BALDWIN, M.: *Care management and Community Care. Social work discretion and the construction of policy*. Ashgate, Aldershot-Burlington-Singapore-Sydney 2000

pursuit of meaning is an important part of social work practice. It is a fundamental tenet of good social work practice that social workers should ensure that they have understood what service users mean in describing their perspective on their condition. There are times when social workers have to impose their views on unwilling service users, but, more often than not, they are trying to understand and respect other people's sense of meaning. What follows is not exclusively about the social work practice of understanding meaning, although, in one sense, that is exactly what assessment practice is all about. It does, however, acknowledge that varying meanings exist. This argument is expanded upon in detail in Chapter Four.

In order to contain this book within the enormity of a subject like community care, the area that will be focussed upon is the assessment task within care management. Following the publication of the White Paper 'Caring for People' (D of H 1989) and the enactment of the NHS and Community Care Act 1990, Local Authority Social Services Departments have been required to introduce new structures for organising the delivery of services to adults in the care sector. This has resulted in the universal introduction of systems of 'care management' in social services departments. In order to assist the process of introducing care management into departments, the government, through the Social Services Inspectorate, produced manuals of guidance for both practitioners and managers. The Department of Health and the Social Services Inspectorate also commissioned the National Institute of Social Work to produce a practice guide. These three documents have been influential in social services departments, most of which have produced their own documents of guidance.

Prior to carrying out the first phase of fieldwork for this research, therefore, I had an idea of what the government's intentions were in relation to care management. The White Paper and the Policy Guidance (D of H 1990) that went with it provide the major policy thrust of government intentions, introducing the key concepts of the community care 'revolution'. The fundamental changes were concerned with introducing an internal 'quasi-market' (LeGrand and Bartlett 1993) into the adult services arena of social welfare, following a similar introduction into the National Health Service. This internal market was believed by the government, informed by a market economy agenda, to provide the best

way of introducing choice of high quality services targeted on those who are in greatest need.

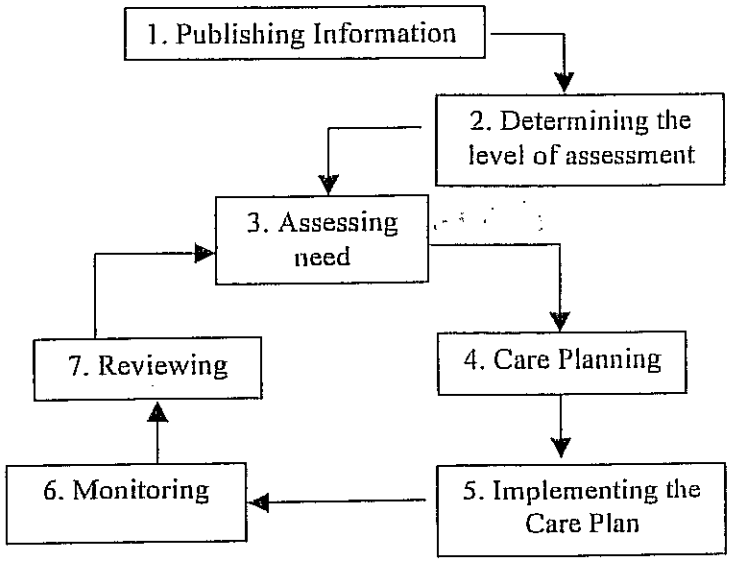
In order to ensure that there is no contamination of the market ideal, those responsible for the purchase of services on service users' behalf should be separated from those within Social Services Departments who are responsible for providing services. Hence, as in the NHS, purchasers of services (those carrying out assessments and putting together care packages) should be in a separate part of the organisation from the providers. Indeed, there is a strong incentive for social services departments to relinquish their traditional role as service providers and to develop a mixed economy of care through the encouragement of the independent sector (private and voluntary).

Care management, along with assessment, has been presented, by the Department of Health as the key form of practice for introducing these changes into the provision of adult services. The definitive versions of care management can be found in the guidance documentation (SSI 1991a and 1991b). The Practitioners' Guide and Managers' Guide have been heavily influential on social services departments in preparing their own guidance documents for care managers. That there are problems of consistency, especially in the area of role definition in these versions of care management requires greater analysis, and this can be found in Chapter Four. Having read the government documentation as well as having studied 28 social services department care management guidance documents, I was keen to establish the extent to which the knowledge embodied in the documents was being used by practitioners to inform their practice. This was the fundamental purpose of the fieldwork described in the next chapter.

The Department of Health through the Social Services Inspectorate has produced a definition of care management (SSI 1991a) which is analysed in considerable detail in Chapter Four. For now, a description of this process is required as it is important as an influential part of the context for community care. Having read 28 of them, it is clear that this document has provided the model for most of the care management guideline documents produced for their care managers by local authority Social Services Departments. Very few of the guidelines I have studied deviate from the SSI document in any way at all. They habitually define care management as a cyclical process, following the model in Fig. 2. Thus providing information in accessible forms to potential service users,

and a system for determining the level of assessment to be offered following referral are the pre-requisites to the cyclical process suggested. A number of local authorities have decided not to follow the option of having levels of assessment, choosing instead to offer a blanket assessment to all who are referred. There is evidence, however (Baldwin 1995) that there is confusion amongst care managers as to whether their authority is sanctioning "levels" of assessment or not. The third stage, of assessing need, is the key stage according to the guidance. The summary of practice guidance urges care managers to look at 'strengths and aspirations' (SSI 1991a: p.11) as well as needs, calling on care managers to bring together contributions from other agencies and specialists as appropriate. Needs are to be assessed 'in the context of local policies and priorities' (SSI 1991a: p.11) which are part of the information to be published in stage one. The care planning stage number four requires care managers to present appropriate resources available from both statutory and independent sectors to enable the potential service user to make a choice of services which would then constitute a "care plan". In stage five the care plan is implemented through negotiation by the care manager with appropriate agencies, including their own. It is also the stage at which financial negotiations are instituted so that responsibility for payment for the package of care can be confirmed. The final two stages, which feed back into the assessment process, involve monitoring the care plan and then regularly reviewing its effectiveness, in the context of service user's and carer's unfolding needs over time. The monitoring would be continuous and is likely to involve service providers keeping the care manager informed of progress. Reviews will occur at specified intervals and would involve care manager, service providers as well as users and carers. These stages would have a general quality assurance function in the 'continuing quest for improvement' (SSI 1991a: p. 11) in the merits of the services provided as parts of the package of care. This structure is the normative approach to care management in community care. As suggested above, there will be further analysis of this model, both in theory, in chapter five, but also in practice in chapter four.

Figure 2 The Care Management Cycle



The importance of role clarity within a task as complex as assessment has not prevented it from becoming a contested arena in its own right. What the research that informs this book has sought to do is seek out the variety of meanings and the forms of knowledge that inform the practice of assessment within care management. We can then draw tentative conclusions about the range and degree of influence that different types of knowledge exert on practice, and their affect on the implementation of policy. If there is no congruence between the knowledge and values that inform the policy implemented through local authority departments and that which informs the practice of frontline practitioners, then it is likely that there will be a gap between intention and practice leading to 'implementation deficit'.

This is a central line of argument within contemporary social welfare. The tension between professional, political, and managerial approaches to service delivery can perhaps be better understood within this context. The voice of users and potential users of welfare services can also then start to find a space within which it can be heard in its many guises. If assessment, as many Learning Difficulties (Souza 1997 in Ramcharan et

do when carrying out a sophisticated task such as assessment? Were there other, as yet unidentified, forms of knowledge that they were using? The forms of knowledge that care managers were drawing upon would provide evidence of the degree to which they were implementing policy as intended, although, as has already been stated and will be established in even greater detail in chapter four, policy intentions are not altogether clear in the most significant literature.

Research Methodology

Choice of Authorities

Between April and September of 1994 interviews were carried out with staff in two local authority social services departments. Originally it had been intended to carry out interviews in three local authority social services departments which conformed to notional points on a continuum of adherence to central government intentions with regard to the introduction of an internal market in social welfare. I was looking for an authority that had pursued the intentions explicitly at one end of the continuum, another that had resisted the intentions and complied with the minimum of statutory requirements at the other, with another authority at the midpoint on the continuum. Unfortunately the authority chosen for the midpoint pulled out of co-operation at a late stage, and after letters of introduction had been sent out. It was too late to renegotiate another similar authority and I chose to continue with only two, which did, at least, afford a direct contrast and comparison.

One of these authorities was a London borough (identified hereafter as Borough) and the other a shire county (to be known as Shire). Shire had pursued the government agenda from an early stage, making an organisational divide between purchase and provision earlier than most other Social Services Departments. This meant that the staff in the authority should have already gained considerable experience of the kind of organisation and practice changes that care managers in other authorities, like Borough, had only been used to for one year. Borough, on the other hand, were recommended to me as an agency who were following government guidance only so far as statutory requirements insisted. A comparative study between these two agencies was chosen on the grounds that there was sufficient differentiation between the two

departments to provide useful comparison and establish a degree of validity in the findings.

After the interviews, I studied the care management guidelines from Shire in order to establish what level of congruence there might be between the intentions of that document and practice in the department. Borough did not have a similar guidance document, but relied on the Social Services Inspectorate guidance (SSI 1991a; 1991b) on care management as the reference point for practice. My principle focus was on the actions of care managers in their role in the *assessment* of potential service users' needs. Inevitably, however, I needed to have some knowledge of the whole care management cycle within which assessment sits, as it is perceived of as a whole within the literature (SSI 1991b) rather than a fragmented part. This cycle was described in Chapter Two (p. 65ff) and is further explored in Chapter Four.

The Participants

Interviews were carried out with care managers and first line managers in both social services departments. In addition two middle managers in Shire, and one senior manager in Borough were interviewed to obtain the view of staff with budgetary control and strategic responsibility within the agencies. In Borough, interviews were carried out with 8 staff doing assessments within adult services. Three of these, as well as carrying out assessments themselves, also had first line managerial responsibility for other staff carrying out assessments. Of these 8, 3 were qualified social workers, one an occupational therapist, and the others had no formal qualification but with training and experience appropriate to the task. I also interviewed three other first line managers in Borough, who had responsibility for the management of teams of workers. Two of these were qualified social workers and one an occupational therapist. Finally, in Borough, I also interviewed a senior manager in one 'area' who had budgetary accountability, responsibility for managing first line managers, and strategic responsibility within the area and the whole borough.

In Shire I interviewed 9 care managers carrying out assessments. Two of these were child care workers, the rest worked in disability teams. All were qualified social workers except for one who was an occupational therapist and another who had the diploma in domiciliary care management. I also interviewed 6 first line managers in Shire who were responsible for budgets and managing care managers. One of these

managed a child care team, the rest were managers of disability teams. All were qualified, one as an occupational therapist, and the rest as social workers. The two middle managers in Shire that I interviewed were both qualified occupational therapists. They had staff management, budgetary and local strategic planning responsibilities. The gender of participants was mixed in both Authorities, and in each grouping of workers. Ethnicity was varied in Borough, but all the interviewees in Shire were white. I noted the ethnicity of interviewees as I felt the possibility of black perspectives on care management might reveal a different approach to the task from their white colleagues.

The Method

The interview schedule was semi-structured, comprising a list of questions that everyone was asked, but with the option of follow up questions, in order to seek clarification where necessary. I maintained a checklist of potential responses that I could prompt interviewees with, should they have problems in answering questions. I was very aware of the problems, in using interview schedules, of misunderstanding. Foddy (1993) from a symbolic interactionist perspective casts doubt upon the usefulness of responses because the 'relationships between what respondents say they do and what they actually do is not always very strong' (Foddy 1993; p. 1). It is very important then, to ensure that the questions are understood in the way intended by the researcher and the answers, conversely, are understood as intended by the respondent. There were important issues of meaning and intention that I was aware of, and determined to avoid the pitfalls of misunderstanding. Other writers on qualitative research methodology (Silverman 1993; Lindlof 1995) urge the importance of interpretation and the need for piloting before and checking out during interviews to avoid the worst excesses of a 'scientism' (Silverman 1993 p.2) and 'abstracted empiricism' (Silverman 1993; p.27). I concurred with Silverman, and did not believe that bias could be 'techniqued out' of an interview schedule (Silverman 1993; p.29), rather seeking to remain vigilant, questioning and flexible in order to proceed with as few assumptions as possible. Prior to the research interviews in Shire and Borough I piloted the interview schedule in a team from a nearby local authority.

When I started the interviews in Shire and Borough the flexibility I was seeking proved invaluable as it rapidly became apparent that

individual workers were fulfilling more or less subtly different roles in different settings, sometimes with the same job title. This was particularly the case in Borough, where decentralisation had created structures within different 'areas' which were very particular to that patch. The fundamental purpose of the interviews, to get at the actual practice of individuals, and compare it with what policy and practice guidance told them they 'ought' to be doing, made the avoidance of assumption a basic value of the research interviews. In a similar vein, it was important that individuals were able to speak freely and in confidence about their work, and the organisational context, again, so that the degree of congruence between the 'ought' and the 'is' could be gauged. Confidentiality and anonymity were 'de rigeur'.

Meaning Revealed

The interviews were all tape-recorded and have been transcribed. The transcripts have been studied in detail, and key themes have been extracted through content analysis. In what follows all quotations in double inverted commas (" ") are direct quotations from participants. In order to avoid being guided purely by my 'hypothesis', that there are limitations to policy implementation as a result of the activities of key implementers, I have looked widely for issues that have arisen, and group them under three different headings:

- *Role of the Care Manager*
- *Use of Procedures and Resource Management*
- *Implementation of the Principles of Community Care*

It should be noted that I had no access to the outcomes of individual's practice in this research, only what they said about what they did. I have used care managers' own words where that is illustrative, but the interpretation is mine.

1. Role of the Care Manager

Under this section we can look at the influences on their practice that interviewees listed. How do care managers see their role? What are the knowledge, skills and values that they believe inform what they do? What

might the difference be between professional backgrounds, or between those with a qualification and those without?

Influences on Practice

I started by asking a general question 'what influences your practice?'. A substantial range of responses was revealed, and I felt that these 'volunteered' responses were at least as significant as those made to prompts about specific influences on practice. The most frequently mentioned pre-checklist responses were factors like "instinct", "gut feelings", "the personalities involved", and "experience". Agency procedures - filling in the forms - was also a frequent response, but training, either in-service or professional was less often stated as an influence on practice, prior to respondents being given a specific opportunity to comment on this. Even when training and theory were offered as prompts, many respondents found the question difficult. Only very few quoted specific theoretical models that they use to inform their practice or by which they evaluate what they have done. One or two of these answers were very impressive, the rest seemed somewhat embarrassed by their inability to dredge up theories they had learnt on training programmes, often some years before. Some practitioners were able to articulate models of practice even though they could not put a name to them.

As far as comparisons between Shire and Borough, qualified and unqualified, social worker and occupational therapist are concerned, there was not a significant difference when the initial question was put. Qualified workers, when given the opportunity to speak of theory were generally better able to do so. There were some notable exceptions, mainly where unqualified staff had made excellent use of prior learning, or in-service training to inform their practice, and were able to cite particular theories or models that they used to inform their actions.

The question of the relevance of training to the task of care management is an interesting one. There were some responses that indicated a feeling that social work training was not relevant to care management, but most did not make a judgement on this. A senior manager in Borough felt that the current teaching on diploma in social work courses was inadequate for the role, but still the best available.

Most assessment practice seemed highly problem focused. This was particularly the case with occupational therapists. Again, there was

very little difference between Shire and Borough in this analysis. It is important to add that the unqualified workers practice in this regard was at least as well informed as the qualified social workers. Some unqualified staff spoke most eloquently about the practice skills involved in needs-led and user orientated assessments.

'Resources' were given as an influence on practice in two different ways. Lack of resources influenced practice in general, but so did knowledge of available resources. This left me with some concerns about the degree to which assessment outcomes were being determined by what care managers believed were the resources available to meet any apparent need. We shall return to this point later.

One of the clearest differences between the two authorities concerned the degree to which 'values', 'attitudes', equal opportunities or anti-discrimination were volunteered as influences on practice. In Shire, these were seldom mentioned before the prompt. Even after Shire care managers were prompted with the question about values as a potential influence on their assessment work, many still volunteered little in the way of response that indicated a widespread understanding of a need to be influenced by, for instance, concerns that some service users may be disadvantaged in particular ways. There were some notable exceptions to this from care managers qualified for some time as social workers.

In Borough, on the other hand, there was almost universal volunteering of the need for ethnic sensitivity, taking cultural difference into consideration and other similar practice values. This was primarily the case in relation to 'race' as a potential area of disadvantage. This sensitivity was perhaps not surprising given that in one of the Borough 'areas' the black population was set at 60% by one care manager. Borough care managers were also more likely to think of equality of opportunity in relation to age, gender, disability, sexual orientation and poverty than their counterparts in Shire. I felt that this level of difference was likely to have an effect on practice. Care management guidance documents from government and local authorities urge consideration of such factors so failure to do so would indicate divergence from policy intention, as well as a less effective assessment outcome.

Several qualified social workers in both Shire and Borough seemed uncomfortable about their difficulty in articulating values in relation to assessment practice - "I realise I haven't really thought about values for ages, it's terrible". There were, as before, exceptions to this point, with some impressive articulation of values by some individuals

(qualified social workers from both agencies and unqualified care managers from Borough). In addition, some teams had well defined and shared values in relation to their practice, the most impressive example of this being in Shire - "as a team we have a stated document which list our aims and values ... an absolute commitment to equal opportunities ... working towards anti-discriminatory practice ... recognising that we do discriminate". The sort of values that were referred to in these cases are in the form of a set of principles to which social workers - in this case as care managers - are committed and which inform them of how they *should* behave (Banks 1995). The Central Council for Education and Training in Social Work (CCETSW) is the body that validates and provides regulations for professional social work courses. CCETSW's current statement of value requirements (CCETSW 1995) includes such phrases as respect for diversity, building upon strengths, promoting rights to choice, confidentiality and protection, countering discrimination and assisting people in increasing control over and improving the quality of their lives. This area of values is returned to in Chapter Seven when social work theory is looked at in detail.

In conclusion it was apparent that of the many influences on practice in assessment, not all relate either specifically or even incidentally to policy guidelines. There was evidence of unconsidered reliance on intuitive approaches to practice - "a lot of gut feeling, a lot of intuition, you've just jolly well got the vibes". The apparent failure to reflect on the origins of this knowledge, added to some resistance to formal sources of knowledge and values - "I don't think I consciously draw on anything, I just think that I do things"; "I've forgotten all these things (theories and models) they all go out of your mind"; "I'm certainly not comfortable talking in the value thing - we're almost getting into mission statements" - makes congruence between policy and practice less likely.

Assessment - Knowledge Skills and Values

Assessment was focused upon in this research because it is argued as a key area in the care management cycle (Social Services Inspectorate 1991b). We have already looked at some of the influences on practice. There are other issues of practice and role. Care managers almost invariably indicated the need for assessments to be needs-led, and for the individual to be the focus of assessment. There was revealed, however, a very widely held belief that service users are not really interested in participating

beyond an assurance that they will receive the service that will meet their needs. This was justified through sentiments such as "I think a lot of service users don't understand". Time constraints on involvement were also revealed - "It really does take time, I mean time and effort to involve people"; "the reality is that you can't sit around and do it with them". This apparent failure of involvement has resulted in care managers adopting a role which shifts away from maintaining the service user at the centre of the assessment exercise. The likely result is an assessment based more on their professional opinion than on an assessment formed through partnership. Using this evidence we can question the extent to which care managers allow their role to be defined by what they believe users want as opposed to what community care policy, procedure and ethos suggests is good practice. User involvement requires the education of service users into greater expectations, as much as it requires the education of staff into new ways of thinking and practice. This was clear evidence of a gap between the intentions of community care policy and the practice of care managers. It is interesting to note that the *values* of service user involvement are contemporary social work values (CCETSW 1995) as well as policy intentions.

Care Management - Procedure versus Practice

My questioning found some debate amongst first line managers in both agencies about two models of care management. Most care managers seemed less interested in defining a new role and more with protecting those parts of their current practice which they hold dear - "I'm actually doing very much the same thing as I always was". The two models were referred to as the "procedural" and the "laissez faire". Also referred to at one point was the "exchange" model from the NISW book which is described in detail in the following chapter (Smale et al 1993) and which takes us close to the good practice intentions of CCETSW requirements. The procedural model was perceived as mechanistic, following agency bureaucratic guidelines, and involved little active reflection on the nature of the relationship between worker and user. The other model is based more on traditional social work as a practice, and involves the forming of relationship and the use of this for exploration and problem solving. In the NISW book there is a similar model of assessment, referred to as the "questioning" model. This model also holds with a basic assumption that

it is the care manager's role to make the judgement, based on their professional expertise.

Although care managers did not talk directly about these models, they are a helpful way of differentiating the forms of practice to which care managers appeared to hold allegiance when they described their aims in carrying out assessments during interviews. Some care managers clearly wanted to continue an approach to assessment built on the use of relationship, as they felt they had always done, and resisted the introduction of bureaucratic techniques as a consequence - "I believe these forms are a barrier between a person and an assessor"; "if you present forms are a barrier between a person and an assessor"; "if you present those (forms) to someone, the walls are up straight away". These tended to be care managers who had been qualified as social workers for some time. It is my view that this practice was closer to the questioning model, which involves a more traditional application of professional knowledge, than the exchange model which defines assessment and care management practice within a participative context. There were few care managers from both Shire and Borough who seemed to be using anything resembling the exchange model. Those who did were the same care managers who were clearest about their role, and seemed to be practising nearest to agency requirements in the Shire Guidance document. Other care managers seemed happier with a procedural model, indicating that they would like the assessment instruments to be more prescriptive: "The forms are just blank pieces of paper", complained one respondent.

I found this debate to be evidence of confusion of role in both agencies. It may be that there is room for different kinds of care manager in a department, but the difference in perceived role does have an effect on practice, particularly in relation to user involvement in the assessment process. The perception of role confusion by care managers in both authorities has a detrimental affect on confidence and results in care managers sticking to what they know and feel assured of rather than moving on into a new and uncertain practice about which many have both concerns and suspicion.

Some first line managers suggested that recently qualified workers were more likely to adopt a mechanistic approach to assessment - "what I find with more recently qualified staff and with student social workers is that they are looking at assessments in a much more mechanical, administrative, bureaucratic way". This was a good critique of contemporary diploma in social work teaching, and there was some limited evidence for the assertion. On the other hand, there were also examples of

exchange practice from newly qualified staff, and, generally, it was hard to associate the approaches to any one group - social workers, occupational therapists, or unqualified workers. One manager made the interesting point that she believed procedural models were "undermining the traditional instincts" of care managers. She was referring to the use of relationship by social workers. There was also a direct contrast revealed between professional and procedural models of assessment, with the interviewee being clearly in favour of the former - "ability to communicate, relate and set up a relationship will be a factor which is not a very measurable factor". This resulted in resistance to the procedures to demonstrate that favour in practice - "there are some people who will try and get round the procedures because they feel they are working against the best interests of the client". This was actively encouraged by some managers - "so I said to her (an anxious social worker) forget the forms, just remember how you make a relationship with an old person ... it (use of the forms) totally deskills some of the most experienced workers in the team".

In both Shire and Borough there was a strong defence of procedure from two care managers who were impressively clear about their role (the Shire care manager was social work qualified, the Borough one was unqualified). Both of them, interestingly, whilst advocating a user focused and needs-led assessment practice, insisted that bureaucratic procedures introduced an element of equity into practice that had been very patchy in the past - "you've got the same set of forms and everyone gets the same ... and you look at the needs"; "I personally feel about social work that it needs to be accountable ... and that's from my past history in (another authority) where I just saw a mish mash response". This approach was supported by team managers in both authorities - "it draws more people into that process, more people can participate in the care management process"; "it would contribute to equity". This seemed to me to be a justification for a hybrid between the two roles, with the procedure serving the purpose of the exchange rather than the other way round. It will be very difficult for agencies to introduce this sort of model for care management, however, against the resistance of care managers who are suspicious of influences such as bureaucracy - "it's certainly a barrier (form-filling) between this relationship thing" - resource control - "in budgetary control terms what label do we put on the relationship? You can't cost it" - and other techniques of managerialism - "(targets) as a management tool, wonderful ... but in terms of dealing with clients as

people it's not all that helpful ... it gives connotations of measurement ... and it doesn't matter what the quality of the work is".

Discretion versus Prescription

There were many examples of resistance to departmental procedures, with care managers using the phrase "we should do" this or "we ought to do" that. The *shoulds* and *oughts* revealed either an unwillingness, which, when challenged produced a grudging acknowledgement that they did, indeed, do it as intended, or, more interestingly, the revelation of a continued adherence to a method of working which was older and more familiar - "If you ask my team manager I'm not supposed to have that role but I do it anyway"; "I'm actually doing very much the same thing as I always was". There was one example of workers in a team running two systems side by side - the old and the new - because they found the new system inimical to their preferred method of practice - "this is not policy, this is x's (team manager) own system".

This is evidence again of role confusion, but it also reveals the strength of adherence to traditional professional practices, as well as the degree of discretion care managers hold, despite the bureaucratic procedures. Care managers have the scope to resist policy intentions, and are doing so successfully, on this evidence. It was not confined to one agency, or to one profession. The corollary of this behaviour is that the baby of good practice is indiscriminately thrown out with the bath water of the new procedures.

One Shire manager spoke eloquently of the need for education in an academic sense, rather than training. Care managers, he believed, needed to have a deeper understanding of the changes of care management over traditional professional practice, so that they could really understand the advantages. This required a more academic approach to learning in his view, and suggested that going away to college was more likely to assist the process of reflection and adult learning than in-service training. We will return to this theme of the importance of reflection in the development of practice in later chapters. It was a central moment of learning and understanding for me.

Individual Care versus Community Care

Whether community care involves a process by which individuals receive their care needs, or is about the management of scarce resources on a more collective basis, takes us to the heart of the enterprise. It articulates the differences between care in the community versus community care, raised in an earlier chapter of the book. My over all conclusion from both Borough and Shire is that this is another issue which adds to the confusion about the role of care manager. Most are involved on a purely individual basis, assessing the needs of individuals and putting together packages of care to meet those needs. We will return to resource deficit recording later, but the resistance to this was most revealing. Most care managers can not see the priority for such activity, have little interest in strategic planning in general, and yet are very irritated by the lack of development of resources in some areas. The senior manager in Borough despaired of this lack of understanding and interest in structural influences on service delivery.

Care managers generally indicated that their prime responsibility is to the individual - "It's the individual we work with". Where there was a difference was in the way that care managers saw their clients within the broader community. There was good practice in networking and multi-disciplinary / inter-agency work revealed in both settings. It was particularly noticeable in Borough, with some good examples of people using networks, both formal and informal, to provide support for individuals. This was no surprise, perhaps, as these Borough workers were operating in small patches, where they had opportunities to get to know their communities and people within the community could get to know them. I was also impressed with the level of commitment, in Borough, to the importance of understanding the mix of culture within the patch. This was especially noticeable from the three black workers, all of whom mentioned the importance of ethnic monitoring, and all of whom noted the need for increased training in ethnically sensitive practice. There were white workers who expressed similar views in Borough, so this may be more an indication of agency ethos at work rather than individual perspective. Two white interviewees commented on how helpful it was to have colleagues from different ethnic backgrounds because their perspective was a dynamic force for the development of practice more generally within their team.

Acute versus Preventative Work

There was almost universal disappointment at the degree to which assessment practice involved patching up situations that had reached breakdown point before referral. Targeting those in greatest need was described as propping up the failures of informal care, and not good prioritisation - "if you don't do the preventative work, you're doing knee-jerk crisis work which is twice as expensive and half as effective". Putting resources into prevention was felt to be a far better way of working, but there was little opportunity for this. One Shire care manager mentioned a figure of 18% put aside for preventative work, but this was a vague allusion that could not be elaborated upon, and which did not crop up again. Such a policy certainly seemed to be undermined by the degree to which only the highest priority cases were being seen for assessment. Targeting those most in need is Government policy. The view of professional workers is that it is not a helpful way of achieving the over all aims of maintaining people in their own homes. Ironically, it was proving more difficult to resist this policy initiative than some of the others which might have a more beneficial affect on service users' lives.

Resource Constraints

Resource constraint was routinely quoted as the major stumbling block to the meeting of needs, although there was variation in this. Some respondents from both authorities said that the problem was not resources in terms of money, but of the availability of specialist service. When care managers were quizzed about this resource constraint issue, however, almost all of them owned that it was not a problem that they had encountered. They put this down to luck in their area, and predicted that things were likely to be much tougher next year. With continuing fiscal crisis, they may be so, although the evidence I collected suggests that the practice of most care managers in tailoring assessments to their knowledge of available resources may be more influential. Most admitted to this in both authorities, usually justifying this by an unwillingness to set up expectations with service users that they knew they could not deliver - "All my judgement is not to encourage people to hope for things which are not in the end going to be there"; "I have to say that if you do know that there are no respite places available to save your client distress and having raised hopes and then smashing them down, you don't recommend it".

This kind of pragmatism is understandable for staff who have to negotiate the complexity of relationships with vulnerable, needy and sometimes hostile people. The result undermines the practice of needs-led assessment. Assessment and care packaging in many of the cases that I heard about was driven by the care managers understanding of resource availability. Care managers, in addition, see very little worth in recording deficit - "there is a service deficit form we're supposed to fill in ... I don't, I haven't got time ... if it's something everybody knows I can't be bothered". These two practices combined, the resource lead to assessment and failure to record service deficit, result in central planks of policy for community care being eroded by care managers' practice. This is clear evidence of the distortion of policy intentions by street-level implementers.

When managers were asked about the likelihood of this occurring, those in Borough denied that it could happen and that all care managers understood the need to assess without considering resource availability - "I think I can confidently say that they are not influenced by the availability or unavailability of resources". In Shire some first line managers acknowledged what was happening and constantly reminded staff of the requirement that assessments should be needs-led. In Borough, care managers with first line management responsibility told of giving assessments back to workers to repeat because they were so evidently resource-led. Without a shift in attitude by care managers, possibly through the provision of opportunities to reflect upon the consequences of their actions and non-actions, this degree of exhortation is perhaps the only way to alter practice.

2. Use of Procedures and Resource Management

Allocation

All respondents were able to describe the system of allocation operating in their team coherently. Whilst systems were variable, there was a problem with the basis on which decisions were made. We will return to the variable use of agency priority systems below, but there was much evidence of the use of systems, designed to establish eligibility for service post-assessment, being employed to make decisions about allocation. This incongruence between procedure and practice was most apparent in Shire. The result was a danger of judgements about need being made prior to assessment. Such practice would undermine policy intentions. One middle

manager in Shire expressed concern about the sophistication of decision-making in allocation. The procedure was believed to be too reliant on subjective judgements, and the hope was that more analytical methods, based on the priority matrix system could be developed - "people do need to learn a bit more about probabilities, making what are subjective, human emotional decisions but in a more analytical way". This desire for greater consistency is understandable. It needs to avoid prejudging priority of service delivery.

The Instruments of Assessment

These bureaucratic instruments were almost universally despised. The designers of these forms must be very thick-skinned individuals to cope with some of the venom directed their way from both care managers and first line managers. The accusation against those who design such forms was that they "only talk to computers", so perhaps they do not hear the complaints. I have already spoken of a few care managers, in both authorities, who found the prescription comforting, and others who felt that they combine flexibility with a consistency that is more likely to ensure equality of opportunity. When care managers were challenged on their negative attitudes to the forms many retracted their initial hostility as they found it hard to substantiate it beyond bare prejudice against bureaucratic procedures.

Some concerns remain, however, and many of them were offered by first line managers rather than their staff. The feeling that the forms were "computer-driven" and more useful for the quantification of assessment procedure was widespread - "it is computer-led and statistic and data-led, rather than practice-led"... Consequently first line managers readily admitted that they were of more help to them than their staff - "they do give me the answers I want if they are followed through". Even then, the kind of information available from the collected data was considered to be disappointing by most managers in both authorities. Managers felt that the quantitative data was crude and unhelpful, giving some weight to demands for more resources, but saying little about quality of work. Less assessments, they argued, may mean more effective assessments, and, therefore, less 'return' of service users, either as complainants, or in what is referred to in the health service as the 'revolving door'.

There was some articulation from managers and care managers in both agencies that the forms "get in the way of" the primary task of assessment, which is the formation of a relationship. One social work manager in Borough managed a team who felt de-skilled by the forms. She had instructed her staff not to think about the forms until after the assessment visit. The forms could then be filled in on their return to the office. This is another area in which policy seems to be unclear, because there was some belief amongst care managers in both authorities that they should complete the forms in the presence of the service user. This practice would maximise the likelihood of service user involvement in the process of assessment.

There would seem to be widespread belief, in conclusion, that the forms are there to serve the bureaucratic and resource control function of the agency. Even though this function is seen as valid, respondents felt that the forms should primarily serve practice needs as these are the ones most likely to affect the quality of service. As one manager said "a good assessment is not going to be a form-filling exercise". Dissatisfaction with the system leads to practice which undermines the good intentions of procedures, such as equality of opportunity, noted above.

Levels and Priorities

This is an area of some confusion, even where, as in Shire, there is a highly rational system of priority formulation, that has a substantial profile in the agency. Neither authority has a system of 'levels' of assessment, apparently. Some care managers said they did, but I understood this to be a confusion with the priority system. There was also confusion surrounding the use of a priority system in allocation as opposed to a priority system for determining service eligibility post-assessment. As far as levels of assessment are concerned, where the concept was understood, it was generally felt to be unhelpful. Once referred, all got "the complete works" as one manager put it. Indeed, there was much evidence of ad hoc arrangements for brief assessments, which did not mean that time resources were spent on "low priority assessments". I understood this to be against the policy of both authorities, but such was the diversity of views that it became impossible to be certain.

In Shire, as indicated, there is a 'high tech' system of priority formulation. It works very variably, according to the responses I received. It is used in a number of teams as a method of prioritising allocations, with priority scores being adapted after assessment, depending on the result. How it is used to establish eligibility is also variable. I understood that

different areas should not have had different policies about which bandings will or will not receive a service, and under which circumstances, but, nevertheless, the practice varied both within and between areas. Even given the attempt at rationality in prioritisation in Shire, managers admitted that it is a "fairly subjective score". The resultant scoring which can lead to service (or not) was seen as a "statutory obligation". As one manager put it "the Committee have said this is what Social Services will do, will offer assessment to anyone (with the right score), but obviously to make a score you have to do an assessment, so we are in a bit of a Catch 22". A second Shire manager said "I think we are being advised to give everything that comes through the door a score". In recognising the "cart before the horse" nature of this advice, he went on to say that "a lot of the practices in the Department are quite idiosyncratic", with many people, in his view, having "their own ways of doing things". Another manager admitted that they write to some referred people refusing an assessment because they do not meet the criteria. This seems to be against agency policy as well as inequitable in the context of an ethos of needs-led assessment. Both ethos and policy would suggest that no judgement should be made prior to an assessment.

One middle manager in Shire admitted that the latest policy on the system was unclear in her mind. Another was much more positive about the system and the way it gave practitioners protection from complaint, in that they could deflect complaints on to agency policy and away from personal decision-making. In order to do this care managers must be clear about what the latest policy is. In addition, the latest policy needs to be readily available to potential service users. In Borough, the system is far less prescriptive, so that the result is more flexibility, more imaginative use of resources, but the danger of less consistency, decisions being open to judicial review (only in Borough did I hear concern about this eventuality), and care managers feeling unsupported and open to complaints being directed at them.

Procedures and Equal Opportunities

There was quite a deal of evidence of care managers routinely and deliberately omitting to give copies of assessments and care plans to service users. Six care managers, between both authorities, stated that they do not routinely complete this task that some admitted was supposed to be mandatory. The reasons given were to do with user disinterest, or inability to understand, due to dementia or learning difficulty. One manager from Shire even claimed it was because users wanted to "save the trees". As implied above, it may well be the case that user's low expectations have resulted in a widespread display of apparent disinterest. Other care managers were clear about the need to give people their care plans and assessments, as of right, and felt that the onus was on them to explain why this was important.

My conclusion, on this evidence, is that there is probably a widespread belief amongst care managers that service users are not really interested in being involved in the process beyond giving information and receiving a service. The dangers of this leading to a practice that denies service users access to information that would be of use to them in making informed choices is worrying. It is another example of the opportunities practitioners have of using their discretion to undermine policy intentions.

3. Implementation of the Principles of Community Care

There are six areas, most already mentioned, that define the principles of community care policy. To what extent are these principles being undermined?

Service User Involvement

I have already said much about the widespread assumption that users are generally not interested in anything apart from getting a service to meet their needs. If this assumption continues, the intentions of a user-focus to assessment will not be realised and policy intentions will be undermined. It was interesting to go through the interview transcripts and note the replies to the question of who was involved in decision-making following an assessment. Only ten out of the 17 care managers said the user or the carer should be. That does not mean that they are not, of course. The point is, that when asked who should be involved in an assessment, user and carer did not immediately come to mind for a substantial proportion of care managers. The same point can be made for the general provision of information in relation to assessment and care packaging. The practice of providing information is very patchy in both authorities. Information provision is a key aspect of the care management cycle (Social Services Inspectorate 1991a, 1991b) and service users are less likely to be involved or enabled to make choices unless they are well informed.

The difficulties of being user-centred were honestly admitted by care managers in both authorities. It is much easier, when working with a user who has poor memory or severe learning disability to take over, particularly when they have no carer willing or able to assist - "you shouldn't do it (make assumptions about service user needs) but I think sometimes we do". Time constraints on care managers are considerable - "the reality is that you can't sit around and do it with them". Committed care managers admitted to being unable to sustain their anti-discriminatory practice under considerable time constraints - "we're not very good at sending the forms back for them to sign, it's time and pressure". The way this undermined morale and confidence was painful to see.

There was a commonly held belief that advocacy should be a role for care managers. Acting on users' behalf in trying to gain access to scarce resources, educating service users into the best ways to access services themselves, how to help users be more needs-focused and less interested in actual services which may not meet needs for that individual were all believed to be important roles for care managers. Such was the level of role confusion, however, that many care managers were not sure whether agency policy allowed them to do this work or not. This, again was undermining of confidence.

The Relationship with Carers

Involvement of carers was generally at a higher level than with service users. One care manager was anxious about this aspect of her practice, recognising that it was time related but disempowering of the user. There was evidence from occupational therapists and some other care managers of a greater emphasis on listening to carers and not users - "I usually am much more comfortable in involving carers particularly as a lot of my clients have got a degree of mental impairment". Despite this, there was some evidence of imaginative practice with users to try and include them to the best of their ability, and recognition from at least one manager of the sophistication of practice necessary in resolving, or managing differences of opinion between user and carer, often where there was a substantial power imbalance between the two.

Choice and the Mixed Economy

Many of those interviewed revealed hostility towards the independent sector which was described as ideological - "I don't think you can trust the care of anybody, especially elderly people, to private concerns where they have to make a profit and they have to undercut". Others were dismissive of the quality of service offered - "they are so unsophisticated". There was also, however, concern expressed about the inflexibility of in-house Home Care Services. In this case independent sector agencies were seen as more responsive. There was little evidence of a burgeoning mixed economy of care services from these interviews. It was unclear, however, how sophisticated the information was that care managers were drawing upon. If such a knowledge base was not routinely developed, how can care managers know what is available within a mixed economy of care, across a formal and informal spectrum?

Community Care Plans and Strategic Planning

Community Care Plans were not mentioned as sources of knowledge for either practitioners, managers or service users, although they were intended by the legislation to be one of the forms of information provision that would improve services. Care managers are the eyes and ears of departments. Data collection for strategic decision-making will be much the poorer if care managers can not be persuaded that they have a part to play in this. Team managers in Shire and the senior manager in Borough felt that care managers need to be more actively involved. One manager said that failure to establish a clear role through a more academic approach to learning "makes it very difficult to get staff to identify service deficits ...as we get more money-led we need these deficits to show up and they are not". Care managers could be more involved by routinely being fed back information based on the collective data derived from their individual assessments. For this to happen they must be persuaded of the importance of deficit recording, as well as balancing needs-led assessment with unreal expectations. In this sense the future of implementation is in the hands of these street level implementers, and the degree to which they are to be encouraged to participate in rather than resist agency activities will be a key to successful implementation.

Financial Control and Service Delivery

Changes in accountability and flexible use of resources by people closest to users has been argued as a key way to provide needs-led services. Accountability and budgetary control has been largely decentralised in both agencies. Respondents enjoyed the opportunities to provide more imaginative and user-led services. This was, after all the negative versions mentioned above, an example of the existence of discretionary power which held the potential to develop policy according to intentions, rather than undermine it. Any loss of this discretion, it was believed, would result in a reduction in quality of service, particularly in the way that services responded to individual need.

Multi-Disciplinary and Inter-Agency Work

Most care managers are operating in a multi-disciplinary setting and feel happy to be so. There was some evidence of unease, however, particularly from recently qualified and unqualified staff. This seemed to be to do with perceived status, although, I felt that there was some concern that lack of role clarity left care managers vulnerable when working with, for example, health workers who were believed to have a clearer idea of their role. The senior manager in Borough expressed concern about the lack of confidence being displayed by care managers in this area of work. He believed that training was very important, and hoped that in-service training, as well as diploma in social work courses would address this area more. Occupational therapists in both authorities and care managers in Shire were less likely to reveal such concerns, and there was a fair deal of evidence, particularly amongst the more experienced practitioners that they felt comfortable and well-equipped to be practising within a multi-disciplinary setting.

Conclusions and Implications

The influences on care management practice in these two local authority social services departments are nothing like as clear as can be detected from reading guidance manuals and other local and central government documentation. When it comes to localised practice the tension between discretionary behaviour and prescriptive procedures finds care managers caught in a web of uncertainty. In these circumstances we find practices

are inconsistent, roles are unclear, and opportunities for flexibility at its best and confusion at its worst, are rife. There is a professional agenda expressed by many care managers, and their managers. It is not a consistent discourse, however, and there is evidence of more than one professional agenda. I had described to me a more traditional practice which is individual based and problem focused. It is an approach which draws upon a medical model of disability, and is at odds with the more contemporary approach of user-centredness within the policy guidelines. There is also evidence of a very procedural approach, which borrows heavily from managerial interpretations of care management. Lastly there is a more contemporary care management practice which is informed by principles of user involvement, needs-led assessment, choice and empowerment. This practice is not exclusive to qualified social workers, although it is congruent with contemporary social work values (Banks 1995; CCETSW 1995).

These interviews would suggest that the procedures outlined in the Shire guidance manual and the Social Services Inspectorate document which serve as the principle source of procedural guidance for care managers in both authorities are 'more honoured in the breach'. The procedures provide a knowledge base for practice which has not been accepted by many care managers who are using their scope for discretion to undermine policy intentions. I have read many social services department care management guidelines and the Shire document is one of the better ones for clarity of practice and intent. It is very procedural, but does, as one Shire care manager said "describe good practice". Role confusion in care management is partly to do with resistance to what is seen as an alien culture by care managers. The definition of a client in the Shire Guidelines as 'someone on whom the Department is spending money' is the kind of 'value in action' that care managers resist. As one put it very prettily - "It makes my gorge rise".

This fieldwork indicates that social workers can make the shift in role and yet retain the fundamental tenets of contemporary social work values. Values are a crucial area for a complex reflective practice such as care management. Social workers are better educated for this approach to working with uncertainty, but the evidence suggests that the values of anti-discriminatory and anti-racist practice are seldom close to care managers thoughts when practising. Being user focused, being aware of the need to balance competing demands - e.g. of users and carers - and appreciating the effects of unrecognised power relationships are all crucial to the

development of empowering practice, which most care managers expressed a commitment to. It is also a key aspect of community care policy.

There was little evidence of needs-led assessment. Resource availability, in both type and quantity, are the major influences on assessment practice. Care managers do not routinely record service deficits they come across. Being resource led, there is none to record. By over-reliance on carers for information, by assuming users are not interested in being involved and by not passing on documentation to them, care managers also fail to routinely involve service users in decisions that crucially effect their lives. These practices, if replicated in other social services departments, are undermining the intentions of government policy in community care.

The lack of interest and knowledge of agency and inter-agency procedures, especially in relation to service development and strategic planning, largely as a result of suspicion of senior management coupled with a focus on individualism in assessment and care planning, is also a great barrier to the success of the community care enterprise. This is again unfortunate, in that service development is going to be a key element if service users are going to be able to have anything other than Hobson's choice with regard to services. The result in relation to the particular needs of marginalised groups like black service users, will be very negative. Better communication between senior management and care managers through bureaucratic processes such as deficit recording and ethnic monitoring could hold the key to greater awareness and understanding, but only with a commitment to sharing information.

Targeting of resources on the most needy is not an efficient use of resources according to the evidence of these interviews. Engaging in mending broken informal support networks is also an ineffective way of maintaining vulnerable people's quality of life. Resources going into prevention and early identification would provide an effective role for care managers, increase morale, save money and provide services to improve quality of life. This would seem to be one of the areas in which care managers' critique of policy strikes a chord.

It is important to recall that I carried out these interviews in 1994. It might be expected that, one year into community care policy implementation, care managers would inevitably be struggling with these issues - trying to work out how to marry up their skills and knowledge with the expectations upon them. Whilst this is a valid perspective upon the

findings from these interviews, there are two points that need to be made. Firstly Shire had made most of the substantive changes in relation to organisation and practice two years before implementation on April 1st 1993. Care managers in that authority had experienced the expectations of change over a long period and yet what they were telling me and what their colleagues in Borough were relating (in both positive and negative senses) was broadly the same. The second point was one that I was not to know at the time of my original analysis of the research interviews in this chapter. In the months after constructing this analysis, I presented these findings to groups of care managers who were carrying out very similar roles to those interviewed in Shire and Borough, at workshops in other local authorities. This occurred prior to the instigation of the co-operative inquiries described in chapter nine. There was admission from most of these participants that much of what I had learnt was still the case two and three years into implementation. With this explanation and hindsight, I am not convinced that all I was experiencing was teething problems with the implementation of a new policy.

I can only claim that this is my interpretation of practice within these two authorities. They all received a copy of the report I wrote for the agencies, upon which this chapter is based, but I received little validation of this despite asking participants for their views on my findings. A couple of first line managers replied that it was much as they expected, and the senior manager in Shire expressed irritation but not surprise by what I had learnt. The care managers, however, were silent. The validity of my learning is, therefore, suspect and this was an area for further exploration in itself.

The gap between expectations of practice from policy guidance and actual behaviour by care managers is, however, clear *from my interpretation*. I have documented the difficulties that care managers had in describing or analysing the origins of the knowledge that informs their practice. I have tried to convey some of the richness of their text in the way I have offered direct quotations. If that seems somewhat thin, then I believe that is a reflection of that struggle that many of them had in defining the knowledge base to their practice. Such reflection is not a routine activity for care managers even if it is considered widely in contemporary social work analysis to be fundamental to any notion of developmental social work (Gould and Taylor 1996). I was still left with not only the question of what knowledge base care managers do draw upon in analysing their practice, but also how they go about the process of