

Commissioning care services for older people in England: the view from care managers, users and carers

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ABSTRACT

One of the key objectives of the community care reforms of 1990 in the United Kingdom was the development of a flourishing independent sector alongside good quality public services. The aims of the reforms were to increase the available range of options, widen consumer choice and promote independence. The purpose of the study reported here was to examine – from the perspective of older service users, their carers and care managers – experiences at the operational level of arranging, delivering and receiving care services. The findings are based on data gathered in seven local authorities including reviews of case files, policy documents and face-to-face, in-depth interviews with 55 users, 37 carers and 28 care managers. There is evidence of a pronounced emphasis on procedure-based systems of care management. Potentially this has two significant consequences. First, the fostering of personal relationships may be subordinated to the organisation of short-term tasks and thereby may threaten patterns of trust and accountability. Second, the associated fragmentation of the assessment and care management process which in turn can lead to discontinuities of care for users and their carers. The paper concludes that there is still some way to go before care managers as micro-commissioners have sufficient and reliable information or available service capacity to match providers' capabilities with users' and carers' needs.

KEY WORDS – Care management, older people, commissioning, users, carers.

Introduction

The 1990s witnessed huge changes in social care provision for older people in the United Kingdom. One of the main aims of the *1990 NHS and Community Care Act* – which introduced a genuine external market in social care services – was to enable people to live at home wherever feasible by promoting the development of domiciliary, day and respite services. Previous arrangements for public funding of care services had contained an in-built

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bias towards residential and nursing-home care. The Act introduced a new funding structure whereby local authorities became responsible for assessing needs and securing the delivery of appropriate care services. The aim was to encourage people to 'achieve the maximum possible independence by acquiring or reacquiring basic living skills', and to 'give people greater individual say in how they live their lives' (Secretaries of State 1989). Local authorities were given the new strategic task of managing the supply and purchase of care services not only from the statutory sector (as had been predominantly the case hitherto) but from an increasing range of voluntary providers. Practical support for carers was given a high priority and the subsequent 1995 *Carers (Recognition and Services) Act* gave them the right to have their own assessment of need. More recent legislation and guidance have continued to emphasise the importance of promoting independence, of prevention and rehabilitation services (Department of Health 1998, 2001) and of breaking down barriers between health and social care (Department of Health 2000).

One consequence of these broad changes has been significant growth in independent sector domiciliary care services, particularly for older people. In 1992 only two per cent of local authority funded home care was purchased from independent suppliers, and by 2001 this figure had increased to 60 per cent (Department of Health 2002). The number of places available in residential care homes is now declining following the rapid expansion in the 1980s and 1990s, but there has been a shifting intersectoral balance within both residential and domiciliary care markets (Knapp *et al.* 2001). Local authorities have been encouraged not only to commission new services from a wide range of potential providers but also to decommission in-house provision where it has not been cost-effective.

This paper reports the findings of a 'micro-commissioning' study looking at care services for older people in England from the point of view of users, their carers and care managers. The focus is on older people because the bulk of domiciliary, residential and nursing care services are for people aged over 65 (Department of Health 2001 *a*, 2001 *b*). The aim of good community care, whatever arrangements are made for purchase, provision and management of care services, is high quality, reliable and sensitive support for individuals and families. The purpose of this study, a follow up to a similar earlier study (Hardy *et al.* 1999), was to consider how such support is being delivered; and, therefore, how macro-commissioning policies are operationalised. It is essential that these experiences of micro-commissioning and service delivery are understood and evaluated, not least because much of the earlier research has focused on the wider commissioning context.

This paper is in three parts. The first comprises an outline of the study and the sample profile. The second presents the findings under six

headings: referral and assessment; choice; information; user and carer views on service delivery; review and multi-agency working. The third explores issues emerging from the findings: the way care management has become over-bureaucratized and fragmented; the need for a greater volume of care services; and the importance of ensuring that good quality services are delivered as intended.

Study design and sample profile

We collected data in seven English local authorities: one London Borough, two unitary authorities – one in the south and one in the north – two southern shire counties and two northern metropolitan authorities. These authorities comprised a sub-group of 25 English local authorities in the ‘Mixed Economy of Care’ research programme¹ which had been selected as representative of the national picture in respect of political control, total service expenditure per head of population, and percentage of social services expenditure going to independent sector services. Previous phases of the research have provided a detailed account of the intentions and actions of these authorities in relation to the implementation of the community care legislation, their management of care markets, and the behaviour and motivations of care providers. (Wistow *et al.* 1994, 1996; Forder 1997; Kendall 2001; Kendall *et al.* 2002; Knapp *et al.* 2001; Matosevic *et al.* 2001; Ware *et al.* 2001).

Data collection was a two-stage process. We asked local authority care managers to identify users who had recently entered the care management system or whose case had recently been reviewed. In each authority we sought to identify eight users and their associated care managers. Following the research design from the earlier study (Hardy *et al.* 1999), we examined users’ case files and interviewed users, their carers and care managers.

In each authority we aimed to select at least one user in each of the following categories: domiciliary care (including in-house, independent and combined independent and in-house care); residential care; nursing care; day care; and users with and without informal carer support. These users were recruited by care managers. In practice we interviewed 55 users, 37 family carers and 28 care managers between August 2000 and May 2001. Table 1 indicates the mix of users that were interviewed and the services that they received.

Referral and assessment

The initial examination of users’ case files sought to ascertain the type and method of referral. Most were made by professionals (53 % by medical staff

TABLE I. *Number of users in each service category by age, sex, marital status and living arrangements (percentages are calculated separately for each cell)*

	Residential care users	Nursing care users	Helped to live at home*	In hospital waiting placement	Total
Sex					
Men	1 (17)	1 (17)	12 (29)	1 (50)	15 (27)
Women	5 (83)	5 (83)	29 (71)	1 (50)	40 (73)
Age					
65–69	0	0	5 (12)	0	5 (9)
70–79	1 (17)	3 (50)	14 (34)	0	18 (33)
80–89	3 (50)	3 (50)	16 (39)	2 (100)	24 (44)
90+	2 (33)	0	6 (15)	0	8 (15)
Marital status					
Single	1 (17)	1 (17)	2 (5)	0	4 (7)
Married	1 (17)	3 (50)	19 (46)	1 (50)	24 (44)
Widowed	4 (66)	2 (33)	20 (49)	1 (50)	27 (49)
Living arrangements					
Alone	0	0	18 (44)	0	18 (33)
With spouse	0	0	17 (41)	0	17 (31)
With adult child	0	0	6 (15)	0	6 (11)
In hospital	0	0	0	2 (100)	2 (4)
Res./Nursing	6 (100)	6 (100)	0	0	12 (22)

* These users received domiciliary, day and respite care services. Of the 41 users at home 32 were using or had experience of LA purchased domiciliary care. Thirteen had only domiciliary care services and nine had day or respite services but no domiciliary care services.

and 7% by home care staff) with 29 per cent being referred by family members. The most common reason for referral was a health crisis, covering 46 per cent of users and nine per cent of carers. The second most common reason (27%) was a general deterioration in the health of the user. Other reasons included carer stress (7%) and requests for equipment and adaptations (6%).

Interviews showed general user satisfaction with the referral and assessment process, although this may have been associated with the majority having been referred by staff who may be presumed to be well acquainted with the referral system. There may, of course, be people who did not negotiate the referral system satisfactorily and who did not receive an assessment. Furthermore, 32 per cent of assessments nationally do not lead to services being provided (Department of Health 2001*f*). As indicated by other reports (Tanner 2001; Social Services Inspectorate 2001*a*), care managers here said that eligibility criteria were seen as rationing tools. However, this study did not include either people who did not obtain an assessment or those whose assessment did not lead to a service. A small minority of users and carers expressed dissatisfaction with the assessment process, usually

caused by delays in receiving services. In general, interviewees' experiences of the assessment of their needs was related to many different factors including: the nature of their physical dependency; whether they readily fitted local authority eligibility criteria; and whether their expectations of care corresponded with what social services were able to provide.

It was difficult to obtain a clear account from the files of what each service user was assessed as needing (and by whom) and subsequently receiving, and at what financial cost. Assessment forms and care plans varied both in the details of the information required and in the consistency with which care managers completed them. In one authority it was not even clear from the files whether the in-house service or an independent provider had provided care. Only one authority was piloting a Common Assessment Tool for use with the variety of agencies involved in services for older people – in preparation for the national standard assessment system, as recommended in recent government policy guidelines (Department of Health 2001a).

The issue of separate carer assessments was a cause of frustration amongst care managers. Most said that they invariably took carers' needs into account when undertaking user assessments and, whereas it was evident that nearly two-thirds of carers had services arranged primarily to help them in their caring role, many had no separate assessment.

Choice

Domiciliary care

We asked users and care managers what choices they had of agency, service and timing. Users in the main reported being offered little choice of care agency, or individual carer, or detailed timing of visits. Care managers said that users rarely exercised or were offered a choice in selecting a domiciliary care agency. In their view it made little sense to users without prior knowledge of what services were available; moreover, even if users have some prior preference, choices are restricted by the availability of agencies to provide the required care. The only user who said she had a choice of domiciliary care agency had to choose an independent sector agency because the in-house service could not supply the calls that were needed. In some authorities, and especially in rural areas, there simply are insufficient domiciliary care providers.

The findings showed that in some instances contracting arrangements were restricting choices through block contract or 'cheapest-first' policies. Choice was also restricted in three authorities operating 'in-house first' policies and another where care managers said they had a personal

preference for in-house services. Most users did not mind which type of provider they had although a fifth said they preferred council-run services.

Another important means by which choice is restricted consists in tightened eligibility criteria. In three authorities care managers said that they would like to be able to offer care outside their authority's current strict eligibility criteria: not offering shopping, bathing or housework services (on their own) restricts the ability of older people to maintain their independence. Such restrictions clearly go against the grain of policy outlined in *Modernising Social Services* and increases the risk that these users, in turn, 'become more likely to need much more complicated levels of support as their independence is compromised' (Department of Health 1998). Clark *et al.* (1998) have shown how undone housework can be a constant reminder of what older people can no longer do, and can adversely affect their mental health and motivation to manage. In general, however, care managers thought that they were able to keep people living at home for longer, in line with the main thrust of community care policy in the last decade.

Residential and nursing care

With choice of residential and nursing home care being subject to the legal 'Direction on Choice' (Department of Health 1992), it was not surprising that sample respondents reported more choice of provider than with domiciliary care. There was more written information for users, such as inspection reports and brochures, and, of course, users and carers can 'view the product' (and even sample it) by visiting the homes directly and making their own assessment in a way that isn't possible with domiciliary care (Hardy *et al.* 1999). Only two users in our sample thought that they had positively opted for residential care, having been presented with the simple choice of staying at home or going into care. Others accepted residential and nursing-home care reluctantly, feeling they had little effective choice: *i.e.* about staying at home with all necessary care support available (and paid for).

In two cases (out of the 12 users in residential and nursing-home care), decisions and placements were made entirely without the involvement of users or carers. In one, a carer was offered no choice for his wife who was in hospital. Social services simply informed him that they were sending his wife into a home the next day. Choice of residential and nursing *respite* care was a particular area of common concern across the sample. Since local authorities still had some in-house residential facilities they were sometimes reserved for respite breaks, but we did not find any evidence of block purchasing in the independent sector to ensure respite availability. Choices, therefore, were narrowed by the cost of services, their availability, speed of funding and the demand for hospital beds.

Information

Information for users

Although, as shown above, choice can be restricted by what services are available, it also depends on useful, reliable, appropriate, sufficient and timely information about services and financial benefits and about individual providers and what they can offer. Yet it is a commonplace that older people are ill-informed about services and benefits and often rely on family and friends for information. There is evidence that nationally things have improved. According to the most recent Joint Reviews Report, social services have made a significant improvement in 'the quality and range of information available to people' (Social Services Inspectorate 2001*b*: 8). According to the Department of Health, many local authorities were making progress in trying to ensure that users and carers were well informed about accessing services for older people (Department of Health 2001*e*). The latter report also stated, however, that in some instances the information about care services was presented inadequately. There was also a lack of information for people from ethnic minorities in their own language. Our interviews indicated that users and carers had insufficient information about services to make an informed choice of care services. In some cases, users found it difficult to know what to ask for unless there was some indication of what services were available.

Information for care managers

Generally, care managers had too little information about independent sector providers. They relied on purchasing or contracts departments to ensure that all the agencies were of a good standard. Not all care managers, however, had confidence in these colleagues. In some cases the agencies selected by contracting sections were those which care managers' experience suggested should be avoided. Many care managers said they were given insufficient information to pass on to users of domiciliary services, about the times paid carers would call, the level of training given to staff or the numbers of carers likely to visit.

Another area where information was sometimes unclear, incomplete or not forthcoming was in relation to user charges. From the user case files, it was not always evident what was the cost to the user and what was the cost to the authority. Moreover, charging policies varied widely such that a user in one authority might pay twice as much as a similar user in another authority. In response to such variations in charging policies – identified in other research *e.g.* Lund and Baldwin 1996 – the Audit Commission issued guidance to reduce inequities (Audit Commission 2000). Our evidence is not

only that care managers need to be trained and aware of these policies, but that there needs to be more systematic and reliable monitoring of what is received.

User and carer views on service delivery

There is considerable research evidence that older people tend not to complain and report high levels of satisfaction with their services (Hardy *et al.* 1999; Dept of Health 2001*c*). In the current study we found that half of our sample of users and carers rated their care services as ‘very good’ and another third described the services as ‘adequate’ (from the options ‘very good’, ‘adequate’, ‘not too good’ or ‘very poor’). There were also many satisfied users who said they appreciated the friendly care workers, patient day care staff, and thoughtful, competent care managers. Despite high levels of satisfaction, three-fifths of the users who had experience of domiciliary care packages mentioned difficulties. The most commonly mentioned were too many care workers, or workers arriving later than expected. Worryingly, one-fifth of those with experience of home care referred to occasions when care workers had failed to turn up at all.

Another area of common concern was care workers without personal identification. Users also noted that new care workers did not ‘shadow’ existing workers ‘to get to know the ropes’. Users then had to explain how to do things. A small number mentioned problems with the attitude of their paid carers, and a recurring problem associated with evening care was that care workers came too early to put users to bed.

Despite the above criticisms, overall only one-in-eight users and carers rated their care as ‘not too good’ and nobody rated it as ‘very poor’. The recent SSI report on older people’s services found that ‘older people and their carers mainly felt valued by staff and were satisfied by the service’ (Social Services Inspectorate 2001*a*). According to Allen *et al.* (1992), older people may well complain about various aspects of the care or service they receive, but when asked to give the service an overall rating, they seem reluctant to criticise it. Our findings in this micro-commissioning study and previous research confirm that most users and carers do not complain about care services or staff – not primarily because they are afraid of repercussions (though this is sometimes said) but because they are ‘grateful for what they get’ (Hardy *et al.* 1999).

Review

Recent government guidelines for assessment point out that councils should review the circumstances of all those in receipt of social care services

(Department of Health 2001*d*). Reviews should establish how far the services provided have achieved the outcomes set out in the care plan. Our 1996 study indicated that systematic monitoring and review procedures were generally underdeveloped and variable within and between authorities. Findings from this follow-up study showed that only two-fifths of users were aware of having a formal review; and this was appreciated, by users and carers, as a way of checking on need and adjusting services accordingly. However, the remaining three-fifths were unaware of having had a formal review. Some users reported having 'friendly visits' but did not know whether these constituted 'a review'.

Generally, reviews were done by home visits but in Authority F, and occasionally in others, they were conducted by telephone. Some carers were concerned about reviews being carried out by a new and unknown person. They also disliked the feeling that they had been 'passed on' to someone else once the care was in place. Care managers too were critical of having to review people they had not personally assessed and did not know. Some said they held on to cases, in the interests of continuity of care for users, for longer than their local protocols suggested. There were parallel concerns that in the course of enquiring about and arranging care, a user or carer may see several different people. What is required is continuous review (seen as a process) rather than episodic review (seen as an event).

It was also clear that older users and carers typically are reluctant to tell their care manager about things that go wrong. Furthermore, if reviews are either done on the phone or are completed by someone whom the user has not met it is much more difficult for them to express concerns or complaints. Typical user comments were: 'You get fed up of fighting', 'I don't want to get anybody in any trouble', and 'I accept what I'm given'. Another expressed shock that they were not to be reviewed for a year. In response, care managers would often say: 'We always tell them they can come back to us if they want an early review'; but the above comments from users and carers suggests that, in many cases, they wait for the contact rather than 'make a fuss'.

Multi-agency working

Bearing in mind the government's policy emphasis on improving partnerships, we asked care managers about the scope for multi-disciplinary assessments and joint working with other agencies (Department of Health 1998, DETR 1998). Most thought that they worked in a multi-disciplinary way, especially with users who had complex needs. In five of the seven authorities, care managers reported links with GP surgeries and regular

meetings with health staff where cross-referrals were made and information shared. This was said to be a significant change of emphasis over recent years.

Generally, joint working was thought to be undermined by what typically remain separate budgets for health and social care. For example, in one authority work was being done to ease the transition from a health-funded hospital prevention service to local authority-funded home care. However, because there were as yet no pooled budgets the local authority insisted that further assessment visits should be made when users were passed across to the home care service, in order to access local authority funds. What care managers, in general, argued was that where there was frequent, face-to-face contact with health workers there was often good communication and an understanding of each other's roles. By contrast, where the links were more formal or less frequent there were unresolved (often cultural) issues.

There was clearly a mixed picture of joint working but there was little evidence that joint teams of health and social services staff or pooled budgets had significantly affected mainstream services, despite closer working arrangements between care managers and primary care staff. This finding is echoed in recent reports of joint reviews and older peoples services (SSI 2001 *a*, 2001 *b*).

Emerging issues

The evidence presented here raises a number of policy and practice issues: over-bureaucratisation and fragmentation of the care management process; insufficient supply of services and unmet need; ensuring good quality services and the need to develop joint working.

Over-bureaucratisation and fragmentation of the assessment and care management process

One of the most significant themes to emerge from the interviews with users, carers and care managers alike was the increasing fragmentation of the assessment and care management process. A quarter of the care managers interviewed reported such fragmentation across a process which can be seen as comprising four main elements: initial screening and assessment; devising and arranging care services; service provision; and review. The essence of the process should be the perception, from the user's and carer's perspective especially, that it is co-ordinated, integrated and continuous. In four of the sample authorities, however, different staff were responsible

for different parts of the process. The result for users and carers is often the perception of discontinuous or episodic care – of being ‘passed on’. The reduction in face-to-face work and an increasingly bureaucratic approach to care management is echoed elsewhere (e.g. Challis *et al.* 2001).

Adoption of a procedure-based system of care management means an important shift in emphasis, with responsibility tending to be held by the local authority through the social services department rather than by an individual worker overseeing the care. This is a markedly different vision of care management from that championed in the early days of the development and implementation of community care (Challis and Davies 1986; Challis *et al.* 1988) and by successive governments (Secretaries of State 1989; Audit Commission 1997). Recent work by Challis and colleagues suggests that there is little evidence that this ‘early’ model has been followed in practice since 1993 (Challis *et al.* 2001). As Sinclair *et al.* (2000) point out, the early demonstration projects differed from typical extant practice in a number of ways. Workers in the original projects carried small caseloads and were in frequent touch with their clients. They provided individually-tailored packages of care which sometimes, for example, included paying neighbours, to help an older person to get to bed at a time to suit the client. In our sample authorities, by contrast, we found a prime focus on financial controls and the routinisation of tasks. There were examples of good practice where care managers recognised the importance of continuing personal relationships and a holistic approach to user and carer needs. However, where care management essentially comprises the organisation of disparate short-term tasks, it is questionable how far the continuity of relationships can be sustained and encouraged.

Insufficient supply of care services and unmet need

Evidence from this study suggests that many care managers have significant difficulties finding enough care services to meet users’ assessed needs. In nearly all authorities in the sample there was a problem with obtaining sufficient home care. In some authorities, care managers said that what was required was not more agencies but for each agency to have more staff. Some care managers thought that their expertise had not been utilised in letting contracts with home care agencies and that paperwork had been more important to central contract sections than their local knowledge of provider standards. There were also concerns about poor recording of unmet needs and using this information to develop and commission new services. In three of the sample authorities there was either no apparent means for formally recording unmet need or care managers had stopped doing anything with any information they had.

One particular area of unmet need was overnight care. This was generally unavailable to care managers because the costs were deemed too high. The lack of this service compromises the choice of vulnerable people to remain in their own homes, and graphically illustrates the tension between maximising choice and containing costs. Innovation, choice and rehabilitation are key themes of the reform agenda but the impact of insufficient supply and cost ceilings were widely thought to reduce the scope for innovative solutions to care problems. Moreover, if information is not channelled from micro-commissioners (care managers) to macro-commissioners, this further impedes the ability of departments to devise innovative projects and services to meet individual needs.

Several care managers expressed concerns that users' emotional and other broad quality-of-life needs were not met under increasingly strict eligibility criteria. The ratcheting up of these criteria means that people suffering isolation, or who need simple domestic services, are increasingly ineligible for assistance. The importance of undertaking (and assisting with) primary 'tasks' such as feeding and toileting appear to have eclipsed the emotional and psychological needs of users: *i.e.* having things to look forward to which give a reason for living. Recent policy guidance emphasises the need for councils to set a low threshold when deciding whether a potential service user needs services (Department of Health 2001*g*). Evidence from other research suggests that health and social care practitioners, whilst welcoming the needs-led philosophy, found conceptual difficulties in separating 'need' from the 'need for a particular service' (Parry-Jones 2001). In fact, because older people are so much more needy physically and with less power over their own lives it could be argued that it is even more important to meet their psychological, emotional, social and spiritual needs. As Nolan *et al.* (2001) argue, we need to move beyond the present pre-occupation with the state of the body to consider what 'counts' for older people if intervention is to promote a meaningful life.

Ensuring good quality services

Despite the general unwillingness of older people in our sample to complain, there were a number of users and carers who mentioned problems with their domiciliary care, such as missed or delayed visits, attitudes of staff, or tasks not performed, although these issues were seldom raised with providers or care managers, often because of the user's reticence. Where care managers are aware of such problems, they need to liaise more closely with both providers and local authority contracts departments.

Our findings in this respect echo the Chief Inspector's recent comments that the unreliability of domiciliary carers is the issue most often referred to

by older people and carers (Department of Health 2001*d*). Other research into domiciliary care has also noted the problem of finding reliable relief carers (Sinclair *et al.* 2000). It is important that care managers monitor providers and ensure a link between users and providers. One care manager in our sample was so worried about the agency carers – and frustrated by a lack of formal monitoring – that she sat outside the user's home to check the carer's attendance. She also checked and found problems with food safety. Care plans are rarely detailed enough to stipulate that 'sell by' dates on food are routinely checked, yet it is crucial to the wellbeing of vulnerable older people that care workers take some responsibility for such issues.

Confidence in care agencies has to be based on both well-founded trust and regular monitoring and review. However, this sort of checking needs regular contact between care manager, user and provider which is not always the case. Such monitoring should be a continuous process, particularly in complex cases, but national figures suggest that it is far from widespread. Formal reviews and re-assessments occurred for less than half (42%) of clients receiving services during 2001–2002 (Department of Health 2001*f*). Formal reviews are a necessary but not sufficient means for measuring service quality (Patmore *et al.* 2000; Qureshi *et al.* 2000). Planned daily audit of selected service users, focus group discussions with both purchasers and providers, quality assurance schemes informed by users, user-led interviews and diary work have all been suggested in other reports on the quality of care services (Raynes *et al.* 2001; Henwood *et al.* 1998; Evans and Carmichael 2002).

Collaboration

Integrated whole systems and partnerships are central to recent legislation and guidance (see for example, Department of Health 2002*a* and Secretary of State for Health 2002). Although our findings indicate that care managers felt there had been a significant increase in multi-agency working, it appeared typically to be parallel rather than joint working. It was often up to the care manager to co-ordinate reports from the various other professionals. Generally, the joint initiatives mentioned were small scale and time limited. It is important to note however, that our fieldwork preceded the introduction of the *Health Act 1999* Section 31 partnership 'flexibilities', which allow for pooled budgets, lead commissioning and integrated service provision. The early evidence (see Hudson *et al.* 2002) is that these levers are being used to facilitate partnership at both strategic and operational levels. Our work also, of course, preceded the introduction of the single assessment process for older people (in April 2003) which should also considerably increase multi-disciplinary and multi-agency team working.

Conclusion

The significant changes over the last decade in the way that care services for older people are arranged and needs are assessed have mirrored changes in policy. The market reforms of the early and mid-1990s were halted in 1997 with the election of a Labour government led by Tony Blair. Beginning with the 1997 White Paper, *The New NHS, Modern, Dependable*, and continuing over the last five years with, notably, the National Service Framework (NSF) for Older People, the *Health Act 1999* Section 31 partnership ‘flexibilities’, *The NHS Plan* (2000), and the *Health and Social Care Act 2001*, the consistent theme has been to replace competition by collaboration and fragmentation by integration.

The predominant mode of governance has correspondingly shifted from markets to networks. There are, however, two important caveats. First, the recently announced proposals to introduce ‘greater plurality and diversity’ in healthcare provision (Department of Health 2002*a*) represents the re-introduction of marketisation. Second, the construction of an increasingly elaborate and stringent performance assessment framework to ensure, among other things, that health and social care services locally are integrated. There is an associated shift from exhortation to compulsion; and whilst the rhetoric is of increased local autonomy, as in *Shifting the Balance of Power* (Department of Health 2001*h*), the reality often seems increased hierarchical control.

It is within this wider context that we need to locate the discussion in this paper of micro-commissioning for older people. Here, too, much of the early rhetoric was of autonomy for care managers locally; but much of their recent experience has been frustration at ever-tightening eligibility criteria and resource constraints. It is also in this context that we need to see our findings, especially of the tendency towards fragmented assessment and care management processes.

New relationships have developed between social services departments and many independent sector organisations. This has given care managers the opportunity to use a wider range of providers, at least for the more dependent users of care services, to enable many more vulnerable people to remain in their own homes. This aggregate increase in choice of providers – as found in our previous study – was invisible to many users and carers who were largely unaware of the differences in provider since the care was arranged through the local authority. There were, however, still a small group of care managers and users who felt that in-house services offered a safer and more trusted option.

Our previous study found that monitoring and review arrangements were generally underdeveloped, and other evidence has underlined the

need for local authorities to be more proactive about reviewing care arrangements (Audit Commission 1997; Department of Health 1998). Our current findings suggest that some authorities have responded by restructuring their care management arrangements to include special review teams; but this can lead to a dislocation in the relationship between user and care manager. This fragmentation may also be encouraged by performance indicators that measure user and carer assessments, review and satisfaction surveys as discrete tasks. There is a need for greater continuity within the process of care provision, both between care workers and users as well as for care managers and users, so that review is a continuous process. There is a danger that the very personal service that is at the heart of care becomes disjointed rather than set into a relationship that develops trust and accountability.

There is a growing shortage of domiciliary care services in some localities and particular difficulties in rural areas. Respite care services and 'Elderly Mentally Ill' (EMI) care are also in short supply. The potential for the worsening of these problems lies within the government's own policy to increase the volume of intensive home care nationally – by 30 per cent by March 2006 (Department of Health 2002*b*) – given the already serious problems of recruitment and retention of care staff in local labour markets in which, typically, there is considerable competition for such workers. As the trend continues for more care to be purchased from the independent sector, local authorities are tending to favour the development of closer contacts with preferred providers. There is, however, still some way to go before care managers as micro-commissioners have sufficient and reliable information to enable them to match providers' capacities and capabilities with users' and carers' needs. It is difficult to see how services to meet needs will be developed without addressing the underfunding of many of these care services and the lifting of restrictions on care managers' ability to build appropriate care packages. One social services user quoted in the Chief Inspector's Annual Report, when asked what he wanted from his social worker replied:

I want a life like yours. One where I don't have to battle every day to get the basic things done. A life where I can do the fun things in life not just bump along the bottom all the time (Department of Health 2001*d*: 5).

Although many users and carers in our study were very satisfied with the care and services provided by their local authorities, there was recognition that the quality of life is not always addressed by the common provision of basic personal care. As one of the care managers put it: 'There is so much more to life than being washed and dressed'. For care in the community to be a reality, there need to be systems in place to ensure trusted and fair

services and for relationships to develop in which older people can be treated as active whole people, not simply as passive service recipients.

NOTE

- 1 These are referred to in the text alphabetically. A and B refer to the two metropolitan authorities, C and D refer to the unitary authorities, E and G to the shire counties, and F to the London Borough.

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