unaided but diff. fragile indep.	Some help needed.	Totally dependent or bedridden.	
(i)	Heavy housework (clean floors, wash windows, make bed)	1	2	3	4	(23)
(ii)	Shopping	1	2	3	4	(24)
(iii)	Laundry (clothes)	1	2	3	4	(26)
(iv)	Soiled linen (if applicable, otherwise code as 1).	1	2	3	4	(27)
(v)	Gardening.	1	2	3	4	(28)

61. Is there anyone who regularly gives you help (with these things) during the week?

Yes 1

No 2 ——→ to Q.63 (29)

a. Who helps you?

b. How often do they give you help) (After each person ask: "Anyone else?")

		No.of days per week.	Hours per week.	Whether CCS Helper Yes	No
(i)	Spouse	☐(31)	☐☐(32)(33)	1	2(34)
(ii)	Other person in household	☐(36)	☐☐(37)(38)	1	2(39)
(iii)	Relative outside	☐(41)	☐☐(42)(43)	1	2(44)
(iv)	Friend or neighbour	☐(46)	☐☐(47)(48)	1	2(49)
(v)	Help provided by SSD	☐(51)	☐☐(52)(53)	1	2(54)
(vi)	Help provided by NHS	☐(56)	☐☐(57)(58)	1	2(59)
(vii)	Private paid help	☐(60)	☐☐(61)(62)	1	2(63)
(viii)	Voluntary Agency	☐(64)	☐☐(65)(66)	1	2(67)
(ix)	Other (Specify).....	☐(68)	☐☐(69)(70)	1	2(71)
(x)	CCS helper	☐(72)	☐☐(73)(74)		

62. a. Are you getting enough help to manage with domestic duties in the week? (Code nearest applicable. Exclude the provision of transport for outside activities).

Prompt: (i) Can you rely on someone being available to help you?
(ii) Are they really helpful? (Do they help in the way that you would like?)
(iii) Are you getting as much help as you need?

b. What about at weekends?

(i) Reliable

	Mon-Fri	Sat-Sun	
Yes	1	1	
Doubtful/mixed	2	2	
Unreliable	3	3	(75)(76)
No, but client not reliant on help	4	4	
No answer	5	5	

(ii) Effective

	Mon-Fri	Sat-Sun	
Yes	1	1	
Doubtful/mixed	2	2	
Ineffective	3	3	(77)(78)
No answer	4	4	

(iii) Sufficient

	Mon-Fri	Sat-Sun	
Yes	1	1	
Would like some extra	2	2	
Extra essential	3	3	(79) CARD 13 (11)
No answer	4	4	

Comments/Special Problems:

63.

		No additional help	Extra help needed	
(i)	Heavy housework	1	2	(12)
(ii)	Shopping/bills	1	2	(13)
(iii)	Laundry(basic)	1	2	(14)
(iv)	Soiled linen	1	2	(16)
(v)	Gardening	1	2	(17)
(vi)	Other	1	2	(18)

64. Interviewer assessment of the welfare shortfall for looking after domestic jobs during the week.

a. Days per week that help required: ☐ (19)

b. Hours per week help required: ☐☐ (21)(22)

c. Predicted effect of additional help in reducing need for residential care or raising quality of life:

Great improvement	1
Considerable improvement	2
Probable improvement	3
Little significant improvement	4

(23)

Comments:

65. For all the above tasks ask (if client usually has help)

How would you manage if the person who usually helps you was ill (or unable to come)?

or (if client does not usually have help)

What would you do if you found yourself unable to manage?

TASKS.	AVAILABILITY OF HELP.				
	Definite source of help available.	Possible or limited source of help available.	Would manage on own.	Don't know/ couldn't manage/rely on chance caller.	
Getting up and going to bed.	1	2	3	4	(24)
Looking after self during the day.	1	2	3	4	(26)
Household tasks during the day.	1	2	3	4	(27)
Domestic jobs during week.	1	2	3	4	(28)

Independence/Control over own daily life.

Now I should like to ask you a few questions about the help you get .....

66. Do you ever feel that you are becoming a burden on your family and friends?

Often	1	
Sometimes	2	
Rarely	3	(29)
Never	4	
Don't know	5	

Comments:

67. Do you ever feel that your life is run too much by other people?
(Elaborate if necessary: I mean that other people make decisions for you).

Often	1	
Sometimes	2	
Rarely	3	(31)
Never	4	
Don't know	5	

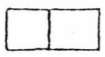
68. Do you feel you need more privacy in your daily life?

Often	1	
Sometimes	2	
Rarely	3	(32)
Never	4	
Don't know	5	

Physical, Mental and Emotional Health.

69. Morale: I should like to ask you a few general questions:

	Yes	No	D/K	
(i) Do things keep getting worse as you get older? (Does life seem to get worse as you get older?)	1	2	3	(33)
(ii) Do you have as much energy as you did last year?	1	2	3	(34)
(iii) Do you feel lonely much?	1	2	3	(36)
(iv) Do you see enough of your friends or relatives?	1	2	3	(37)
(v) Do little things bother you more this year? (Are you more easily upset by minor events this year?)	1	2	3	(38)
(vi) As you get older do you feel less useful?	1	2	3	(39)
(vii) Do you sometimes worry so much you can't sleep?	1	2	3	(41)
(viii) As you get older are things better than expected? (Do you find things are worse now than you had thought?)	1	2	3	(42)
(ix) Do you sometimes feel life isn't worth living?	1	2	3	(43)
(x) Are you as happy now as when you were younger?	1	2	3	(44)
(xi) Do you have a lot to be sad about?	1	2	3	(46)
(xii) Are you afraid of a lot of things? (Do you have a lot of fears or worries?)	1	2	3	(47)
(xiii) Do you get angry more than you used to?	1	2	3	(48)
(xiv) Is life hard for you most of the time? (Do you find life a struggle most of the time?)	1	2	3	(49)
(xv) Are you satisfied with your life today?	1	2	3	(51)
(xvi) Do you take things hard? (When things go wrong does it affect you a lot?)	1	2	3	(52)
(xvii) Do you get upset easily?	1	2	3	(53)



Physical Health:

70. Overall, how would you describe your state of health?

Very good	1	
Fairly good	2	
Not very good	3	(54)
Very poor	4	

Comments:

71.(a)Is the Subject either extremely overweight or malnourished and emaciated?

0	No, neither	(Interviewer assessment).
1	Yes, extremely overweight	(55)
2	Yes, malnourished or emaciated	
3	Not answered.	

(b)Do you suffer from physical pain?

Intensively	(i) Frequently	5	
	(ii)Sometimes	4	
Moderately	(i) Frequently	3	(56)
	(ii)Sometimes	2	
Slightly/normal		1	

Comments:

72. Do you suffer from any illness or disability which might limit your activities? (CHECK "YES" OR "NO" FOR EACH OF THE FOLLOWING. IF "YES", ASK: "How much does it interfere with your activities? Not at all, a little (some), or a great deal? AND CHECK THE APPROPRIATE BOX).

(IF "YES", ASK: How much does it interfere with your activities?

0 NO	1 NOT AT ALL	2 A LITTLE	3 A GREAT DEAL	COMMENTS
				(57) Arthritis or rheumatism
				(58) Glaucoma/eyesight
				(59) Hearing
				(61) Emphysema or chronic bronchitis/breathlessness
				(62) Giddiness
				(63) High blood pressure
				(64) Heart trouble
				(66) Effects of stroke
				(67) Fracture/joint replacement
				(68) Swollen ankles
				Are there any others not already mentioned. (Probe if necessary).
				(69) Loss of limb
				(71) Asthma
				(72) Tuberculosis
				(73) Circulation trouble in arms or legs
				(74) Diabetes
				(76) Ulcers (of the digestive system)
				(77) Colostomy
				(78) Other stomach or intestinal disorders or gall bladder problems
				(79) Liver diesease
				(CARD 14)
				(11) Kidney disease
				(12) Other urinary tract disorders (including prostrate trouble)
				(13) Cancer or Leukemia
				(14) Anaemia
				(16) Migraine
				(17) Parkinson's Disease
				(18) Epilepsy
				(19) Cerebral Palsy
				(21) Multiple Sclerosis
				(22) Muscular Dystrophy
				(23) Effects of Polio
				(24)Thyroid or other glandular disorders
				(26) Skin disorders such as pressure sores leg ulcers or severe burns
				(27) Speech impediment or impairment
				(28) Teeth
				(29) Other (record)
				(31) Other (record)

73. Does subject appear to be at risk of falling? (Interviewer assessment).
(Record 'severe' if constant risk at any time during day).

None	0	
Moderate	1	(32)
Severe	2	

74. Do you ever experience difficulty in getting to the toilet in time?
(Ask about 'slip-ups' and frequency).

Incontinence	- Urine	Never	0	
		Occasionally	1	(33)
		Totally/Frequently	2	
	- Faeces	Never	0	
		Occasionally	1	(34)
		Totally/Frequently	2	

75. Can you manage to climb stairs?
(If unnecessary for client, e.g. living in bungalow, record 0).

Freely (alone)	0	
With difficulty	1	
With help	2	(36)
Not at all	3	

DEPRESSION INVENTORY.

76. 1. Do you feel miserable?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(37)
No, not at all	3	

2. Do you find it easy to do the things you used to do?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(38)
No, not at all	3	

3. Do you get frightened or have panic feelings for apparently no reason at all?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(39)
No, not at all	3	

4. Do you have weeping spells, or feel like it?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(41)
No, not at all	3	

5. Do you still enjoy the things you used to?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(42)
No, not at all	3	

6. Do you find you feel restless and unable to keep still?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(43)
No, not at all	3	

7. Do you get off to sleep easily without sleeping tablets?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(44)
No, not at all	3	

8. Do you feel anxious when you go out of the house on your own?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(46)
No, not at all	3	

9. Have you lost interest in things?

Yes, defintely	0	
Yes, sometimes	1	
No, not much	2	(47)
No, not at all	3	

10. Do you get tired for no reason?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(48)
No, not at all	3	

11. Do you feel more irritable than usual?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	(49)
No, not at all	3	

12. Do you wake early, and then sleep badly for the rest of the night?

Yes, definitely	0	
Yes, sometimes	1	
No, not much	2	
No, not at all	3	(51)

(N.B. For scoring invert all codes other than 2, 5, 7.). TOTAL SCORE _____ _____

(52)(53)

77. Sometimes people find that they tend to forget things. I'd like to ask you a few questions to see how well you remember things.

Can you tell me.....?

a. What day of the week it is	Correct	1	(54)
	Incorrect	0	
b. Month	Correct	1	(56)
	Incorrect	0	
c. Year	Correct	1	(57)
	Incorrect	0	

Income/Expenditure.

78. Can we discuss what income you have coming in and how you manage?

(Prompt)

	Yes	No	
1. Retirement pension	1	2	£_____(58)
2. Supplementary pension	1	2	£_____(59)
3. Supplementary benefit	1	2	£_____(61)
4. Work pension	1	2	£_____(62)
5. Income from subletting	1	2	£_____(63)
6. Part-time work	1	2	£_____(64)
7. Savings/Investment Income	1	2	£_____(66)
8. Cash help from family	1	2	£_____(67)
9. Other	1	2	£_____(68)
10. Rent rebate	1	2	£_____(69)
11. Rate rebate	1	2	£_____(71)
12. Attendance allowance	1	2	£_____(72)
13. Invalid care allowance	1	2	£_____(73)

BLANK (74)

(Check: So altogether you have £_____ per week

(76)(77)(78)

79. Have you any savings? Yes 1 / No 2 (79)

If Yes - Is it?

< £100	1	(CARD 15) (11)
£100 - £500	2	
£500 - £1000	3	
£1000 - £2500	4	
£2500 - £5000	5	
- £5000+	6	
Would not disclose	7	

80. If receiving Supplementary Pension:
Does your pension include allowances for: (E.C.A.'s).

	Yes	No	
Diet	1	2	(12)
Fuel	1	2	(13)
Laundry	1	2	(14)
Other	1	2	(16)

81. If receiving Supplementary Pension:
Have you had an extra payment in the last year for: (E.N.P's).

	Yes	No	
Clothing/foot-wear	1	2	(17)
Household goods	1	2	(18)
Bedding/furniture	1	2	(19)
Removal expenses	1	2	(21)
Fuel debts/rent arrears	1	2	(22)
Redecoration	1	2	(23)
Funeral expenses	1	2	(24)
Emergency	1	2	(26)
Other	1	2	(27)

82. Do you find your income is sufficient for your needs?

'Yes', definitely	1	
Yes, with doubt	2	(28)
No	3	

If evidence of doubt: What expenses do you find it particularly hard to meet?
Prompt:

	Yes	No	
Fuel	1	2	(29)
Clothing	1	2	(31)
Food	1	2	(32)
Services	1	2	(33)
Other	1	2	(34)

83. How much rent (including rates) do you have to pay? (If applicable).

.....per week/month/year
£ ☐☐.☐☐
Code as (36)(37).(38)(39) pence per week

DIFFICULTIES

And now I would like to ask you about particular difficulties, crises or changes in your life which have affected you over the last 2 years(1 year for second interviews)

84. You have already told me about the difficulties you have had with.....
(name any difficulties which subject has already mentioned, recorded on tab).
Have there been any other particular difficulties for you during the last two years?
Anything that has been getting you down?Any periods in hospital?

Difficulty or group of related difficulties (objective description) including those recorded earlier.	Time span of difficulty. How long ago		Duration (months)	Severity High 1 Low 0		Major/ Minor	Health/ non-health	If related to event give time sequence number of event (see Q85)
	Started	Finished		Objective	Subjective			
1.	(41)(42)	(43)(44)		(46) 0 1	(47) 0 1		Yes 0 (48) No 1	(49)
2.	(51)(52)	(53)(54)		(56) 1 0	(57) 1 0		Yes 0 (58) No 1	(59)
3.	(61)(62)	(63)(64)		(66) 1 0	(67) 1 0		Yes 0 (68) No 1	(69)
4.	(71)(72) (CARD 1C)	(73)(74)		(76) 1 0	(77) 1 0		Yes 0 (78) No 1	(79)
5.	(11)(12)	(13)(14)		(16) 1 0	(17) 1 0		Yes 0 (18) No 1	(19)
6.	(21)(22)	(23)(24)		(26) 1 0	(27) 1 0		Yes 0 (28) No 1	(29)
7.	(31)(32)	(33)(34)		(36) 1 0	(37) 1 0		Yes 0 (38) No 1	(39)
8.	(41)(42)	(43)(44)		(46) 1 0	(47) 1 0		Yes 0 (48) No 1	(49)
9.	(51)(52)	(53)(54)		(56) 1 0	(57) 1 0		Yes 0 (58) No 1	(59)
10.	(61)(62)	(63)(64)		(66) 1 0	(67) 1 0		Yes 0 (68) No 1	(69)

Coding

How long ago:	
Still present	98
< 1 week ago	00
1 week - 1 month ago	01
1 month - 2 months ago	02
2 months - 3 months ago	03
3 months - 4 months ago	04
.....	..
Unsure	99

85. LIFE EVENTS

(Events should be listed in the lower half of page)

(a) Health

(i) Have you suffered from any illness or accident? Any falls?

(Bring up any previous material in sections 69 - 71)

(ii) Have your relatives or friends suffered from any illness or accident?

Have any died?

Have there been any pregnancies among relatives or friends? (Probe for miscarriages or other complications.)

(b) Role Changes

(i) (Ask about any role change of the subject which has already been mentioned; e.g. separation).

(ii) Have there been any important changes in the way of life of your relatives or friends; e.g. marriage, divorce, retirement, unemployment? (If subject is living with relatives probe on their circumstances.)

(c) Interaction changes

(i) Have you made or lost any friends?

(ii) Is there anyone you see much more or less of?
Have any friends or relatives moved away from this area?
(Probe on any tension or quarrels with relatives mentioned in section 21. If living with relatives or friends, probe on their relationship and its effect on the client.)

Event or group of related events (objective description)	Event time sequence	How long ago	Severity (points) Objective short term	Objective long term	Subjective short term	Subjective long term	1 Severe/ 0 non-severe	Health / Non-Health
1.	☐(71) (CARD 17)	(72)(73) ☐☐	(74) ☐	(76) ☐	(77) ☐	(78) ☐	1 0	Yes 0 No 1 ☐(79)
2.	☐(11)	(12)(13) ☐☐	(14) ☐	(16) ☐	(17) ☐	(18) ☐	1 0	☐(19)
3.	☐(21)	(22)(23) ☐☐	(24) ☐	(26) ☐	(27) ☐	(28) ☐	1 0	☐(29)
4.	☐(31)	(32)(33) ☐☐	(34) ☐	(36) ☐	(37) ☐	(38) ☐	1 0	☐(39)
5.	☐(41)	(42)(43) ☐☐	(44) ☐	(46) ☐	(47) ☐	(48) ☐	1 0	☐(49)

Coding

How long ago:

Use difficulties time scale(Q83)

Severity: Marked 1
Moderate(subject focus) 2
Moderate(other focus). 3
Little or none 4

Short term threat: that implied on the day it occurred or soon after.
Long term threat : that implied one week or more after its occurrence.

(d) Housing

(i) (If applicable) Have you had any trouble with the Landlord?

(ii) Have you any plans to move house at some stage?
(Probe on any bad news concerning rehousing)

(iii) Have there been any fires or burglaries or flooding at home?

(e) Money
(Probe on any financial difficulties raised in Section 81, e.g. shocks over large fuel bills, difficulty with H.P. arrangements)

(f) Crises

(i) Has there been any crisis or emergency involving you or your relatives or friends?

(ii) Have you lost any pets?

(g) News/Disappointments

(i) Have you received any news which shook you?

(ii) Did you learn anything unexpected about others close to you?

(iii) Have there been any big disappointments?

(iv) Have you had to make any important decisions?

86. And now I would like to ask about any pleasurable things which have happened to you during the last 12 months.

Holidays (number) ☐☐ (51)(52) Enjoyed Y 0 / N 1 / D/K2 (53)

Would you like a holiday? Y 0 / N 1 (54)

Visits from relatives (number) ☐☐ (56)(57) Enjoyed Y 0 / N 1 / D/K2 (58)

Financial windfall greater than £10 Y 0 / N 1 (59)

Contact with children (if pleasurable); eg with greatgrandchildren Y 0 / N 1 (61)

Has anything else particularly pleasurable happened to you this year?
Any specially good news? Any present?
Anything which particularly helped you?
Anyone you are getting on much better with?

1
2
3
4
5
6
7
8
9
10

Total number of other pleasurable happenings ☐ (62)

Future Plans/Attitude to Residential Care:

87. And what is your date of birth?

(63)(64) (66)(67) (68) (69)

88. a. Had you ever considered the possibility of going into a home?

Yes	1	(71)
No	2	
Not sure	3	

b. What do you feel about this possibility?

Wants to go	1	(72)
Against	2	
Not sure	3	

Comments:

89. Do you think it is likely that you will go into a home in the next year?

Yes	1	(73)
No	2	
Unsure	3	

Comments:

BLANK (74)

Obtain name and address of principal helper and permission to visit.

Name:

Address:

Telephone No.

Close Interview.

Social Worker's Assessment.

(To be completed as soon after interview as practicable).

1. Suitability of housing:

Very suitable	1	
Suitable	2	
Unsuitable	3	(76)
Detrimental	4	

Reasons:

2. Informant's attitude in interview:

Cooperative	1	
Poor information	2	
Hostile	3	(77)

3. Difficulties impeding interview:

None	0	
Hearing	1	(78)
Speech	2	
Confusion	3	
Vagueness	4	
Other (specify)	5	
.....		

4. Valuation of different need areas:

(Rate 1 - 5 according to degree of need)

	Rating	
Rising and retiring	☐	(79) (CARD 18)
Personal daily needs	☐	(11)
Social integration	☐	(12)
Daily domestic needs	☐	(13)
Weekly domestic needs	☐	(14)
Morale	☐	(16)
Self esteem/independence needs	☐	(17)
Relationship with family/ informal carers	☐	(18)

5. Additional help required:

	Yes	No	
Residential care (permanent)	0	1	(19)
Residential care (temporary	0	1	(21)
Sheltered housing	0	1	(22)
Rehousing	0	1	(23)
District Nurse	0	1	(24)
Chiropody	0	1	(26)
Home help	0	1	(27)
Meals on Wheels	0	1	(28)
Voluntary Visitor	0	1	(29)
Radio/TV.	0	1	(31)
Social Club (with transport)	0	1	(32)
Social Club (no transport	0	1	(33)
Aids/adaptations	0	1	(34)
Holiday	0	1	(36)
Medical attention (physical)	0	1	(37)
Medical attention (psychiatric)	0	1	(38)
Financial Help	0	1	(39)
Social casework (old person)	0	1	(41)
Social casework (family)	0	1	(42)
Telephone	0	1	(43)
Laundry service	0	1	(44)
Day Centre	0	1	(46)
Community psychiatric nurse	0	1	(47)
Other NHS Services	0	1	(48)
Community care helper	0	1	(49)
Emergency telephone	0	1	(51)
Alarm system	0	1	(52)

Night sitter	0	1	(53)
Occupational therapy	0	1	(54)
Specialist Social Worker blind/deaf	0	1	(56)
Material improvements (e.g. decorating)	0	1	(57)
Luncheon club	0	1	(58)
Other	0	1	(59)

6. Degree of confusion:

a) If subject appears drowsy:

Yes 0
No 1 (60)

b) Does subject look puzzled?

Yes 0
No 1 (61)

c) Does subject have difficulty in paying attention to what is said?

Yes 0
No 1 (62)

d) Does subject look vacant?

Yes 0
No 1 (63)

e) Does what subject say make sense?

Yes 1
No 0 (64)

f) Does subject's appearance look appropriate?

Yes 1
No 0 (66)

7. Mental State assessment:

a. Confusion::

None apparent	0	
Mild	1	
Moderate	2	(67)
Severe	3	

b. Depression

None apparent	0	
Mild	1	
Moderate	2	(68)
Severe	3	

c Anxiety

None apparent	0	
Mild	1	
Moderate	2	(69)
Severe	3	

d. Other mental abnormalities: e.g. drink, paranoia, etc. (71)

8. Client's attitude to life:

a.

Content	1	
Fairly content	2	
Neither content nor discontented	3	(72)
Discontented	4	
Openly unhappy	5	

b. Whether has attitude of resignation?

Yes	1	
No	2	(73)

9. Client's attitude to help: (On evidence of present interview and previous history if known).
(Code nearest applicable)

Independent	- Rejecting/hostile; not receptive	1	
Independent	- tends to refuse, requires persuasion	2	
Accepting	- acceptance/able to accept	3	(74)
Dependent	- demanding	4	
Dependent	- passive	5	

Comments:

BLANK (76)

10. Interviewed:

Alone	1	
By proxy	2	
With relative present	3	(77)
With others present	4	

11. Client's dwelling - if owner-occupied:

Date of construction	
Type of construction	
Type	(78)
Number of rooms	
With/without garden	

SOCIAL RESOURCES RATING SCALE.

12. RATE THE CURRENT SOCIAL RESOURCES OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT CIRCUMSTANCES.

(79)

1. Excellent social resources.
Social relationships are very satisfying and extensive; at least one person would take care of him(her) indefinitely.

2. Good social resources.
Social relationships are fairly satisfying and adequate and at least one person would take care or him(her) indefinitely.
OR
Social relationships are very satisfying and extensive and only short term help is available.

3. Mildly socially impaired.
Social relationships are unsatisfactory, of poor quality, few; but at least one person would take care of him(her) indefinitely.
OR
Social relationships are fairly satisfactory, adequate; and only short term help is available.

4. Moderately socially impaired.
Social relationships are unsatisfactory, of poor quality, few; and only short term care is available.
OR
Social relationships are at least adequate or satisfactory; but help would only be available now and then.

5. Severely socially impaired.
Social relationships are unsatisfactory, of poor quality, few; and help would only be availeble now and then
OR
Social relationships are at least satisfactory or adequate; but help is not even available now and then.

6. Totally socially impaired.
Social relationships are unsatisfactory, of poor quality, few; and help is not even available now and then.

MENTAL HEALTH RATING SCALE.

13. RATE THE CURRENT MENTAL FUNCTIONING OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT FUNCTIONING.

Check for drowsiness, puzzled looks, poor attention, common sense in making judgments and decisions, ability to handle major problems, vacant looks, neat appearance.

(CARD 1) (53)

1. Outstanding mental health
   Intellectually alert and clearly enjoying life. Manages routine and major problems in his life with ease and is free from any psychiatric symptoms.

2. Good mental health:
   Handles both routine and major problems in his life satisfactorily and is intellectually intact and free of psychiatric symptoms.

3. Mildly mentally impaired
   Has mild psychiatric symptoms and/or mild intellectual impairment. Continues to handle routine, though not major, problems in his life satisfactorily.

4. Moderately mentally impaired
   Has definite psychiatric symptoms, and/or moderate intellectual impairment. Able to make routine, common-sense decisions, but unable to handle major problems in his life.

5. Severely mentally impaired
   Has sever psychiatric symptoms and/or severe intellectual impairment, which interfere with routine judgments and decision making in every day life.

6. Completely mentally impaired
   Grossly psychotic or completely impaired intellectually. Requires either intermittent or constant supervision because of clearly abnormal or potentially harmful behaviour.

PHYSICAL HEALTH RATING SCALE

14. RATE THE CURRENT PHYSICAL FUNCTIONING OF THE PERSON BEING EVALUATED ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT FUNCTIONING.

(54)

1. In excellent physical health
   Engages in vigorous physical activity, either regularly or at least from time to time.

2. In good physical health
   No significant illnesses or disabilities. Only routine medical care such as annual check ups required.

3. Mildly physically impaired
   Has only minor illnesses and/or disabilities which might benefit from medical treatment or corrective measures.

4. Moderately physically impaired
   Has one or more diseases or disabilities which are either painful or which require substantial medical treatment.

5. Severely physically impaired
   Has one or more illnesses or disabilities which are either severely painful or life threatening, or which require extensive medical treatment.

6. Totally physically impaired
   Confined to bed and requiring full time medical assistance or nursing care to maintain vital bodily functions.

ACTIVITIES OF DAILY LIVING RATING SCALE

15. RATE THE CURRENT PERFORMANCE OF THE PERSON BEING EVALUATED ON THE SIX POINT SCALE PRESENTED BELOW. CIRCLE THE ONE NUMBER WHICH BEST DESCRIBES THE PERSON'S PRESENT PERFORMANCE.

(56)

1. Excellent ADL Capacity
   Can perform all of the Activities of Daily Living without assistance and with ease.

2. Good ADL capacity
   Can perform all Activities of Daily Living without assistance; although this independence is fragile.

3. Mildly Impaired ADL capacity
   Can get through any single day without help; needs help with weekly household care or long-term personal care.

4. Moderately Impaired ADL capacity
   Regularly requires assistance with Daily Household Care.

5. Severely Impaired ADL capacity
   Needs help daily with personal care but not necessarily throughout the day or night.

6. Completely Impaired ADL capacity
   Needs help throughout day and/or night to cope with personal care. Requiring very frequent supervision (once every two or three hours). (e.g. Bedridden).

ECONOMIC RESOURCES RATING

16. RATE THE CURRENT ECONOMIC RESOURCES OF THE CLIENT ALONG THE SIX-POINT SCALE PRESENTED BELOW. CIRCLE THE NUMBER WHICH BEST DESCRIBES THE PERSON's PRESENT CIRCUMSTANCES.

(57)

1. Economic Resources Excellent
   Income is ample; client has reserves and no anxiety about managing.

2. Economic Resources Satisfactory
   Income is adequate and either client has no reserves or expresses anxiety about managing in the future (or both).

3. Economic Resources Mildly Impaired
   Income somewhat inadequate; client experiences difficulty or anxiety over managing in the present.

4. Economic Resources Moderately Impaired
   Income is inadequate; client requires financial assistance to reach a satisfactory standard; expresses difficulty or anxiety over providing for essentials.

5. Economic Resources Severely Impaired
   Income is totally inadequate; unable to manage at tolerable level; requiring immediate help with money.

6. Economic Resources Completely Impaired
   Client is destitute, completely without income or reserves.

Summary of Ratings:

Social Resources _____

Mental Health _____

Physical Health _____

Activities of Daily Living _____

Economic Resources _____

Cumulative Impairment Score
(Sum of 5 ratings). _____

17. Brief descriptive sketch of client

Difficulties/life events/pleasurable happenings

Summary list of items brought up earlier in questionnaire for use in questions 84 - 86.
Code difficulties as D
unpleasant life events as E
pleasurable happenings as P

Item	Code (D,E or P)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

TIME ONE CARER INTERVIEW SCHEDULE

NEW KENT - 1 - VARIABLE NAMES

TIME 1

PRIVATE AND CONFIDENTIAL

PRINCIPAL CARER INTERVIEW

a. Name of client .....

b. Name of principal carer .....

c. Address of principal carer .....

---

d. Interview Number [ ][ ][ ] (1) (2) (3) (PCASE*, PCASE2, ...)

e. Scheme [ ] (4) (PSCHEME*, PSCHEME2, ..., PSCHEM10, ...)

f. Test 1 2 3 4 (6) (PTEST*, PTEST2, ...)

g. Card Number [ ][ ] (7) (8) [OMIT PCARD]

h. Area

EXPERIMENTAL	CONTROL
2 Sheppey	5 Faversham
3 Tonbridge	6 Tonbridge

(PAREA*, PAREA2, ...) (9)

i. Date of Interview [ ][ ] / [ ][ ] / [ ][ ] (11) (12) / (13) (14) / (16) (17)

(PDAY1)* (PMTH1)* (PYEAR1)*

j. Any special difficulties in interview; eg. time, answers.

Descriptors

1. Age of carer ☐☐ (AGE) (18) (19)
   Sex M 1 F 2 (PSEX)* (21)

2. Marital status of carer
   single 1
   married 2
   widowed 3 (MS) (22)
   separated 4
   divorced 5

3. Relationship of carer to client
   spouse 1
   daughter/son 2
   daughter-i-l/son-i-l 3 (RELCL)
   niece/nephew 4
   niece-i-l/nephew-i-l 5 (23)
   sister/brother 6
   sister-i-l/brother-i-l 7
   unrelated 8
   other 9

   BLANK (24)

4. Number of persons in household ☐☐ (PHHOLD)* (26) (27)

5. Of these (a) how many are children under 16? (KIDS) ☐☐ (28) (29)

   (FTCS) (b) (full-time carers) how many over 16 are available to provide care throughout the day? ☐☐ (31) (32)

   (PTCS) (c) (part-time carers) how many over 16 are available to provide care while home from work ; or at times during the day? ☐☐ (33) (34)

6. Size of accommodation. Number of rooms. (HOMSIZE) ☐☐ (36) (37)

7. Does client live with carer?
   n 1 (CATHOME)* (38)
   y 2

8. If yes, who owns the house/holds the tenancy?
   (TENANT) Carer's family 1
   client 2 (39)
   other 3

9. How long have you been caring for G?
   (CARE)
   Less than 1 month 1
   1 mth - 3 mth 2
   3 mth - 6 mth 3
   6 mth - 1 yr 4 (41)
   1 yr - 2 yr 5
   2 yr - 3 yr 6
   3 yr - 5 yr 7
   5 yr - 10 yr 8
   greater than 10 yr 9

Ways in which the household helps G

Could we discuss the ways in which you and your household help G? Do you...

10. ...help G. in getting up and going to bed?

(RISRET)

yes: always/nearly always 4
yes: sometimes 3
yes: occasionally 2
no: not at all 1

(42)

recode blank = Ø

11. ...prepare any meals for G?

(If yes) How many per week on average?

breakfast (BRFAST) ☐ (43)

lunch (LUNCH) ☐ (44)

tea (TEA) ☐ (46)

12. ...assist G in doing light housework,

(SIHWKG)

yes: all/nearly all tasks 4
yes: some tasks 3
yes: a few tasks/occasionally 2
no: not at all 1

(47)

13. ...help G with tasks involving personal care or heavy lifting; e.g. transferring to chair or commode, bathing, stripping beds to wash soiled linen, cleansing sores?

(PCCAREG)

yes: all/nearly all tasks 4
yes: some tasks 3
yes: a few tasks/occasionally 2
no: not at all 1

(48)

14. ...make regular pop in visits to check that G is alright; e.g. in case of an emergency, such as a fall?

(CHECKG)*

yes: every/most days 4
yes: some days 3
yes: occasionally 2
no: not at all 1
no: living with and regularly supervising G. 9

(49)

15. ...spend some time with G simply for supervision purposes; I mean, to make sure she does not get into any danger, due to frailty or confusion?

(SUPERVG)

yes: every/most days 4
yes: some days 3
yes: occasionally 2
no: not at all 1

(51)

16. ...spend time helping G away from the home; e.g. shopping, taking G for outings, gardening?

(LIJOBSG)

yes: every/most days 4
yes: some days 3
yes: occasionally 2
no: not at all 1

(52)

17. ...spend time with G which is mainly for companionship or to cheer her up?

(SOCIALG)

yes: every/most days 4
yes: some days 3
yes: occasionally 2
no: not at all 1

(53)

BLANK (54)

Total time taken and assistance from others

18. How many hours do all these tasks take you, and your household, on average, a week?
Comments: (HOURSPW) (56) (57) (58) hours

(PCOMM1)*

(59)

19. Which do you find to be the most unpleasant, upsetting or difficult task or aspect of G?

Record: (WORST) (61)

20. Are there any (other) aspects of G's behaviour which cause problems? (Probe)

		Constant/ Periodic	Occasional	None	
(i)	Dangerous to self or others (BEHAV1)	3	2	1	(62)
(ii)	Apparantly wilfully uncooperative/ personality conflicts	3	2	1	(63)
(iii)	Uses odd speech, expresses unusual ideas, 'bizarre' behaviour	3	2	1	(64)
(iv)	Hypochondriasis	3	2	1	(66)
(v)	Requiring nursing or physical care	3	2	1	(67)
(vi)	Demanding excessive companionship	3	2	1	(68)
(vii)	Daytime wandering	3	2	1	(69)
(viii)	Noisy or wandering at night	3	2	1	(71)
(ix)	Deafness/communication difficulties	3	2	1	(72)
(x)	Falling	3	2	1	(73)
(xi)	Other - record:	3	2	1	(74)
(xii)	Incontinence of urine	3	2	1	(76)
(xiii)	Incontinence of faeces (BEHAV13)	3	2	1	(77)

recode blank→0

recode 3→2

recode 2→1

recode 1→0

21. Which of these cause most difficulty to you? (Code appropriate numbers in boxes.)

1. ☐☐ (78) (79) (DPROB1) 2. ☐☐ (Card 2)(11)(12) (DPROB2) 3. ☐☐ (13)(14) (16) (DPROB3)

Comments:

(PCOMM2)*

22. Do you get any help in looking after G from....

	Personal Care	Housework/ shopping	Moral Support
(a)...other family members, relatives or friends within your household?			
Yes...intensively / regularly / occasionally	(FAMSUP1) 4 3 2	(FAMSUP2) 4 3 2 (18)	(FAMSUP3) 4 3 2 (19)
No... never	1	1	1
(b)...other family members, relatives, friends or neighbours outside your household?			
Yes...intensively / regularly / occasionally	(RELSUP1) 4 3 2 (21)	(RELSUP2) 4 3 2 (22)	(RELSUP3) 4 3 2 (23)
No... Never	1	1	1
(c)...Social Services/other statutory agencies			
Yes...intensively / regularly / occasionally	(SSSUP1) 4 3 2 (24)	(SSSUP2) 4 3 2 (26)	(SSSUP3) 4 3 2 (27)
No...never	1	1	1
(d)...Voluntary agencies			
Yes...intensively / regularly / occasionally	(VOLSUP1) 4 3 2 (28)	(VOLSUP2) 4 3 (29) 2	(VOLSUP3) 4 3 2 (31)
No....never	1	1	1

recode blank→1 throughout

Comments: (PCOMMT1)*

Later, in pcmerge, recode 4→3, 3→2 } →1; 2→1, 1→Ø } →Ø

for all 12 variables – but not recoded in nkevmon.sav

23. (a) What types of (additional) help from Social Services do you think would assist you and G? (32)

Record: (OTHHELP)

(b) (Experimental group, second interview only). In what ways has the CCS been able to offer increased service to you and G during the past year? (33)

Record: N/A

Effects upon self and family

And now I would like to ask you about the effect upon you and your family of helping G.

24. Have you found that looking after G has affected the household routine?

recode blank→1

(i) Shopping	Yes	2	(SHOPDIF)	(34)
	no/tolerable	1		
(ii) Mealtimes	Yes	2	(MEALDIF)	(36)
	no/tolerable	1		
(iii) Getting to work on time	Yes	2	(PUNCDIF)	(37) (38)
	no/tolerable	1		

Comments: (PCOMMT2)*

(HHOLDR)

Extent of interference with household routine 1 2 3 BLANK (39)

recode: ↓ Ø ↓ 1 ↓ 2 ↓ Ø

25. And now, the effect on your employment. Has looking after G meant that ...

recode blank=1

(i) You have had to give up a full-time job? (FTWK)	yes completely	3	
	yes partly	2	(41)
	no	1	
(ii) You have had to give up a part-time job? (PTWK)	yes completely	3	
	yes partly	2	(42)
	no	1	
(iii) Your husband's/wife's work has been affected? (HUSBWK)	yes substantially	3	
	yes a little	2	(43)
	no	1	

Comment: (PCOMM3)* (44)

recode (EMPDIFF)

Extent of interference with employment BLANK 1 2 3 (46)

↓ Ø ↓ Ø ↓ 1 ↓ 2

26. Since looking after G, have you ...

recode blank→1

(i)	... stopped visiting friends/ relatives? (NOFRND)	yes: entirely/almost entirely	4	
		Yes: sometimes	3	
		yes: a little	2	(47)
		no not at all	1	
(ii)	... stopped going out? (NOOUT)	yes: entirely/almost entirely	4	
		yes: sometimes	3	
		yes: a little	2	(48)
		no not at all	1	
(iii)	... stopped social activities? (NOSOC)	yes: entirely/almost entirely	4	
		yes: sometimes	3	
		yes: a little	2	(49)
		no not at all	1	
(iv)	... stopped having visitors? (NOVIS)	yes: entirely/almost entirely	4	
		yes: sometimes	3	
		yes: a little	2	(51)
		no not at all	1	
(v)	(if applicable) spend less time with your husband/wife? (NOFAM)	yes: entirely/almost entirely	4	(52)
		yes: sometimes	3	
		yes: a little	2	
		no not at all	1	
(vi)	... stopped having holidays ? (NOHOLS)	yes: entirely/almost entirely	4	
		yes: sometimes	3	(53)
		yes: a little	2	
		no not at all	1	

Comment: (PCOMM4)* (54)

	recode		(SOCDIFF)	
Extent of interference with social life	BLANK → 0	1 → 0	2 → 1	3 → 2 (56)

27. And now the effect on your children.

(a) Observed

(i) Are you able to spend as much time with your children as you would like? Yes 1, no 2 (KDPROB1)* (57)

(ii) Is their sleep disturbed? Yes 2, no 1 (KDPROB2)* (58)

(iii) Are they restricted from bringing friends home? Yes 2, no 1 (KDPROB3)* (59)

(iv) Does it interfere with their homework? Yes 2, no 1 (KDPROB4)* (60)

(v) Has the quality of your care of the children suffered? Yes 2, No 1 (KDPROB5)* (61)

(b) Inferred
Are there any other problems due to G? (Probe)

(v) Are there school attendance difficulties? (NSA) Yes 2 no 1 (62)

(vi) Any delinquency? (DELINQ) Yes 2 no 1 (63)

(vii) Any bedwetting? (ENEURE) Yes 2 no 1 (64)

Comments: (PCOMM5)* (66)

Extent of interference with children BLANK 1 recode 2 3 (KIDIFF) (67)
↓ ↓ ↓ ↓
Ø Ø 1 2

28. (Physical health)
And now your health.

(i) Has looking after G affected your physical health in any way?
Yes 2
No 1 (PHLTH) (68)

(ii) Has anybody else's health at home been affected?
recode BLANK → 1 Yes 2
No 1 (OTHLTH) (69)

Comments: (PCOMM6)* (71)

Extent of difficulty BLANK 1 recode Ø ↑ 1 ↑ 2 1 ↑ 2 2 ↑ 3 (HDIFF) (72)
Have you suffered any backstrain due to lifting G?
yes: frequently 4
yes: sometimes 3 (BACK) (73)
yes a little 2
no not at all 1 (74)

Comments: (PCOMM7)*

Recodes { 2 → 1 / 1 → 0 } throughout

30. Psychosomatic symptoms / Mental health

(i) Do you often have backache?	yes	2	(STRESS1)	
	no	1	(CARD 3)	(21)
(ii) Do you feel tired most of the time?	yes	2		
	no	1		(22)
(iii) Do you often feel miserable or depressed?	yes	2		
	no	1		(23)
(iv) Do you often have bad headaches?	yes	2		
	no	1		(24)
(v) Do you often get worried about things?	yes	2		
	no	1		(26)
(vi) Do you usually have great difficulty in falling asleep or staying asleep?	yes	2		
	no	1		(27)
(vii) Do you usually wake unnecessarily early in the mornings?	yes	2		
	no	1		(28)
(viii) Do you wear yourself out worrying about your health?	yes	2		
	no	1		(29)
(ix) Do you often get into a violent rage?	yes	2		
	no	1		(31)
(x) Do people often annoy and irritate you?	yes	2		
	no	1		(32)
(xi) Have you at times had a twitching of the face, head or shoulders?	yes	2		
	no	1		(33)
(xii) Do you often suddenly become scared for no good reason?	yes	2		
	no	1		(34)
(xiii) Are you scared to be alone when there are no friends near you?	yes	2		
	no	1		(36)
(xiv) Are you easily upset or irritated?	yes	2		
	no	1		(37)
(xv) Are you frightened of going out alone or of meeting people?	yes	2		
	no	1		(38)
(xvi) Are you constantly keyed up or jittery?	yes	2		
	no	1		(39)
(xvii) Do you suffer from indigestion?	yes	2		
	no	1		(41)
(xviii) Do you often suffer from an upset stomach?	yes	2		
	no	1		(42)
(xix) Is your appetite poor?	yes	2		
	no	1		(43)
(xx) Does every little thing get on your nerves and wear you out?	yes	2		
	no	1		(44)
(xxi) Does your heart often race like mad?	yes	2		
	no	1		(46)
(xxii) Do you often have bad pains in your eyes?	yes	2		
	no	1		(47)
(xxiii) Are you troubled with rheumatism or fibrositis?	yes	2		
	no	1		(48)
(xxiv) Have you ever had a nervous breakdown?	yes	2	(STRESS24)	
	no	1		(49)

(xxv) Are you receiving any psychiatric care? (MH7) yes 2 / no 1 (13)

(xxvi) Are you taking sleeping pills? (MH4) yes 2 / no 1 (14)

(xxvii) Do you take "pills for nerves"? (MH8) yes 2 / no 1 (16)

(xxviii) Has anybody else in the family been affected to this extent? (MH9) yes 2 / no 1 (17)

X Record family members affected: (18)

Comments: (PCOMM8)* (19)

recode

Effect upon carers' mental health (MHLTH) BLANK→1→Ø 2→1 3→2 (51)

31. (Housing/accommodation) And now ways in which the layout of your home may lead to difficulties in looking after G.

(i) Are there any problems with stairs? (PSTAIRS)*
yes: definitely 3
yes: some 2 (52)
no: little or none 1
no: not applicable 9

(ii) Are there difficulties in access; e.g. to the toilet/bathroom or front/back doors? (ACCESS)
yes: definitely 3
yes: some 2 (53)
no: little or none 1

(iii) Is there sufficient space to care for G? (PSPACE)*
yes: definitely 3 (54)
yes: but problems 2
no: 1
no: not applicable 9

Comments: (PCOMM1Ø)*

32. Overall, would you say that looking after G has meant that the household has suffered a sense of burden? (SUBJB) recode
yes: severe 3→2
yes: some 2→1 (57)
no: little or none 1→Ø

If yes: In what ways has this been worst for you?
Record: (PCOMM11)* (58)(59)

Coping Mechanisms of principal carer.

And now I would like to ask you about your ways of coping with the daily routine of care.

33. Do you

(COPE1)

(i) depend on yourself to solve most problems? yes 2 no 1 (61)

(ii) seek much help or advice? yes 2 no 1 (62)

(iii) yell or shout to let off steam? yes 2 no 1 (63)

(iv) sit quietly to think things through? yes 2 no 1 (64)

(v) keep your mind off worrying by constant activity? yes 2 no 1 (66)

(vi) talk things over when there are conflicting opinions? yes 2 no 1 (67)

(vii) try and overlook some of G's behaviour? yes 2 no 1 (68)

(viii) rely on discipline? yes 2 no 1 (69)

(ix) feel things tend to work out in the end? yes 2 no 1 (71)

(x) feel able to accept your situation as a necessary part of your life? yes 2 no 1 (72)

(COPE11) (COPE12) (COPE13) (xi) have periodic breaks away from G (a) evenings (etc.) out; yes 2 no 1 (73)

(b) holidays away from home yes 2 no 1 (74)

(c) Part III holidays for G? yes 2 no 1 (76)

have other ways of coping too? Record:

(COPE14) (xii) yes 2 no 1 (77)

(COPE15) (xiii) yes 2 no 1 (78)

(COPE16) (xiv) yes 2 no 1 (79)

Which of all these ways of coping to you find the most effective? (Code appropriate number in box.) (COPEEFF)* CARD 4 [ ][ ] (11) (12)

(COPE17) (xv) (Psychological coping resource) Do you get a lot of satisfaction out of looking after G? yes 2 no 1 (13)

Comments: (PCOMM13)* (14)

34. (Looking back) (a) If you had it to do over again, would you make the same decision again and have G live here/become as closely involved in caring for G? (CARENOW) yes 3→2 recd yes (no alternative perceived) 2→1 (16) no 1→Ø

(If no, ask why not).

Comments: (PCOMM14)* (17)(18)(19)

(b) (If no and control group). Might your answer have been yes if help were available which provides you with sufficient support in looking after G? (ALTPOSS) yes 2 no 1 (21)

We are very concerned to find out some of the costs of people caring for elderly relations. Perhaps I can ask you if you find that living with G/looking after G leads to any expenses above the usual? (Probe different areas: if positive ask for weekly expenditure.)

recode blank = 0

35.
(i) Loss of earnings £ ☐☐☐ (22)(23)(24) (CASH1)
(ii) Housing £ ☐☐ (26)(27)
(iii) Fuel £ ☐☐ (28)(29)
(iv) Food £ ☐☐ (31)(32)
(v) Transport £ ☐☐ (33)(34)
(vi) Services £ ☐☐ (36)(37)
(vii) Laundry £ ☐☐ (38)(39)
(viii) General financial support £ ☐☐ (41)(42)
(ix) How much per week worse off would you say you are through looking after G? £ ☐☐☐ (46)(47)(48)
(x) How much does G contribute to the costs? £☐☐☐ (51)(52)(53) (CASH10)
(xi) Are other relatives/friends helping out financially in caring for G?

BLANKS (43)(44)(49) (FAMCASH) Yes 2 no 1 (54)

36. And as a last question, could you tell me which of these groups the family weekly income falls into?

(Show card)
less than £25 1
£25 - £50 2
£50 - £75 3
£75 - £100 4
£100 - £150 5
£150 - £200 6
greater than £200 7

(FAMINC) (56)

Close interview. Thank informant.

Interviewer Assessment

1. Informant's attitude to interview:

Co-operative	3	
A little unhelpful	2	(57) (PATTINT)*
Hostile	1	

2. Overall rating of strain upon helper:

	recode	
None/acceptable	1 → Ø	
Some difficulty	2 → 1	(58) (STRAIN)
Very difficult	3 → 2	
Intolerable	4 → 3	

3. Overall rating of tension in the home:

	recode	
None	1 → Ø	
Some	2 → 1	(59) (DOMTENS)
Severe	3 → 2	

4. Warmth expressed toward G in the interview

	recode	
Very little warmth; matter of fact description	1 → Ø	
Some evidence of warmth, but generally undemonstrative	2 → 1	(61)
Moderate degree of warmth, sympathy and understanding, but not very demonstrative	3 → 2	(WARMTH)
Very warm, loving and sympathetic but more restrained than 5.	4 → 3	
Extremely warm, sympathetic, open affection	5 → 4	

5. Hostility expressed toward G in the interview

	recode	
No evidence	1 → Ø	
Minimal evidence	2 → 1	(HOSTILE) (62)
Despite hostility, not often observed in open form	3 → 2	
Marked rejection or hostility openly revealed	4 → 3	

6. Brief descriptive sketch.

APPENDIX 3

FEEDBACK FORM

COMMUNITY CARE SCHEME

SIX-MONTHLY FEEDBACK TO FIELDWORKER

CASELOAD PROFILE: ALL KENT

FEEDBACK NUMBER: 6 FOR SIX MONTHS ENDING 31ST MARCH 1986

(I) BASIC CASELOAD INFORMATION

NO. OF CCS FIELDWORKERS: 17.0(17.0) NO. OF ASSISTANT CCS FIELDWORKERS: 13.0(11.5)

NO. OF CASE REVIEWS COMPLETED: 1306(1185) NUMBER OF CASES OPENED: 395(328)

PROPORTION OF FIRST REVIEWS: 25%(25%) NUMBER OF CASES CLOSED: 300(219)

PROPORTION OF CLOSED REVIEWS : 17%(17%) NUMBER OF OPEN CASES: 702(638)

CLOSED CASES:- DIED: 47%(35%) LONG-TERM RESIDENTIAL CARE: 21%(21%)

LONG-TERM HOSPITAL CARE: 7%(11%) AVERAGE TIME IN CCS: 10 MONTHS(9 MONTHS)

AVERAGE AGE: 82(82) SEX:- MALE: 23%(23%)

FEMALE: 77%(77%)

(2) INFORMATION ON CASES OPENED DURING THE SIX MONTH PERIOD

DEPENDENCY: -LONG INTERVAL NEED: 2%(4%)

SHORT INTERVAL NEED: 13%(10%)

CRITICAL INTERVAL NEED: 63%(66%)

SEVERE CRITICAL INTERVAL NEED: 22%(20%)

INFORMAL CARE : -

PROPORTION OF CASES WITH PRINCIPAL INFORMAL CARER: 74%(71%)

(3)CASE REVIEW DATA

(ONLY FREQUENCIES OF 10% AND OVER ARE INCLUDED UNLESS OTHERWISE STATED)

(A) USER PROBLEMS TACKLED

Physical disability/illness	63%(59%)
Visual difficulties	14%(14%)
Hearing difficulties	15%(14%)
Incontinence	19%(21%)
Difficulties arising am/pm	49%(46%)
Personal care problems	62%(54%)
Daily household problems	58%(54%)
Weekly household problems	52%(48%)
Psychol./emotional disorder	- %(11%)
Cognitive impairment	19%(19%)
Behaviour problems	13%(13%)
Social isolation/loneliness	29%(31%)
Family relations problems	21%(22%)

(B) SOCIAL WORKER ACTIVITIES

None	15%(16%)
Exploratory/(re-)assessment	33%(36%)
Information/advice	34%(29%)
Mobilising resources	36%(37%)
Co-ordinating resources	43%(43%)
Check-up/review visits	74%(71%)
Facilitate prob. solv./decision making	21%(17%)
Sustaining/nurturing user	72%(64%)
Sustain/nurture-family/informal carers	51%(44%)
Sustaining/nurturing-CCS	65%(59%)

AVERAGE NUMBER OF CONTACTS WITH USER OR FAMILY: 5.9(5.6) PER QTR.

(C) OUTSIDE AGENCIES CONTACTED (INCLUDING FREQUENCIES DOWN TO 5%)

None	41%(44%)
General Practitioner	44%(42%)
Geriatric Hospital/O.P.D.	9%(6%)
Other hospital/O.P.D.	- %(5%)
Housing Department	5%(7%)
DHSS (Social Security etc.)	6%(- %)
Age Concern	6%(7%)

(D) RESOURCES REQUIRED BUT UNAVAILABLE NUMBER OF TIMES NOTED:

Home Help	0(2)
Night Sitter	1(0)
Incontinent laundry service	1(7)
Occupational Therapy	2(0)
Specialist S.W. blind/deaf	1(0)
Aids for blind/partially sighted	0(1)
Aids-other	0(1)
Meals on wheels	1(7)
Group Home	0(1)
Sheltered Housing	0(1)
Community Nurse	3(2)
Bath Attendant	2(1)
Day hospital -geriatric	1(0)
General hospital admission	0(1)

(E) PRACTICAL SERVICES USED

(i) DOMICILIARY AND COMMUNITY RESOURCES

Home Help	70%(70%)
Volunteer Involvement	14%(16%)
Paid helper	70%(64%)
Aids for mobility	37%(40%)
Aids for toileting	35%(37%)
Aids for bathing	16%(19%)
Aids for household use	16%(15%)
Telephone	13%(11%)
Day Centre	13%(12%)
Meals on wheels	16%(16%)

(ii) RESIDENTIAL SERVICES (INCLUDING FREQUENCIES DOWN TO 5%)

Part III- short term	5%(- %)

(iii) NHS SERVICES

Community Nurse	50%(46%)
Bath Attendant	23%(22%)

(4) COSTS INFORMATION

	(A) OCT- DEC 1985		(B) JAN -MAR 1986	
AVERAGE WEEKLY SSD COST:	£ 41.86	(£ 40.62)	£ 41.33	(£ 42.49)
PROPORTION OF SSD COST FROM: -				
(1) HOME HELP:	0.26	(0.28)	0.25	(0.26)
(2) COMMUNITY CARE:	0.64	(0.63)	0.66	(0.63)
(3) DAY CARE:	0.05	(0.05)	0.04	(0.05)
NUMBER OF CASES WITHIN 10 % OF TWO-THIRDS THE COST OF RESIDENTIAL CARE:	150	(104)	160	(148)
TOTAL QUARTERLY COST (1) SSD:	£ 361530	(£ 293631)	£366428	(£342408)
(2) COMMUNITY CARE:	£ 231859	(£ 186214)	£236740	(£214629)

APPENDIX 4

SOME STUDIES OF PROBLEMATIC CASES

1 Some studies of problematic cases in Sheppey

1.1 Supporting a stroke victim and an over-protective over-worked spouse

Mr X had suffered a moderately severe stroke four years before being referred and this rendered him very shaky on his feet. Even with the aid of a Zimmer frame he was considerably at risk of falling when walking short distances. This came as a big shock to him as he had been used to an active outdoor life as a docker. In addition the stroke had affected his speech. Friends found his slurred speech difficult to understand and stopped visiting out of embarrassment. The stroke had also caused a reduction in power to co-ordinate his right hand, making holding things difficult and resulting in breakages.

Shortly after his stroke another tragedy befell the couple. Their house was flooded and Mr X was trapped downstairs in waist deep water for twelve hours. He was too heavy for his wife to drag him to the first floor and the situation reduced her to a state of panic. The experience was traumatic for both of them, and most of their furniture was lost. After this the couple was rehoused to their present warden-supervised bungalow. Subsequently Mr X suffered a bowel haemorrhage.

Although Mrs X responded to her husband's danger of falling by standing behind him giving instructions and being ready to cushion any fall he might have whenever he went to the lavatory, Mr X resented this as an intrusion on his independence and would derive impish pleasure out of 'playing her up'. He hated being so dependent upon her so he tried to spite her. Such marital tensions frequently arise from transitions in lifestyle (Parkes 1971).

The warden supervising his bungalow made a referral following a deterioration in his relationship with his wife, who had become depressed. On visiting to assess the situation, the care manager found Mrs X to be very taxed in caring for her husband. A urinary infection had rendered him frequently incontinent causing broken nights, and she was exhausted through lack of sleep. There was little support from relatives or neighbours and she was tied to the house. Nevertheless, she was very ambivalent about accepting help, and initially refused any domiciliary support.

Part of the aim of Community Care involvement was to alleviate the marital tension. Mrs X had responded to the series of tragic events directed at her husband by being over-smothering, while he found it extremely difficult to accept his dependence on her. The care manager therefore encouraged both partners to express their frustration and helped them overcome their feelings of guilt. This provided an important first step in improving their relationship (Allen *et al.* 1983).

It is frequently the case that a succession of shocks can precipitate a depressive episode (Brown and Harris 1978) as it had done in Mrs X, who also lost a lot of weight, was smoking heavily and was taking tranquillisers. The care manager enabled the couple to talk about these shocks to help them ventilate their feelings.

Following a fall, the GP, after discussion with the care manager, arranged periods of three weeks in a local hospital on a three-monthly basis, with the aim of providing relief for his

wife as well as giving him a physical boost. Unfortunately his physical habits deteriorated each time he was admitted to hospital as he did not receive the personal attention he obtained from his wife. This meant that the first week back at home was always particularly difficult for Mrs X. She resented his returning from hospital but felt guilty about her feelings. However, as he preferred hospital and liked the company he got there the arrangement was allowed to continue.

While at home Mr X would just sit in the chair all day. The care manager was able to respond by arranging day care twice a week, which gave him further opportunities of meeting people, with a helper getting him ready and accompanying him in a taxi. Mrs X eventually agreed for the helper to visit the home on other occasions. Mr X enjoyed the company of this helper and her three year old boy. Both the day care and the helper visits allowed Mrs X to get out to the shops. Mrs X subsequently let the care manager negotiate for a community nurse to get her husband in and out of bed. This considerably eased the physical strain on Mrs X, who had been lifting him before, resulting in a bent back. Meanwhile, through close cooperation with the GP, community nurses and hospital, the urinary infection had been treated and cleared up, giving the couple more settled nights. As Mrs X came to trust the care manager and accept more help, she allowed two more helpers to visit and assist with personal care tasks.

These continued to provide support until the death of the user some twelve months after referral. The care manager and helpers continued to visit Mrs X following her bereavement; this type of help would not normally have been provided by an area team. The case was closed three months later.

Thus the care manager approached the enabling process by providing counselling for the loss, shocks and marital tension suffered by the couple. Cooperation with the GP had facilitated the treatment of medical problems. The husband was provided with the social stimulation he lacked. As his wife accepted more help she became less worn out. Moreover, the outlets outside the home offered to each partner had assisted in reducing marital tension.

1.2 Managing an older lady at risk whose informal carer had an over-smothering attitude to the user

Mrs Y, aged 90, lived on her own in a ground floor council flat. At the time of referral she had had a recent fall, when the police had broken in and had taken her to hospital for observation. A neighbour living on the third floor provided considerable support. Mrs Y's son, who lived locally, did little to help. When the neighbour went away on summer holiday for several weeks, Mrs Y was admitted to a fortnight's short-term care in a county residential home. On discharge, she received day care five days per week as an interim arrangement by the social services department and was referred to CCS for care in the longer term.

The care manager found Mrs Y needed help in getting up and going to bed and with meal preparation and housework but had restricted mobility with the aid of a Zimmer frame. She had a very direct way of communicating and could be harsh in her demands. Her attitude to the care manager would alternate between kissing her hand on some occasions, while being aggressive at other times. The care manager found her relationship with Mrs Y improved once she began responding very firmly to her aggression. Although the neighbour had said before her holiday that she did not wish to continue caring for Mrs Y, she ended up doing even more on her return. It appeared that Mrs Y could be quite

demanding, and the neighbour was unable to resist these demands, even though this meant taking on too much. This contrasts with the previous case study, in which the user wanted his wife to be less involved. Although the son wished to have Mrs Y admitted to long-term residential care, his mother adamantly resisted change.

It was clear that the care manager would need to provide a package of care which sufficiently off loaded the neighbour to prevent her support from breaking down completely, and yet still allowed the neighbour to feel fully involved, without having to take overall responsibility. Mrs Y grudgingly accepted the need for Community Care involvement. Home help visits were arranged for three mornings a week with meals on wheels on two of these days, and day care twice a week. Community Care helpers prepared a midday meal for the remaining three days and visited every evening to assist Mrs Y to bed. The neighbour continued to help get Mrs Y up in the mornings and provide general support. Mrs Y gradually adjusted and became quite happy with this programme of care, which continued unchanged over the next year.

The neighbour continued to be fully involved. Although she initially opposed having the helpers visit, she slowly came round accepting them. Over the year Mrs Y's mobility steadily deteriorated until she became chairbound. Fortunately she was not confined in this way all the time, as the neighbour obtained a wheelchair and would wheel Mrs Y shopping, collecting her pension, along the sea wall and to coach outings organised by local groups. Nevertheless by the time Mrs Y had been receiving Community Care for one year, the care manager felt that the neighbour had made Mrs Y totally dependent on her, depriving her prematurely of some of the things she might have been able to do.

The care manager therefore decided to arrange for Mrs Y to be assessed at the day centre to see whether she was capable of performing more tasks for herself, and after much initial protest, Mrs Y agreed to the idea.

The neighbour's involvement remained crucial to Mrs Y's well being. However, she did not wish to be contained by a contractual agreement and receive payment as a helper as she did not want to have official responsibility for Mrs Y. This meant that the care manager had less influence in persuading the neighbour to let Mrs Y do more for herself. The neighbour needed to feel needed, and Mrs Y fulfilled this. The neighbour would not accept that Mrs Y would naturally deteriorate and was quietly angry that the care manager did not arrange more help for Mrs Y. Her criticism was never direct, but the grapevine method achieved the desired result. There was still a danger that the neighbour could overtax herself and withdraw completely.

The care manager tried in vain to persuade the son to become more involved. He would visit only once a fortnight. He refused to invite his mother to his home over Christmas as he maintained that this would not fit in with his social life. At the same time, Mrs Y refused to accept phased care as a means of providing relief to the neighbour.

Unfortunately the plans for Mrs Y to be assessed at the day centre were overtaken by her sustaining a number of falls, which resulted in a two week stay in hospital. She was transferred to a local authority residential home for one month's assessment and convalescence. Because the falls had caused her condition to deteriorate she decided to remain in residential care, though this decision had been in part a result of intense family pressure, and despite the care manager having been willing to provide continued support at home.

This case had been difficult to manage because of the way in which the neighbour wished to be involved which, although providing stimulation in some ways, had been over-smothering in other ways and probably accelerated the user's physical decline. As a consequence, much of the effort of the care manager had been towards supporting the neighbour and enabling her to accept relief rather than in providing direct help to the user. However, despite the limit to which the neighbour would let go, the user was able to spend a year at home in the scheme.

1.3 Supporting an older lady with brain failure who was severely at risk

At the time of her referral Mrs Z, aged 79 years, who suffered from senile dementia lived alone in her own terraced house. She had one daughter who lived outside the county and visited every three months. The relationship was not a good one and the daughter was afraid of the mother's mental state. The son-in-law, who had power of attorney, carried out all the negotiating with the social services department. Both were school teachers and worked full-time.

Until six months before referral, Mrs Z had had two sisters, one of whom moved in with her because she had been wandering at night, the other sister living about half a mile away. The latter sister became ill and the sister living with Mrs Z left to look after her. However, it was the fit sister who died very suddenly and the other sister was placed in a nursing home in another area. Mrs Z was left with no relatives available to help.

Mrs Z was subsequently referred to the social services department by the Senior Medical Officer for Older People who described Mrs Z as a 'very distressing case'. The Medical Officer had had numerous contacts with the son-in-law which resulted in a place being offered to Mrs Z in a private home for the mentally impaired. Mrs Z demanded to be taken back home after having been there for three hours and so her place was lost. The Medical Officer indicated that seven day supervision was needed as Mrs Z was not going to bed, was wandering in the street at night, left gas turned on and put rubbish on the electric fire, examples of *event risk*, arising through failure to carry out actions and tasks at a suitable time or in appropriate manner, so leading to danger. She was living on biscuits and sweets and refused to wash or change clothes. Mrs Z would not accept help and rejected anyone in uniform, would not let a doctor near her and on most occasions would not open the front door. This illustrates the problem of *entrée*, so often encountered with cognitively impaired older people, of gaining access to and acceptance by the user. The main fears were hypothermia, malnutrition and dehydration, examples of *process risk* brought about by self-neglect arising from confusion (Davies and Challis 1986, Challis and Davies 1986). The neighbours and anyone who knew Mrs Z frequently stated that she should be 'taken away' because of these risks.

Mrs Z opened the door to the care manager when she visited but she still refused to have anyone come on a regular basis. Mrs Z was difficult to understand as her sentences were mixed and there was no continuity of expression. She complained of pain in her neck, and her hands and feet were quite deformed by arthritis. The sole source of heating was a single electric bar fire.

The initial plan was for a helper to visit at lunch time to provide a hot meal and to attempt socialising. Mrs Z allowed the care manager to bring a 'friend' along to visit her and as it was lunch time and the 'friend' was a good cook she brought along lunch as well. In this way entrée had been established and Mrs Z allowed this helper to visit daily from then on. After one month a second helper was introduced, and they each visited daily. However, the

improvement in Mrs Z's diet was only limited, and she still lived mainly on sweet things, though accepted some flavoured Complan.

After Mrs Z had been in the scheme for two months, the Medical Officer called a case conference, since other agencies and neighbours were still concerned about Mrs Z's wandering at night and living at risk. It was agreed that the Community Care Scheme would continue its current involvement and would monitor the situation. The case conference requested that the question of central heating be explored as Mrs Z continued to be at risk of hypothermia. The plan was then to encourage Mrs Z to proceed with a home improvement grant to allow installation of central heating. However the installation had to be postponed as Mrs Z was refusing to let the work be done.

Throughout the involvement of the scheme, Mrs Z suffered severe spells of confusion and disorientation every three to four weeks. During these periods she would wander out at night. The neighbours were unsympathetic and called out the helper regardless of the time of day or night. The helpers provided extra cover during these agitated periods.

At these times Mrs Z was prone to aggressive bouts but the helpers seemed able to deal with this. One would hold Mrs Z when she became aggressive and rock her to sleep. Although she initially refused all medication, she eventually agreed to take a mild tranquilliser which helped reduce the severity of these episodes. The care manager arranged for a CPN for older people to visit at monthly intervals to monitor Mrs Z's mental state.

After four months in the scheme Mrs Z allowed the helpers to clean through her house. Initially it took them several days to remove maggot infested 'parcels' from all imaginable places. From then on, as Mrs Z refused to have a home help, the two helpers visited together one morning a week for cleaning the house; one helper spent her time with Mrs Z while the other did the housework. After the initial helper had been visiting for six months Mrs Z allowed her to give her a wash. Mrs Z's clothes were stuck to her skin which was inflamed and infected. Although the helper was able to wash the inflamed areas, Mrs Z would not allow the doctor to see them. He therefore prescribed ointment for the helper to apply according to the helper's description of the skin condition. The inflamed areas improved, though lumps still remained. Although Mrs Z's feet were in a poor condition, with the nails bent over, she refused to be seen by a chiropodist. However, when her feet were troubling her, she would sometimes let the helper soak her feet to reduce the pain.

Two months later, Mrs Z eventually agreed to the rewiring of the house and installation of central heating. She visited the initial helper's home while the work was being carried out. The risk of hypothermia was thereby eradicated together with the fire risk associated with the electric fire, illustrating how some forms of event risk can be overcome permanently.

Both helpers became very fond of Mrs Z and found that she had quite a sense of humour and loved children. Cognitively impaired older people can be helped by *patterning care* (Davies and Challis 1986, Challis and Davies 1986) which involves restoring old familiar routines and re-establishing previous skills. In addition to the use of medication already referred to which allowed a return to more normal periods of sleep, the helpers enabled Mrs Z to take up knitting again and she was quite proud of her efforts. Mrs Z never refused the helpers entrance to her house and she agreed that the helpers had a key in case anything went wrong.

By the time that Mrs Z had been in the scheme for one year she received three helper visits daily. Considering the problems involved in getting Mrs Z to accept any help at all, progress was very encouraging. Physically she improved and also she appeared brighter and happy for most of the time. However, she was still very cognitively impaired and her poor diet probably contributed to this.

After nearly two years in the scheme Mrs Z eventually agreed to attending a day centre twice a week and this added some further interest and variety to her daily life. One year later the initial helper took over all support, visiting four times daily. Day care continued successfully for three years, though was then stopped as Mrs Z was finding it becoming too tiring.

After six years in the scheme Mrs Z, then 85, was still being successfully supported at home. This was no mean achievement bearing in mind the difficulties, referred to in section 10.4.4.3, found in maintaining this user group at home. Although the care manager had spent a lot of time in enabling her to accept help to a limited extent, this had been successful in eradicating much of the event risk while reducing process risk and so reducing the fears of relatives and neighbours. The stability of the pattern of care offered provided Mrs Z with a sense of security. Disruption of such a routine could threaten the continued capacity of a cognitively impaired older person to survive at home, being experienced as a major life event (Evans, 1982). At the same time, by re-establishing previously adopted routines and activities, and restoring some of the companionship and social stimulation which she used to receive from her sisters, her quality of life had been considerably improved.

1.4 Responding to both the physical and psychological needs of a bedbound user and her informal carer

Miss W had rheumatoid and osteoarthritis and was bedbound and catheterized. She had previously moved in to live with her neighbours, Mr and Mrs V, when she was no longer able to cope on her own, since when the couple had provided substantial support.

The case was referred to the social services department because Mrs W's catheter leaked and she was left for periods in a wet bed as there was no-one to help lift her when the bed needed to be changed. The community nurse was unable to provide adequate care. A hoist had already been refused by the user. There was, however, no need for help with household tasks, as the carer could cope with this. Because the carer was likely to need support in other ways in order to continue coping with Miss W, the case was taken on for Community Care.

When the care manager visited, she found Miss W to be in poor physical health as a result of osteoarthritis, recurrent bladder infections and dietary problems following abdominal surgery. Miss W was unable to help herself due to the osteoarthritis. She had to be lifted carefully otherwise bones could easily have been broken. Her skin needed regular care in order to deal with pressure areas. However, mentally Miss W was alert and took an interest in what was going on. Unfortunately she was confined to her bedroom on the first floor. She had very little privacy but felt her surroundings to be adequate. She had the use of a telephone extension in her room, but was unable to use it if it were not left close to her. Apart from an older gentleman who visited once a week her social contact was with the carer's family whose members popped in and out. Initially, Miss W seemed to be afraid of change, so a few visits by the care manager were needed in order to enable her to accept help.

Mrs V was willing for a helper to visit every evening to help Mrs V in lifting Miss W provided Mr V, who worked shifts, could continue to help his wife perform this task when he was at home. This required a helper who could be adaptable. No other social services resources were needed. Miss W was unable to attend a day centre, did not require meals on wheels and could not make use of any aids to daily living. The GP visited when requested, which was approximately once a month, and a community nurse called twice weekly to attend to the catheter. As she would not have been eligible for local authority residential care because of the amount of care needed, Community Care could be seen as preventing an admission either to long-stay geriatric hospital or to a private nursing home.

The aim of the care manager was initially to respond to the presenting problem of the carer's need for help with lifting by arranging for a helper to visit most evenings. This support with personal care tasks could then be increased as and when appropriate. In addition to these personal care needs the care manager saw the need to respond to the psychological needs of the user and carer, which services providing support at the time of referral had completely ignored. During the carer's summer holiday six weeks after the initial assessment a second helper accompanied the first on visits to take over from the carer in lifting, 'Crossroads' providing the rest of the care. When the carer returned there was still evidence of resistance from her and the user, who both admonished the helpers on several points with remarks such as 'This is how *we* do things here'.

There seemed to be a lot of ambivalence towards receiving help from both user and carer. Mrs V was well meaning and had taken on caring for 'a stranger' when her own health was better. Mrs V was now clearly under a lot of pressure through the demands of giving Miss W the care she needed. Mrs V now suffered from migraine and arthritis and she resented the additional disruption caused by her husband's shift work. This led to marital conflict. Miss W, in turn, was angry at 'imprisonment' but grateful for being cared for. She had been an industrial nurse herself, and was a very particular lady who required everything to be in its very precise place. Procedures had to be meticulously observed. In the early stages, the care manager assisted the helper in becoming aware of how the user must feel being confined to four walls with no privacy and totally dependent on others, so that the helper could respond sensitively and tolerate Miss W's obsessions. By this means, Miss W found the help she received from the scheme more palatable than that originally provided by services, as it took account of her psychological needs.

In addition, the helper needed regular ongoing support from the care manager in order to cope with feelings of frustration, particularly with the carer.

When Miss W went through 'very ill' phases for which more care was needed, the helper increased her involvement over these periods. However, sometimes the carer would make unreasonable demands directly to the helper without first contacting the care manager. The care manager supported the helper in encouraging her to say 'no' under such circumstances.

The case clearly required an ongoing assessment, and the care manager depended upon the helper to provide much of the necessary feedback. A problem faced by the care manager in visiting Miss W was that she could rarely talk with her alone. However she did have the phone which, if left near her, could be used when the carer was out shopping. This means of communication assisted the care manager in obtaining a realistic understanding of what Miss W's feelings and wishes were.

The care manager was faced with the question regarding the extent to which she should become involved in the carer's marital problems. She decided to talk things over with them in a limited, focused way which impinged directly on their ability to support Miss W, provided they agreed, and this they were willing to do. However, full marital therapy could not be justified in view of the time this would have taken up which could instead have been employed in supporting other users. Such activity would have been beyond the remit of Community Care.

This study illustrates some important features of a well managed scheme and in particular some of the methods of supporting users and their informal carers described in section 10.4.3. Firstly, help was provided to the informal carers in a way which they found acceptable, providing them with much needed support and relief while not undermining their role. Secondly, tact and consideration were shown to the older person regarding the way in which help was offered; in this instance by accommodating her obsessional whims. Thirdly, because the stress involved in caring experienced by the couple providing help had led to marital conflict, the care manager offered focussed marital counselling to the extent that this would improve their support of the older person. This illustrates how a care manager should set boundaries regarding activities which are suitable in assisting frail older people.

2 Some studies of problematic cases in Tonbridge

2.1 Working through family, friends and neighbours in a case of alcoholism

Mrs A, aged 90, lived alone in Tonbridge in a mid-terraced house. Her common law husband died eighteen months previously after she had nursed him. She had had a long-standing problem of alcoholism for some 40 years, though while her husband was alive he used to manage their money and hence restrict the amount she could spend on drink. Since his death her consumption had risen to some four bottles of whisky per week. This was now undermining her physical and mental health and general ability to cope and her cognitive impairment was probably a result of prolonged alcohol abuse. The only relatives in contact were two adopted daughters, one living locally, and a grandson. A married couple living next door, Mr and Mrs B, were very supportive and referred Mrs A to the scheme via the grandson, as she was buying insufficient food and neglecting herself.

At first the care manager was not allowed in, Mrs A preferring to leave her care to Mr B, who lit the fire and was occasionally allowed to clean the floor. Indeed, the neighbours were ambivalent about the extra help they had requested from the scheme, and the care manager had the task of maintaining their goodwill and not encroaching on the support they already provided (see section 10.4.3). On gaining entrée, the care manager found the user to be lonely and depressed and not eating adequately. Her conversation was extremely restricted and repetitive and centred around how she prevented her two adopted children from staying in an orphanage. The home was sparsely furnished but clean and she managed to keep up to date with paying bills. Although she was bronchitic and slightly arthritic, she was physically agile and could get out to the shops.

An important aim was therefore to get her to eat adequately. After one month she agreed to a helper calling once a week to join her for a meal and hence encourage her to eat more. However, she thought the helper was her adopted daughter and would not admit her more often than once a week, as it used to be with her daughter, although the helper tried to call daily. The Bs seemed to resent this involvement and harassed the helper with unreasonable complaints, such as regarding her responsible for Mrs A's allowing the kettle to boil dry. As a result of these difficulties and occasional bad language from Mrs A when she was

drunk the helper, who did not appear to be quite suitable, was eventually tactfully withdrawn by the fieldworker, and replaced by another (a man). Because Mr B had a severe chest complaint, he had given up making the fire and since then Mrs A had used an electric fire. Unfortunately this presented a fire hazard as she sometimes tripped over the flex, leaving the fire face downwards on the carpet. On one occasion, she caused clothing to smoulder by leaving it too near the fire. Mr and Mrs B were concerned about the fire risk to their own property. Such anxiety to neighbours was reduced through consultation and involvement (Davies and Challis 1986).

The new helper worked in the local day centre and it was hoped that with his assistance she might agree to attend. This would prevent the fire risk during the day time and might help relieve her loneliness. Mrs A thought the new helper was a doctor and initially allowed him to visit daily to bring her a meal.

Mrs A obtained her alcohol by standing in the front garden asking passers by to buy her whisky, she providing them with the money. As her pension was £30 per week and she had no savings this fortunately maintained a limit on the amount of drink she could afford, and she still managed to pay her bills. When she had obtained the whisky she would hide it, and she would never admit her drink problem to the care manager. The neighbour, Mr B, tried to cut down the supply of alcohol, but Mrs A responded with abuse. He also complained about her habits, such as blowing her nose on the chair backs, urinating in the sink and spending irregular hours in bed, and did not see that she had a right to do what she wanted in her own home. The care manager worked throughout to reduce this tension between neighbour and user and neighbour and helper.

The care manager was able to mobilise other neighbours into bringing over meals during the winter. However, following Mrs A's falling and cracking her ribs, she became once more abusive and these neighbours pulled out. The falls were fairly frequent and the care manager arranged for the GP to examine her regarding their cause. They appeared to be solely as a result of drunkenness. She was becoming more cognitively impaired and deluded. She blamed the breakages which occurred when she was drunk on a poltergeist. After she had been drinking she would invite anyone in and there were undesirables in the neighbourhood. Mr B monitored from his window who went in and out.

There was again evidence of self-neglect and getting her to eat a balanced diet became more difficult. Mrs A refused meals on wheels, and would only sometimes let the male helper in with a lunch of sausage and chips. She appeared to live off a bread and bacon diet. Mrs A spent much time in her petticoat and had had no bath for a long time, though her hands, face and hair appeared to be clean.

Mrs A still suffered from periods of depression, appeared lonely and sometimes said she wanted to die. She never watched TV or listened to the radio and tended to sit and brood over the fact that her adopted children had stopped visiting. In spite of the care manager's attempts to reinvolve the relatives, they were not prepared to tolerate the old lady's difficult behaviour and patronising attitude. The care manager tried to persuade Mrs A to attend day care which would provide her with companionship and the opportunity of a bath as well as giving the neighbours some relief. The male helper eventually managed to take her to day care once a week for two months, but she later withdrew, claiming that items were missing from her home. She sometimes accused Mrs B of taking money and would no longer allow Mr B to clean the floors, which became increasingly dirty.

Mr and Mrs B began inviting her into their home and sometimes cooked her breakfast. However, Mrs B was suffering from glaucoma, partly as a result of stress and Mr B's health was also suffering. The care manager arranged for the Bs to have a telephone installed through a welfare organisation for use in an emergency. Despite the stress they were under, the neighbours refused offers of relief from the care manager. Mrs A became increasingly demanding towards the neighbours, perhaps knocking on the wall several times a day for snacks. The couple were now saying they were not prepared to continue offering their support and withdrew much of their involvement. The male helper continued to try and persuade Mrs A to accept further help but without success. In view of increasing signs of stress shown by Mr and Mrs B, as well as the increased self-neglect of Mrs A, the care manager decided to introduce another helper, a woman, in order to take some of the pressure off the neighbours and respond to the user's need for companionship and care. Concerns that Mrs A might no longer be able to manage her weekly budget adequately also needed to be addressed.

This helper, who had a strong character, built up a good relationship with Mrs A, who allowed her to collect her pension and shop for her. Over the weeks, with the helper's encouragement, Mrs A started to eat a more varied diet, including fresh fruit for the first time in years. Moreover, in six weeks she appeared to stop drinking altogether, after some nine months in the scheme. Both adopted daughters started visiting again and gave the house a general clean.

The new helper subsequently noticed a slight deterioration in Mrs A's general appearance and she quickly became doubly incontinent. The care manager arranged through the GP for a geriatrician to visit. Mr B started to complain again about the insanitary conditions, but she remained at home supported by the family, meals on wheels and the helper. However, when the care manager discovered her with a severe burn on her leg a compulsory admission to hospital by the community physician under section 47 of the 1948 National Assistance Act was arranged in view of the severe health risks involved in remaining at home, as she refused to go on a voluntary basis. She remained there for eight weeks while her burn and incontinence were treated. She agreed to enter a private residential home but after two weeks agitated so much to go home that she was allowed to return. The family were very hostile towards the idea of her returning home and the Bs would have no further involvement. She was very cognitively impaired and the care manager was very actively involved in providing support. This paid dividends, as Mrs A settled back at home well. She would now accept a home help as well as meals on wheels. Mrs A continued to eat a varied diet and her health improved. She accepted the introduction of a second helper who visited at weekends.

There was a further setback when Mrs A fell and cracked two ribs. Since then she had eaten and drunk very little. The helper started cooking meals in place of meals on wheels to try and encourage her to eat more, but her general health deteriorated. Mrs A seemed to be giving up and her depression increased. She was admitted to a geriatric ward of a hospital. Here she fell and fractured her hip. Due to her health and age it was decided not to operate. Because her lungs, kidneys and heart were showing signs of failure it was decided that she become a long-stay geriatric hospital patient. She died in the following month.

This study illustrates how, with persistence, the scheme could provide valuable support and achieve considerable improvement in a lady with a deeply entrenched alcohol dependency who was fiercely independent. In the face of neighbours and relatives who

were ambivalent about the help they provided and sometimes appeared to cause more problems than they solved, the care manager had responded by working through their feeling with them and building a package of care around the contribution which they wished to make. By this means, Mrs A had been enabled to spend most of her last two years at home. In view of the reluctance of both user and informal carers to accept help, the choice of helper was clearly crucial in order to obtain entrée. The care manager had been willing to try different helpers in order that Mrs A could respond best to offers of help.

This case featured both event risk and process risk. The event risk resulted from the underlying alcoholism and associated dementia, leading to frequent falls and dangerous behaviour. In view of Mrs A's right to drink alcohol, and the difficulty of limiting the supply (section 10.4.4.4), the habit was tackled indirectly through a helper, who was truly acceptable to Mrs A, befriending her. The success of this helper's intervention undoubtedly lay in her ability to build a warm relationship with the user, so enabling her to accept the help she then offered (section 10.4.1). By this means, the underlying depression was eased, hence reducing her need to drink. Mrs A's process risk was manifested in her self neglect, particularly in regard to her inadequate diet. By encouraging her to eat and offering a healthy diet, the helper reduced further the need for Mrs A to drink, while assisting her body to cope with the harmful effects of alcohol. In the hands of this competent helper, the strategy had apparently enabled Mrs A to give up drinking altogether within six weeks.

2.2 Managing a physically disabled older lady with a character disorder

Mrs C was a very disabled lady who had had a variety of operations. She was very arthritic and had had a hip replacement. Her feet were in a poor condition and her mobility was severely restricted. She could be very demanding and had been known to the social services department for over two years. She received a home help, and the home help organiser referred her to the Community Care scheme when Mrs C complained that she could not get into bed due to her legs 'locking'.

The care manager introduced a male helper who visited seven evenings a week and had the strength to help her into bed. He gave her his phone number but because of the number of demanding phone calls she made he decided to withdraw after ten days. By this time Mrs C did not want him to visit any more either. The choice of a male helper appeared to have been unfortunate. Mrs C had had some three husbands. She had thrown out the last of these and appeared to have difficulty getting on with men.

The care manager then introduced two female helpers to take over the evening visits five nights per week. This arrangement was superficially satisfactory. However, Mrs C seemed bent on stirring up antagonism between the home help and helpers by telling the home help that the helpers were nicer than her. This was hard on the home help who, although not particularly thorough, had been willing to tolerate her, all other home helps having refused to visit. Indeed on one occasion the user had physically attacked this home help. The care manager explained this situation to the helpers.

The user's manipulative behaviour continued when she developed a stomach complaint, the result of a virus infection, and became doubly incontinent. She instructed the helpers to leave the washing of incontinent laundry to the home help and vice-versa, to try and cause antagonism between them.

The care manager visited Mrs C and contacted the GP, who called but was unable to treat the infection. The care manager urged the user to receive nursing care but she refused. The GP nevertheless arranged for a rather forthright community nurse to visit, who had some psychiatric training, and the user allowed her to enter regularly and help cope with her incontinence. Although the infection cleared up, the double incontinence continued and the GP prescribed Kaolin to help reduce the incontinence of faeces.

When the care manager next visited jointly with the Community Care nurse, she found the user's condition had deteriorated since her infection and she had become more frail. Mrs C said she wanted the helpers withdrawn because they fed back information to the care manager. Mrs C was resistant to offers of help, but demanding on the care manager's time, and the care manager had to leave her still talking.

The care manager wanted the two helpers to continue supporting Mrs C but at the same time was concerned that she might lose them altogether from the scheme as a result of the user's attitude. Fortunately, the helpers continued to manage, while the care manager worked closely with the community nurse.

It was clear that Mrs C had a deeply entrenched personality problem. She now sometimes expressed a wish to die, while desiring to remain at home. However, in view of the almost intolerable demands placed on those involved in providing care, the option of institutional care had to be considered. More recently she had been calling in neighbours to help clean her up. However, she later said she would sue for slander the neighbours who had helped her.

Mrs C was clearly very attention-seeking. It was even possible that her difficulty in getting into bed was contrived as a means of attracting visitors. Although she refused to bath, she took trouble over her appearance, keeping her hair looking nice and manicuring her nails. Because she tended to prolong helpers' visits indefinitely, the care manager advised the helpers to arrange for their husbands to collect them and insist that they get into the car.

During the next few months there were several changes of GP, through mutual consent between GPs, in an effort to contain the demands that Mrs C made on them. Mrs C refused to let the community nurse continue to visit. This left the two helpers and the home help providing the only support, together with meals on wheels twice a week. Attempts were therefore made at persuading her to enter long-term geriatric hospital care. Although she refused on two occasions, she ultimately agreed to be admitted. Following the admission the helpers were withdrawn and the case was closed.

Clearly, the main problem with this case had been the ambivalent attitude of the user towards receiving help, being demanding and attention-seeking at one stage and then totally critical and rejecting of all the help she received. Mrs C was fairly typical of this type of user who can put considerable demands of time and energy on both the care manager and the helpers. The importance of setting clear limits to the extent of Community Care involvement so that other users do not have to suffer as a result, emerges as a significant conclusion. The importance of close liaison with the GPs to provide a consistent approach in the face of Mrs C's manipulative behaviour is also clear. Even though an admission to long-term geriatric hospital care had to be contemplated at a rather earlier stage than would have been otherwise necessary, the scheme was nevertheless able to support Mrs C at home over a period of eighteen months.

2.3 Supporting an older lady who had become chronically apathetic, living as a recluse in filthy conditions

Miss D, aged 70, lived on her own in an upper floor council flat. She used to live with her mother before her death and had had a highly responsible job in the Civil Service. While Miss D had been absorbed in her job, her mother had seen to the housework. Miss D retired at the age of 60 and shortly after this her mother died. The mother had apparently been very domineering towards her, and after this Miss D withdrew from the world, living in one bedroom which became her lounge and never leaving her flat. She changed from being a meticulously tidy person to becoming totally dishevelled and increasingly dirty. Having been used to her mother's doing all housework, she made no attempt to take over after her death. She developed a chronic drink problem. A referral was initially made to the social services area team as a result of Miss D's self-neglect. A social worker eventually gained entry and visited twice a week for two years. The social worker was successful in weaning Miss D off alcohol. However, her self-neglect and agoraphobic behaviour continued. A home help was arranged who visited twice weekly to manage housework, laundry and shopping.

Because the case caused quite a drain on the social worker's time, and because of the multiple problems involved, the case was referred to CCS. On visiting to assess the situation, the care manager found Miss D still living as a recluse. She would wear the same clothes - tights, skirt and vest - day and night, rarely changing, and never going to bed. She never bathed and did not bother to prepare meals, living off a diet of pork pies, crisps and lemonade. She spent day and night on a broken couch, covering herself with army blankets which belonged to her father, with a towel handy for nose bleeds and a chair back cover over her head. The couch was saturated with urine, apparently a result not so much of loss of bladder control but of apathy and laziness. The smell caused annoyance to the man occupying the flat below, who would 'retaliate' by playing his radio loudly, causing her harassment. Miss D's legs appeared striped due to an accumulation of substances which had run down them. Her gait was shuffling due to hammer toes. Miss D's toenails were very long but she refused to be seen by a chiropodist. Indeed, apart from the social worker, the home help and a neighbour who visited fortnightly, she would let no-one in; not even the man to read the gas meter. She was terrified of meeting people since she was aware of her state though could not change it. Her present condition and situation contrasted enormously with that which had applied while she was in her executive job and the social circle in which she then mixed. Financially she was still comfortably off.

Miss D's health was clearly at risk as a result of her poor diet and insanitary conditions. It was difficult for the care manager to decide why she lived in such squalor. She appeared to be mentally very alert. Her tendency to avoid household chores and leave them to others could be understood partly in terms of her childhood environment. Although she would not talk about this, there was clear evidence that her father had worked abroad in the army. Miss D could well have been accustomed to a gracious early life with servants, such as might have been the case in India.

She liked to abide by rules and control others, and when confronted by change could become upset and agitated. Although she did not display classic symptoms of depression such as gloom, poor appetite and sleep loss, her self-neglect, apathy and agoraphobia suggested some form of underlying depression, triggered by her retirement and the death of her mother. In view of this it was felt that she could benefit from the companionship of a helper.

Miss D had already responded very positively to the friendship offered by the previous social worker and seemed very cheerful and pleased at the care manager's visit. She eventually agreed for a helper to visit to provide companionship but only once a week. Miss D said she liked to be left alone for most of the time. She spent some of her time alone reading. Miss D was pleased to pay for a gardener provided he did not enter the flat. As the helper gained Miss D's confidence it was hoped that she could be encouraged to dress herself properly and to eat a more regular diet. Miss D accepted the transfer of companionship from the social worker to the helper who built up a good relationship with her and managed to get some of the blankets changed. Although the helper had tried tempting Miss D with a variety of different types of food she would usually not respond, though her diet was widened a little. After four months she was still spending all day and night reclining on the broken couch, but without the chair back cover over her head, and the helper had managed to get her to change her skirt.

During the following three months she became more trusting, allowing the helper and home help to have front door keys and to take bills for payment. Although she refused to be seen by an optician, she allowed the helper to bring in large print books. After six months in the scheme she allowed the gas man in to read the meter. The helper was geared up to take Miss D on an outing in her car should the opportunity arise.

Once a year had passed since referral, the helper was fully accepted and Miss D allowed her to call daily. Miss D was in need of having her ears syringed but refused to let the GP call. She still would not change her clothes regularly or allow her couch to be replaced.

However, during the following three months Miss D allowed the helper and home help to have a 'blitz' on the flat, remove the sodden couch and install her on the bed. She also agreed to have a commode in the bedroom which she used. She allowed the helper to put drops in her ears to clear the wax. At last she was accepting a more balanced diet, provided she was fed.

Progress continued for another two months. Her health then deteriorated rapidly as a result of an infection and she died after being supported by the scheme for nearly two years.

Clearly progress in this case had been slow and only some of the care manager's aims had been realised. The process of enabling Miss D to accept help continued throughout, carried out by the care manager and later by the helper. In view of Miss D's deeply entrenched psychological problems, the care manager responded initially by building up a relationship with her and arranging for a helper to visit and provide companionship. As Miss D got to know the helper, she came to look forward to her visits. As a relationship of trust was developed, Miss D began to gradually accept improvements to her personal care and diet, though progress was only limited. At the same time both care manager and helper accepted Miss D's right to continue her current lifestyle when she could not be persuaded to change it (section 10.4.4.6). It was probably the persistence of some of her unhygienic habits which led to her infection and death. Nevertheless, Miss D's wish to remain at home had been respected despite the risks this entailed. In view of the gradual progress being achieved a compulsory removal to institutional care under Section 47 of the 1948 National Assistance Act would have been inappropriate. Unfortunately it had never been possible to get her to leave the flat for an outing. Nevertheless, the changes achieved undoubtedly contributed to her quality of life.

2.4 Supporting a cognitively impaired older lady and her rather uncooperative family who provided help

Mrs E suffered from senile dementia and lived alone, her husband having died three years previously. She was referred to the social services department by the GP about the possibility of residential care, following a rapid onset of dementia, after which she deteriorated physically and became bedfast. However, because she was both cognitively impaired and doubly incontinent no local authority home would take her. The GP then urged the son to try and arrange private residential care, saying that she only had six weeks to live anyway. Meanwhile the referral had been passed to CCS. At the initial assessment visit, the care manager found Mrs E to be suffering from a chest infection, still doubly incontinent and very cognitively impaired with hallucinations, being unable to remember fairly basic tasks like eating. These symptoms suggested that the chest infection could have caused some poisoning or reduction of oxygen supply to the blood reaching the brain, leading to an acute confusional state superimposed on the underlying dementia. Consequently, if the chest infection could be successfully treated her mental condition might improve.

Mrs E had a son, Mr F, living seven miles away married with two children at primary school. He had provided support since his father's death.

Mrs E and Mrs F did not get on well. Mrs F visited most mornings simply to put the milk in the refrigerator, and did not even go into the room where her mother was. Although Mrs E was at severe risk of falling, Mrs F claimed that she would nevertheless be able to detect if her mother-in-law were in any difficulty. Clearly it would have been preferable for Mrs E if a suitable helper could have visited in place of Mrs F, but the daughter-in-law refused to let this happen. It may have been the case that she wanted to be seen by others in her village as a caring daughter-in-law.

At referral, a home help was visiting Monday to Friday to prepare lunch and do cleaning. The community nurse visited every morning to transfer her from a night to day uribag and a bath nurse called regularly. The son called each evening with a meal cooked by his wife.

It was clear from the outset that Mr and Mrs F disagreed over the type of care Mrs E should receive. The strained relationship between the couple clearly influenced the quality of care which they provided. For example, there was never much food in Mrs E's house. Whenever the care manager discussed this with Mr F, he made out a shopping list but handed it over to his wife and she was not prepared to get in extra food. Mr and Mrs F would not talk about their differences to the care manager. Mrs F resented the time which her husband spent with his mother each evening. On the other hand she spent a lot of her time with her own mother who lived locally.

Mrs F would not admit to her husband that she provided no help during her morning visits, and the care manager rightly felt that it would be inappropriate to tell him herself.

Mr F turned down the offer of CCS taking over all his evening visits which would have allowed the couple more time together. This suggested that Mr F may have wanted to get away from his wife. He was however generally caring with his mother. At the same time Mrs F probably resented the fact that Mrs E did not die the previous year as the GP had predicted. Mrs F certainly had a lot to put up with.

Clearly both Mr and Mrs F were closely tied to their mothers, causing resentment between the couple. Moreover, Mrs F appeared to have little satisfactory outlet in her life. Her children were at school during the day and she had no employment. The care manager therefore persisted in trying to offer the couple relief, in order that she could get out more.

Mr F was asking for CCS help just two evenings per week, and the care manager could not persuade him to accept more than three evenings relief. Although Mrs F had been visiting with the milk every morning, she would only accept relief on two mornings. Also Mr F liked his wife visiting. Unfortunately Mrs F harassed the home help and helper and as a result the first helper gave up visiting and had to be replaced. Originally a neighbour had been visiting in the mornings but Mrs F had had a dispute with her and the neighbour withdrew.

During the three months following referral Mrs E's chest infection cleared up following treatment from the GP and she became physically much fitter, though her mental condition had not yet improved. Although she was no longer bedfast, she was unable to prepare meals or see to housework, laundry or shopping. The home help felt under less pressure now that a helper was sharing in the responsibility of care. The helper saw to incontinent laundry as there was no laundry service available. The provision of meals on wheels eased things further. Mr F was now agreeing to the helper's putting Mrs E to bed every evening, though Mrs F was still harassing the home help and helper. Nevertheless the CCS package was now allowing Mrs F to get out more. Clearly the close cooperation with the GP in assisting Mrs E to overcome her chest infection had caused a general improvement in the quality of life of both user and informal carers.

Over the subsequent three month period Mrs E started to improve slightly mentally and was making herself an afternoon cup of tea. However, she later became more cognitively impaired again and stopped making a hot drink. She was disorientated in time and muddled helpers, home helps and their names. It was planned to encourage her to become a little more independent and since then the home help regularly took her out to a luncheon club.

After seven months in the scheme, Mr F and his family went away on holiday leaving CCS to arrange a full package of care. This was a further step in the direction of allowing CCS to take over more help.

Unfortunately one month later her physical health began to deteriorate through suspected kidney failure. Mrs F felt under pressure and was now willing for the helper to call every weekday morning and two afternoons in addition to the evening visits. As a result of her medical state two months later she was unable to remain at home, and since the condition was incurable, she was admitted to long-term geriatric hospital care and the case was closed.

It had been unfortunate that during the period of CCS involvement Mr and Mrs F had appeared rather rigid in their attitudes and were unwilling to discuss their problems. Nevertheless, CCS had made remarkable strides in improving Mrs E's general health and well-being and in taking some of the pressure off Mr and Mrs F. This had required a protracted period of enabling the couple to accept help. The situation had required a sensitive and tactful approach by the care manager throughout (section 10.4.3). This study brings out clearly how very difficult it can be to establish a successful package of care when a relative is providing inadequate support but refusing to co-operate or withdraw.

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GLOSSARY

Average cost This is obtained by dividing total cost by the number of units produced.

Care manager The grass roots SSD-based worker taking on full case responsibility.

Community care group The *experimental group* of users receiving the community care scheme.

Comparison group See *control group.*

Control group (or comparison group). A group of cases receiving normal services.

Cost function An expression for cost in terms of a linear combination of *quasi-input* and output terms, obtained using the technique of *ordinary least squares (multiple regression analysis).*

Endogenous Causally determined by the system.

Exogenous Independent of the system.

Experimental group A group of cases receiving a special type of service to be compared with a *control group* receiving normal services.

Guttman scale A scale which consists of a number of questions relating to a range of extremes of a particular dimension.

Horizontal target efficiency The proportion of cases eligible for a service that receive it.

Interaction term These sometimes arise in *cost function* modelling, when the effects of two of the terms in a cost function are known to influence each other. *A joint supply* term is an example of an interaction term.

Interval scale An *ordinal scale* in which adjacent points are equally spaced.

Joint supply A term used in conjunction with *cost function* modelling. When inputs can improve two outputs, then as well as a term involving each output separately, the cost function should include a product term of both outputs as well. This last term should have a negative sign, since the joint supply effect improves efficiency and reduces cost.

Lickert scale This consists of a series of *rating scales*, each with a similar set of scale points.

Marginal cost The extra cost of each additional unit of a commodity produced.

Multiple regression analysis See *ordinary least squares.*

Nominal scale A scale which classifies into groups without attempting to sequence them.

Non-resource inputs The factors influencing outcomes in addition to *resource Inputs*: either *quasi-inputs* (independent of the system) or characteristics of the system providing care.

Opportunity cost The cost of a commodity expressed in terms of the resources which would have to be given up, assuming a fixed budget.

Ordinal scale A scale which allows users to be arranged in groups which can be arranged in a sequence.

Ordinary least squares A type of modelling in which a dependent variable is expressed as a linear combination of predictor variables, such that the sum of the squares of the errors is minimised.

Outcome (or output) A measure of improvement in some aspect of the subject's life.

Production of Welfare An approach to understanding both qualitatively and quantitatively the relationship between the needs/circumstances of the user/carer, inputs/services and welfare outcomes, using economic principles of factory production.

Quasi-experimental A form of research design in which the effects of a new approach on an *experimental group* of cases are compared with those of a traditional approach on a *control group.* Allowance is made for the effects of group differences on outputs.

Quasi-input Need/circumstance of user/carer affecting outcomes in the Production of Welfare model – a type of *non-resource input.*

Rating scale A scale which allows an item to be measured by choosing one of a number of levels of varying intensity.

Ratio scale An *interval scale* whose absolute values are fixed, so relative magnitudes can be compared.

Resource inputs The different types of service or manpower used in the Production of Welfare model.

Revenue cost The cost of a service from the standpoint of a particular agency. This is calculated by adding the component costs to the agency of the service itself, including interest on loans, and then adding a notional amount for central recharges and administrative overheads.

Two-stage least squares A technique for modelling two dependent variables in terms of predictor variables. An equation is obtained for each dependent variable in which the other dependent variable is included as a predictor.

Vertical target efficiency The proportion of cases receiving a service that are suitable.