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COMMUNITY CARE

REPORT OF A STUDY DAY HELD AT THE KING'S FUND CENTRE ON

22nd July 1982

King's Fund Centre
126 Albert Street
London NW1 7NF
Telephone 01-267 6111

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KING EDWARD'S HOSPITAL FUND FOR LONDON

COMMUNITY CARE

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Chairman: ADRIAN WEBB, Professor of Social
Administration, Loughborough University

Contents

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In late 1981, the DHSS published a study entitled Community Care[1] which examined some important issues in the development of community-based forms of care.* The purpose of the study day was to discuss the document and to consider the policy implications for some of the issues it raised. Three themes from the study were selected for detailed examination:

the role of the voluntary sector;

progress towards developing community based care for one of the "boundary groups" - mentally handicapped people;

cost-effectiveness and community care;

Three speakers in the morning session each addressed one of these themes, and in the afternoon led a discussion group to develop the issues further. The conference ended with a plenary session at which rapporteurs from the three groups outlined the main points which had been discussed and their conclusions.

Participants were welcomed to the Centre by Ann Foster, Project Officer, who then handed over to the Chairman for the day, Professor Adrian Webb.

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* Two other studies, The Acute Sector[2] and The Respective Roles of the General Acute and Geriatric Sectors in Care of the Elderly Hospital Patient[3] were published simultaneously. Study days were also held to discuss these documents and the reports are available from the King's Fund Centre[4, 5].

Introduction to the conference, Adrian Webb, Professor of Social Administration, Loughborough University

The Chairman opened the conference by reminding participants that it was as long ago as 1962/3 when ten year planning was first developed. At the time, he had felt that this would provide the 'cutting edge' required to give reality to notions of community care which, even then, had been around for some time. That was twenty years ago, and a cutting edge was still needed today. Professor Webb admitted that when he first read the DHSS document 'Community Care' he felt a little cheated that more progress had not been made in those twenty years and that more positive conclusions could not have been drawn from the study. On reflection, however, he felt that it was valuable for the DHSS to have undertaken a 'stocktaking' exercise at this point. In particular, it was important that the Department had taken stock conceptually and had raised again questions such as "what do we mean by 'community care'?" and "how do planners and practitioners understand 'community care'?".

This questioning allowed other issues about the desirability and feasibility of community care to be examined. It also, said Professor Webb, led to the admission that, on any definition of community care, there had so far been a failure to achieve objectives. The past difficulties coupled with current resource constraints suggested that, if real progress towards community care was to be made in the future, a sharper perception of the best use of resources was required.

Professor Webb felt that the DHSS document was altogether too optimistic about both the immediate resource environment and the future resources likely to be made available for care in the community. Work on levels of service provision carried out at Loughborough University and recently submitted to the Select Committee on Social Services, had produced some disturbing findings that were contrary to the tone of the DHSS study.[6] The whole range of domiciliary service provision (e.g. home help cases and meals-on-wheels), though not day care and sheltered housing, had been shown to have suffered an absolute decline over the last two years. If services for the elderly are considered separately, the process of decline can be seen to have begun in 1978/79 and in some cases as early as 1976/77. In other words, said Professor Webb, the provision of some social services relative to need was at its peak in 1975/76 and in these cases there had already been a long period of decline in provision.

In this context, the Chairman felt it was even more important to look closely at the problems indicated in 'Community Care' and to tackle the question of how best to use scarce resources in the future. How can the boundary groups which need to be given particular attention be identified? If there is to be a continued decline in statutory service provision, what are the implications for the voluntary sector?

Professor Webb said that he had used the privilege of being chairman to set the conference off on a slightly more negative and perhaps more critical note than that of the DHSS document, in view of the changed circumstances since it had been written.

Professor Webb then introduced David Gilroy, to describe the background to the 'Community Care' study and discuss its main themes.

Overview of the 'Community Care' study David Gilroy, Principal Social Work Service Officer, DHSS

Mr Gilroy opened his presentation by saying that the detailed nature of his overview of the study would necessarily be influenced by his specific background in personal social services. He wanted to begin, however, by saying that in his view the successful development of community care policies must in practice be based on a multidisciplinary approach. It was a major challenge to all professions to ensure that their component contribution to community care interlocked effectively with all the others. The aim of this multidisciplinary effort should be the provision of integrated 'packages' of care based on the individual needs of clients - 'packages' which in turn interlock with local, informal networks of support. There was no place for 'Lone Ranger' activities in community care, said Mr Gilroy.

Background to the study

Mr Gilroy first described the background to the study and the reasons for it being carried out. He said that over the years a great deal of attention had been given to community care for specific client groups - the mentally ill, the elderly, and so on. This had resulted in a substantial body of literature on the needs of these client groups and the services they receive. Much less attention had been given to analysing the policy objectives underlying the concept of community care and the methods of achieving these objectives. Mr Gilroy said that one of the main ideas behind the study was to provide just such an overarching kind of analysis, based on examination of existing data. This stocktaking exercise had been undertaken with a view to identifying questions that required further consideration by field authorities, by the DHSS or by both.

It had been hoped to examine in some detail existing policies for the move away from long-term institutional care; document progress in relation to those policies; indicate problem areas or blockages and identify, within resource constraints, possible ways forward. Additionally, said Mr Gilroy, the intention had been to explore the relationship between the informal, voluntary and statutory sectors and also to throw light on the highly complex and often controversial question of cost-effectiveness. Clearly, the scope of this remit was vast and it was recognised early on that there was a need to focus on what the document calls 'boundary groups', that is people, whether elderly, mentally ill or mentally handicapped, whose needs put them on the boundary between long-term institutional care and other forms of provision. Mr Gilroy emphasised that taking this focus meant that a great deal of the work carried out by professionals providing community care was not examined in the course of the study. Therefore it does not purport to be a comprehensive overview of community care policy and practice as a whole, and should not be evaluated as such.

Mr Gilroy also said it was important to stress that the study had not set out to question the philosophy or desirability of community care. Rather, it was intended as a sober appraisal of progress. In the report, the study team express the view that they may have under-estimated the numbers of elderly people who, in the long-term, would require residential or hospital care. This view is also taken in a recent study of family care and the handicapped elderly by the Policy Studies Institute,[7] which states that for some people residential care may be preferable to

> 'an increasingly exhausting relationship with informal carers which merely destroys love and affection.'

Mr Gilroy pointed out that although the community care study offers an appraisal, it also accepts that most people, given the choice, would prefer both to provide and receive care in ways that maintain what we would regard as an ordinary life.

The aim of publishing the study was to stimulate discussion at a number of levels and to provide a background of fact and analysis for continuing debate. Sir George Young, who was Junior Minister at the DHSS when he announced the publication of the report, said that it did not attempt to set out Department policy. Its function, along with the two other studies published at the same time, was 'to raise issues, set discussion going and stimulate new ideas'. The report would clearly not be the last word on the complex issues involved in community care.

The main themes of the study

Mr Gilroy then went on to highlight some of the main themes in the report.

The meaning of community care

Mr Gilroy said that one of the study team's first tasks had been to get to grips with the different interpretations of the term 'community care'. The term can be used to describe services, but equally often is used to state a policy objective or as a kind of slogan. The study highlights the importance of both avoiding the use of 'community care' as a convenient but ill-defined catchword and the need to specify what is meant when the term is used.

The costs of care

A substantial part of the study tackled the very complex subject of cost-effectiveness and community care. Review of a number of studies suggests that for some people on the boundaries of institutional care the packages of care needed to support them in the community may not always be a less expensive alternative to hospital or residential provision. This may be particularly the case in relation to people who live alone.

Mr Gilroy also emphasised the point made in the report that in some cases the relative cheapness of community care may be a function of inadequacies in current provision or a result of no financial value being assigned to care by families, friends or neighbours. These are the informal carers, who may be shouldering very considerable burdens and expending an immense amount of time and physical and emotional energy on caring. Mr Gilroy felt that our society had tended to link practical care in the family or neighbourhood with notions of love, obligation and duty. Increasingly, however, people were beginning to raise both the academic question of whether a 'price' should be put on informal care when costs were computed, and the much more practical question of whether informal carers should be paid to care, and if so in what ways and in what circumstances.

The effectiveness of care

Considering the effectiveness side of the equation, Mr Gilroy noted that much current policy rests on the assumption that people would rather be cared for at home than in institutions. Fewer studies have looked at questions of effectiveness than questions of cost, but the impression formed by the study team was that where adequate support is available at home, many people and their families do indeed prefer community rather than institutional care. However, the study did highlight the importance of taking into consideration not just the wishes of clients but of their families or carers as well. Mr Gilroy said that the necessity for informal carers was a recurring theme throughout the report and there was a need for research into the most effective ways of supporting carers.

'Packages' and flexibility

Mr Gilroy drew attention to a common feature of successful care in the community for the three boundary groups considered in the study. Elderly, mentally ill and mentally handicapped people all require individualised 'packages' of services suited to their needs. No one community-based service is likely to be able to shoulder the whole burden of providing an alternative to institutional care and the conclusions of the study emphasise the importance of the closest collaboration between health, social services and the voluntary sector. Mr Gilroy said that a recent publication by the National Council for Voluntary Organisations, Housing and Community Care[8], strongly reinforced these points and showed that the components of any community care strategy must have great flexibility if effective responses are to be made to individual needs. Standard doses of fixed and rigid support services are unlikely to meet the challenges presented by the requirements of boundary groups.

Elements of the voluntary sector

The study team had decided that it was necessary to look at the constituent elements of the voluntary sector, stretching from formally-constituted voluntary organisations through mutual aid and neighbourhood care to the so-called informal sector of family, friends and neighbours. Each element makes its own distinct contribution to community care and perhaps more important, said Mr Gilroy, has its own distinct implications for the policies and practices of health and personal social services.

Mr Gilroy reminded the conference that the study placed particular emphasis on informal carers and had revealed that the strength, or otherwise, of informal support in the community is often the critical factor in determining the feasibility and, indeed, the cost-effectiveness of community care.

Supporting the carers

Following his comments on informal carers, Mr Gilroy explored in more detail the question of support for those in caring roles in the community. He observed that a number of surveys of 'full-time informal carers', that is people who take responsibility for providing physical and emotional care to those in the community who were unable to care for themselves, had been published since the report of the community care study. All these surveys emphasised that caring is very often experienced by the carer as onerous, draining and demanding. All the carers interviewed for the surveys made little or no mention of the benefits they felt they derived from caring. Mr Gilroy felt that it was equally significant and challenging that carers do not always experience formal services as supportive. One survey[9] reported, with special reference to the personal social services, that

> 'there is a widespread belief that the authorities do not wish to know as long as there is somebody who will take responsibility for the dependent.'

Another survey cited by Mr Gilroy concluded that from the carer's perspective it was very often the client or patient who was seen as the focus of attention and that carers felt they 'disappeared into the wallpaper'.[10] Mr Gilroy used the results of these surveys to underline the theme running through 'Community Care' that supporting the carers is a feature of community care which must increasingly be the focus of attention in the development of policies for care in the community. This is especially important in view of the social and demographic changes that are reducing the numbers of people who traditionally, as part of their sense of family or individual duty, provided informal care.

Mr Gilroy recognised that there were already schemes for supporting carers and referred to the work of the Crossroads Care Attendant Scheme and other attempts to share the physical and emotional burden of caring, as well as to mutual aid schemes which provide emotional support. But he felt these schemes were not yet 'in the bloodstream' of community care and developing them was one of the very considerable challenges uncovered by the study.

Questions and discussion

Following Mr Gilroy's presentation, the Chairman invited participants' comments and questions.

Paddy Coulter, Vice Chairman, Haringey CHC, asked why the study team had not looked at housing and community care, especially since their brief included cost-effectiveness. Mr Gilroy explained that the origin of the study was within the DHSS and it sought to illuminate the policies of that department. The study team was aware that their perspective was limited and therefore they welcomed the NCVO's broader analysis, which incorporated the housing dimension.[8]

Dr P E Brooks, Specialist in Community Medicine, Cheltenham, pointed out that the study also did not explore the implications for other DHSS resources, notably social security. The Chairman took up this point and said that with a longer historical perspective on residential care, it was apparent that the development of social security and perhaps also housing policy have enabled more people to live in the community. He felt these were more important developments than some of the issues which were focused on within the much narrower frame of reference of the study. Professor Webb asked Mr Gilroy what would happen as a result of the publication of the document. Would the Department discuss the possibility of making quite marginal changes in the social security programme that could release resources for community care, or, on the contrary, improvements in social security that could enhance the capacity of people to live in the community and buy services for themselves ? Mr Gilroy said that questions about the detail of social security policies had not been the subject of much debate and needed addressing. For example, is the social security system the most effective mechanism for supporting carers ? Experimental projects were currently being carried out, said Mr Gilroy, on the personal social services side of policy development, and these involved paying people a notional wage or honararium for undertaking care in the community. These experiments may help us to address questions about the best ways of underpinning informal care financially, where this is necessary. In response to Professor Webb's question about where publication of the study would lead, Mr Gilroy said that it was being drawn on to inform policy development within the DHSS. 'Community Care' was written in part as preparation for the Minister's policy document 'Care in Action'.[11] Mr Gilroy felt that one contribution publishing the study had made was to show the complexities that Ministers and the Department recognise as underlying the development of policies for community-based care.

Mr G Darvill, Development Officer, The Volunteer Centre, said he had one message that he would like Mr Gilroy to take back to the Department. He hoped that more aggressive attempts would be made to talk directly to members of DHAs and Social Services Committees about the issues addressed in the document. These were the people ultimately responsible for making major decisions about care in the community. Mr G F Goodall, South East Thames RHA, said he was surprised to hear that the Department saw policy development as its role. His experience had been the opposite: policies were developed locally. Mr Gilroy said he hoped he had not given the impression that policy development took place on a 'top down' basis. Equally, he hoped that the study demonstrated that thinking on policy development took place at a national level as well as in the field. The process of taking policy forward involves a complex interplay and a continuing series of exchanges between different levels.

Moving on to the first of the presentations focussing on specific themes in the study, the chairman introduced Nicholas Hinton who had been asked to comment on how the 'Community Care' study dealt with the voluntary sector.

The role of the voluntary sector Nicholas Hinton, Director, National Council for Voluntary Organisations

Mr Hinton began his presentation by reminding the conference that the terms of reference for the study included

> 'To clarify policies for the development of community care for the Health and Personal Social Services in terms of the resources now expected to be available, including self-help, the contribution of the voluntary sector and the contribution of the private sector......'

Although institutions and individuals' relationships to them were relatively well understood in contemporary society, said Mr Hinton, the study demonstrated that the community was a much more complicated world where relationships were more difficult to understand. He admitted that discussions about community care made him feel uneasy as it seemed such shaky ground. 'But how must the client feel to be told that rather than going into hospital he is to be given a 'package of community care'?' Clarification was urgently needed if the elusive concept of community care was to be pursued. The test should not be whether professionals understood what was meant but that the man in the street understood - to the same extent that the role of the hospital or the prison was understood. Mr Hinton also pointed out that the claim that community care was better than institutional care could be confusing and destructive from the client's point of view.

Mr Hinton thought that the study began well by acknowledging that little effort had been devoted to an overall analysis of what was meant by community care. Analyses had often been fragmented by an emphasis on popular client groups, for example little attention had been paid to alcoholics and community care. They had also been fragmented by the various service divisions, such as housing and employment; or segmented into areas such as 'maintenance' or 'prevention'. The intention to take an overview therefore received Mr Hinton's support but he felt that the study team had set themselves high standards - standards which their report did not reach. Client groups were treated in a fragmented way; objectives and patterns of services were not questioned and the report often referred to clients as though they were pieces on a draught board: 'to be moved from here to there, from hospital to home, from day care to family care at will.'

Mr Hinton felt that the result was a rather unoriginal, unambitious and antiseptic-sounding set of proposals. This criticism, said Mr Hinton, applied particularly to what was written about the voluntary sector and its various segments. Although he was delighted to see that the voluntary sector had been divided into its component parts, Mr Hinton felt that the interaction and overlap between the various parts had been ignored, for example, the close interdependence between formal organisations and volunteers.

Looking at each of the segments of the voluntary sector in turn, Mr Hinton made the following comments:

Informal care

The study said little about this sector apart from acknowledging its existence. There is little information about informal care, who undertakes it, what they do, and so on, but if informal carers are to be at the centre of policy for community care then we need to know much more about them, their choices, their wishes, their tenacity, their personal needs, etc.

Self-help

It was good that the report recognised the existence of self-help, its diversity and its potential power. Again, however, if self-help groups are to play an important role in the world of community care, then more information is required about their strengths and weaknesses, how they begin, why they are on the increase, their needs and, particularly, how they view the value placed upon them by professionals.

Neighbourhood care schemes

It was surprising to see so much emphasis in the report on the monitoring role of neighbourhood care schemes because, in Mr Hinton's experience, neighbourhood schemes saw themselves primarily as providing services within a given locality.

Volunteers

The report gave a much clearer picture of volunteers in the formal, traditional sense of the word. But again there were a number of important gaps, for example, how do we differentiate between paid work and volunteering ? This is an issue that has not been resolved but must be considered if the concept of community care is to be developed.

Voluntary organisations

This part of the voluntary sector most resembles the more familiar organisations of the statutory sector. It is not surprising, therefore, that the formal voluntary sector is by far the best understood and the best documented part of voluntary work. However, a number of opportunities for raising questions had been missed in the report, including questions about who should do what and why, for example in child care where there is a mixture of statutory and voluntary provision.

Relationships between the statutory and voluntary sectors

The report dealt well with the relationships between statutory and voluntary services: at least, those at the more formal end of the voluntary spectrum.

Considering the report as a whole from the voluntary sector point of view, Mr Hinton drew attention to the following seven points.

- Funding: many voluntary organisations, large and small, are preoccupied daily with funding and survival. The report paid scant attention to the issues around funding, although mention was made of 'pump-priming'.

- Missing client groups: voluntary organisations are often associated with the client groups <u>not</u> mentioned in the report, for example the single homeless and alcoholics. Consideration of these client groups might have changed the way voluntary organisations were viewed within the philosophy of community care.

- Crossing boundaries: voluntary organisations have the capacity to straddle the boundaries of statutory organisations, draw together resources from different agencies and often develop projects that are more comprehensive than those devised by a single agency.
- Quality of care: although the report describes a wide variety of forms of community care, no attempt is made to assess their quality.
- Client's changing needs: community care is a 'revolving door'. Over time many different community care services may be called upon to meet a client's needs. This requires liaison between the agencies providing care, but voluntary organisations may find difficulty in relating to statutory agencies.
- Flexibility: the report emphasised the diversity of the voluntary sector but did not show how its various elements may connect. Learning to make much more flexible use of the 'bits and pieces' is the next step.
- Income maintenance policies: regrettably the study had not looked at the relationship between income maintenance policies and policies for provision of services. A closer examination was required of the extent to which more generous income maintenance policies might encroach on provision of services.

Mr Hinton then considered where the stocktaking exercise by the DHSS might lead. He identified seven main points that he felt needed further attention if progress was to be made.

- More information is needed about the role of the voluntary sector. There was currently a danger of making unjustified claims about the capacity of the voluntary sector, especially informal care.

- How can we sustain and support the parts of the voluntary sector ? 'Supporting the supporters' should not become a catch-all phrase that lets us off the hook.

- There should be more experimentation, but not only when 'we feel brave and have a few spare resources'.

- The report makes little of user-consultation. Consultation is extremely important if packages of services are to be developed.

- The report makes virtually no mention of trade unions and their roles in health and personal social services. The implications for the development of the voluntary sector, particularly volunteers, need to be considered.

- Without changing public attitudes to community care little headway is likely to be made.

- Community care is about autonomy, the ability to give people more control over their lives.

Mr Hinton concluded his presentation by saying that he had been critical of the report in order to raise questions that might be considered in the afternoon's discussion groups. He thought the study would be a useful step in the right direction for many people, even if they had not yet decided whether to follow the sign-post marked 'Barclay' or the sign-post marked 'Patch'. Perhaps we were still at the stage where the sign-post was marked 'toutes directions (community care)'.

Questions and discussion

Dr B A Castleton, Senior Registrar in Geriatric Medicine, Frimley Park Hospital, asked what changes in public attitudes Mr Hinton would like to see in relation to community care. Mr Hinton thought that, as in many other areas of policy, we ignore at our peril that the public has views and stereotypes, and that those stereotypes tend to be set in the past rather than the present. It will be necessary to make a trade-off between how far members of the public are prepared to go along the path to community care and what is seen as appropriate by the professionals. Mr Hinton felt the report gave the impression that if only we got the sign-post right, the great British public would charge along behind us. Mrs C Osborne, Islington CHC, pointed out that professionals also needed to change their attitudes about community care, but this was likely to be difficult, as they would lose power and resources in a move away from institutional care.

Mr B Kat, Principal Clinical Psychologist, Northumberland District Psychology Services, pointed out that informal carers are often in relationships where there can be no reciprocity. Most relationships are based on reciprocal satisfaction of needs, but caring requires a redefinition of relationships that many people find impossible. The alternative is to ask people to care out of duty or obligation. Caring then becomes a burden without reward. Is it realistic to ask informal carers to break with usual ideas about the quality of human relationships ? Perhaps, suggested Mr Kat, we need to encourage vocational employment to provide the motivation needed by carers. Mr Hinton felt this was an important consideration and said it may be one reason why paid fostering was becoming more popular in a number of fields, including mental handicap.

Mrs M Burfoot, Eastbourne CHC, asked Mr Hinton about the difficulties encountered with trade unions in relation to volunteering. Mr Hinton said he merely wanted to draw attention to this as an obvious difficulty which needed to be handled carefully. Professor Webb, as Chairman of the Volunteer Centre, commented that given the current level of unemployment, unions were remarkably cooperative and the Volunteer Centre had established, over a long period of time, good relationships with unions and unionists. However, if paid work became more scarce and contentious and as the distinction between traditional volunteer work and paid employment becomes more blurred, this must be a point of potential conflict with trade unions.

The chairman introduced Dr Albert Kushlick, whose presentation would focus on one of the 'boundary groups' considered in the Community Care study - mentally handicapped people.

Some developments in community care for mentally handicapped people

Albert Kushlick, Director of Research, Health Care Evaluation Team

Dr Kushlick said he would describe some of the ways in which the Research Team had looked at the development of services for mentally handicapped people and use this as a way of commenting on the Community Care study, particularly on Chapter 4.

For any client group, Dr Kushlick said the Team had found it useful to distinguish between the different people involved in caring for the client. It was helpful to consider two categories:-

> 'Direct carers' - people who give direct care to the client for hours at a time. This category includes those providing 24 hour care, for example parents, spouses or paid carers; those providing up to 12 hours of care, such as nurses or volunteers; and those providing care for two to six hours, for example, relatives, school teachers or child minders.
>
> 'Specialist professionals' who may be with the client for only ten minutes. This category includes psychologists, doctors, etc., whom Dr Kushlick referred to as the 'hit and run' professionals.

Clearly there are fundamental differences between the direct carers and specialist professionals in the quality of relationships they are able to develop with the handicapped person. Highly-paid, specialist professionals make minimal contact with both clients and their direct carers. Also in the constellation surrounding the client are managers and supervisors - administrators and maintenance staff who keep the institution running - and providers and planners who develop policies for allocation of resources.

Dr Kushlick pointed out that unpaid volunteers may be found in all these categories of people providing direct care for the client. With current levels of unemployment there are increasing numbers of highly-qualified volunteers. Also, the formal voluntary sector has its own providers and planners.

Over the last ten years there have been major technological developments in rehabilitation as well as changes in how the problem is viewed. It is now accepted that mental handicap is a problem of educational deficit and there are now very powerful technologies for helping people overcome that deficit. Objectives can also be much more carefully defined and these can apply in all settings and for all services. For mentally handicapped people, these objectives were set out by Dr Kushlick in diagram I.

For a mentally handicapped person the learning environment is crucial as learning must be appropriate to a wide range of circumstances. An important part of the learning environment is accessibility to family and friends - inaccessibility becomes a major obstacle. Three important environments in which learning takes place are the home, the school and the work place. Institutions are homes for many mentally handicapped people but all the places people live are places of learning where objectives need to be attained. 'Teaching homes' are staffed by professional parents whose job is to teach social skills. The quality of interaction is very carefully structured around teaching new skills and the rationales for learning them. The diagram, said Dr Kushlick, indicates that there are many boundaries: the boundary between hospital and home is only one of many that should be considered.

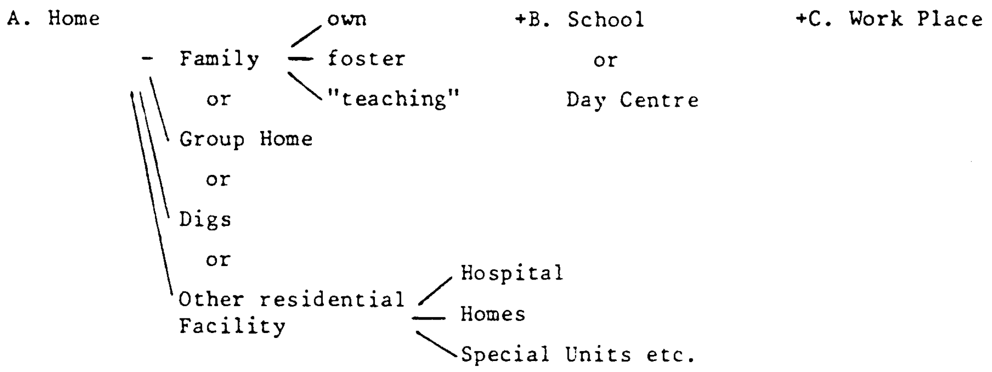
From the policy point of view, Dr Kushlick felt the Community Care study could have usefully considered the objectives that should be attained and the sort of settings in which they could be attained. The second half of diagram I is a statement of some objectives for a mentally handicapped person. In the first place it is important to know what the client can do, to define his long-term objectives and to declare his 'rights'. In terms of learning, category I activities - learning new skills and relearning old skills - will take up a relatively small proportion of time in relation to those of category II, which focus on practising existing skills.

Learning programmes are devised according to individual social skills. Setting up environments where people need fewer skills to manage quite complex tasks, known as devising a prosthetic environment, is a highly technical skill and in Holland there are specialists in this field. This sort of environment is particularly valuable because it allows disabled people to participate in self care, in caring for others and caring for their environment. Handicapped people should be removed from environments where they are systematically deprived of opportunities for this sort of participation, said

Diagram I

Objectives TO BE ATTAINED IN THE INTEREST of/for the Handicapped Person

Location - In natural environment - open, local, general
- accessible to family and friends
- accessible to key amenities of urban living



Given current repertoire assessment
+
Given long-term objectives of/for Handicapped Person
+
Given defined "rights" + minimal restrictions

I	learn new relevant and age-appropriate skill re-learn old relevant and age-appropriate skill	
II	practice existing appropriate skills and elaborate these)	under appropriate conditions of complexity and intensity of:
	(includes participating in all obligations of self-care, other-care and care of the environment)	i) Instructions ii) Prompts iii) Reinforcers and corrections
		and under appropriate conditions of complexity and of prosthesis:
III	avoid or control disruptive behaviour)	under appropriate conditions as above
IV	follow anatomical and/or physiological procedures relevant to client objectives	
	monitored, recorded	and accounted

Dr Kushlick. However, even if cared for in their own homes, people may not necessarily have these opportunities or providing them may be a cause of considerable strain to 24 hour carers.

Dr Kushlick then drew attention to diagram II, which describes what should be avoided in all these situations. He felt it was important to emphasise this because it was not discussed in the Community Care study. We should avoid locating vulnerable people in closed, specialist environments that are inaccessible to friends, family and the community. In these settings no one knows what the client is able to do, no long-term goals are set and there are no defined rights. These are characteristics of institutional care of which Goffman[12] was so critical, especially the lack of defined rights. In these settings people do not learn new relevant skills and do not have the opportunity to practice existing relevant skills.

Thus, said Dr Kushlick, the problem is not so much a boundary problem as the difficulty of attaining objectives given the facilities and opportunities for developing resources. Policy decisions should relate to the skill levels of carers in different settings. How are we to arrange that the specialist professionals, the most powerful people, and those representing voluntary bodies, agree on mechanisms by which clients will be able to set the objectives they want to attain and which can be attained with the help of their relatives ? These are the relevant objectives and the ones that people will work for.

In terms of evaluating achievements, said Dr Kushlick, the new technology of evaluation allows us to consider how many goals are being set and the areas of people's lives in which goals are set. Indices of effectiveness allow measurement of the extent to which these goals are being attained and the rate of goal attainment.

Dr Kushlick then described the objectives for direct care personnel, that is people who spend more than 10 minutes with the client. They would be expected to:

i) teach client old or new relevant skills
ii) arrange (including sequencing) or support client practice of existing appropriate skills

Diagram II

Objectives TO BE AVOIDED IN INTEREST of/for Handicapped Person

Location - In unusual specialist environment - closed, regional, specialist
- relatively inaccessible to family and friends
- relatively inaccessible to key amenities of urban living

A. Home +B. School +C. Work Place

- Family own / foster / "teaching"
  or
  Group Home
  or
  Digs
  or
  Other Residential Facility — Hospital / Homes / Special Units etc.

School or Day Centre

Not Given current repertoire assessment
+
Not Given long-term objectives of/for Handicapped Person
+
Not Given defined "rights" and minimal restrictions

I not learn new relevant age-appropriate skill
not re-learn old relevant age-appropriate skill

II not practice existing appropriate skills and elaborate these) under appropriate conditions of complexity or practice under appropriate conditions of:

i) Instruction
ii) Prompts
iii) Reinforcers and corrections

and under inappropriate conditions of complexity of prosthesis

(excluded from participation in obligations of self-care, other-care and care of the environment)

III not avoid nor control disruptive behaviour) under appropriate) conditions as above

IV not follow anatomical and/or physiological procedures relevant to clinical objectives or follow procedures irrelevant to client objectives

not monitored not recorded, not accounted

(including participation in self-care, other care and environmental care)

iii) avoid or correct clients disruptive behaviour

iv) support anatomical or physiological procedures relevant to client objectives

v) attain independent personal objectives
- support monitoring, recording and accounting.

For some handicapped people living in their family homes these objectives are being attained but in many they are not. The strategic problem, said Dr Kushlick, is how to identify those people whose objectives are not being attained and to help them. Similarly, for people living away from family homes, whether in group homes or in specialised residential units, where probably few are attaining their objectives. These problems are not addressed in the Community Care study.

Dr Kushlick thought solutions to these problems would be found through research and development but it is apparent that little is being done. However, where projects have been undertaken they have been very effective. For example, a home teaching package was developed in Wisconsin in the US called the Portage Home Teaching Service.[13] This work was replicated in Winchester and the Research Team has been given funding to carry out a survey in the UK to see how extensively this is used. Portage allows parents to teach their children in their own homes. It is also a major resource for 24 hour carers, enabling them to care confidently and competently for people they might otherwise struggle with alone, their work unrecognised by professionals. Dr Kushlick thought this was an increasingly important contribution towards domiciliary and possibly preventive care.

Finally, Dr Kushlick referred to interventions for attaining the objectives he had talked about. We should consider

i) clients and direct carers as 'individual' political constituents

ii) clients and direct carers as 'group' political constituents

iii) clients and direct carers as members of trade unions

iv) direct carers, managers and planners as individual political constituents

v) direct carers, managers and planners as 'group' constituents

vi) direct carers, managers and planners as members of trade unions.

On all these fronts there are useful steps that could be made towards common objectives. If people know where they are going, said Dr Kushlick, collaborative effort is more likely. Defining more clearly objectives for the client would help. However, client objectives are not necessarily the same as those of the 24 hour direct carers. There may be major conflicts of interest and without very careful attention being directed towards clients, particularly the most vulnerable groups, they are likely to lose out, particularly when resources are being cut back.

Questions and discussion

Mrs C Partridge, Honorary Research Fellow, Health Services Research Unit, University of Kent, said she, as one of the ten minute professionals, felt her role was to help 24 hour direct carers to feel they were effective and making an important contribution to care. Professor Webb said he was particularly struck by Dr Kushlick's point that a weakness of the study was that it did not say what should be avoided. We may fall into the trap of stating platitudes if there is no explicit description of what to avoid. Was this, asked Professor Webb, a general problem of the way in which community care has been formulated as a 'portmanteau policy' rather than just a problem of this document? Dr Kushlick said he found the document very traditional in its approach to community versus non-community care and felt this reflected the approach of social policy makers. Over the last ten years there had been major developments in setting goals for clients; examining professional practices to see that they help clients reach their goals; and looking at the quality of life for individuals in different care settings. These developments seem not to have been noticed and have not been recognised in debate. Now resources are being cut, said Dr Kushlick, we must decide how best to spend the money we have and some of it should go towards the development of technologies for helping clients.

The chairman then introduced the final speaker, Mr Ken Wright, to discuss issues about cost-effectiveness raised by the study.

Cost-effectiveness and community care

Ken Wright, Senior Research Fellow, Institute of Social and Economic Research, University of York

Mr Wright said that the objective of his presentation was to paint some broad principles of cost-effectiveness analysis, as there was insufficient time to go into the details of measuring costs or the thorny problems of measuring effectiveness. It was disturbing that cost-effectiveness had become a 'buzz word' - it was now common to hear something described as 'cost-effective' and no further questions would be asked. However, nothing can be cost-effective in its own right, because cost-effectiveness is a relative concept. There are always at least two options which have to be evaluated in terms of their costs and relative effectiveness. One of the options might involve doing nothing, therefore the comparison would be doing nothing compared with doing something new. In response to the statement 'this is cost-effective' we should learn to ask the question 'compared to what?'.

Origins and limitations

Mr Wright explained that the origins of cost-effectiveness lay in ideas about economic efficiency - i.e. getting the most out of a given set of resources. The classical framework of cost-effectiveness analysis is either consideration of two options, both of which have the same effect, therefore their relative cost can be compared or examination of how limited resources can be used differently and then judged on their relative effectiveness. This, said Mr Wright, is fine providing effectiveness and costs are measured correctly. One limitation of cost-effectiveness analysis that is apparent in the 'Community Care' study is that it cannot be used in its own right where there are two options, one of which costs more than the other but is also more effective. There is no decision rule in cost-effectiveness analysis to indicate which option to choose in these circumstances. Mr Wright thought this was important because it means that technicians, the people doing the analysis, cannot give 'answers'. All they can give is information on the relative costs and effectiveness. It then depends on the political decision-making process to decide how to use that information. All the 'balance of care' type of studies, including 'Costing Care'[14], that are reviewed in community care, fall into the trap of comparing costs with costs. Therefore, the comparison of institutional care and community care often shows that community care costs less. What is not known, because few people have tackled the problem, is the relative effectiveness of these major types of care. As Albert Kushlick pointed out, this is not just a technical problem, because methods of measurement have been devised. It is a problem of goals, who sets them, on what terms they are set and whether they compete with one another. There is a further difficulty of determining whether goals are being achieved because of current policies or because of other circumstances. In such a broad spectrum as community care, there may be many other influences on goal achievement besides service delivery and a very careful experimental set-up is required to isolate their different effects. Chapter 3 in the community care study shows how complex this is: all the studies which set out to look at cost-effectiveness were defeated on the effectiveness issue and resort to cost-on-cost comparisons. Mr Wright felt this had created problems for the research community which had been accused of not providing answers. However, on short-term research grants it is rarely possible to tackle over a long period the issues of effectiveness.

Measurement of costs

Measurements of costs can be a controversial question for economists, people working in the field and the DHSS, because all have different notions of what the term cost means. From the economist 's point of view, the resources in question in cost-effectiveness analysis are the resources of the whole community, not just tax payers' or rate payers' resources. Whatever resources are taken into account there are also problems with valuing. Mr Wright said that he had no methodology for costing informal care even though he recognised its importance. On the other hand, informal care resources would be relatively unimportant if the only concern was tax payers' resources or how different policies impinge on the public purse or the public sector borrowing requirement. Different notions of cost can cause tensions. The resources, and therefore the costs, most important to a health service treasurer are not the same as those most important to a director of social services. Mr Wright emphasised that the standpoint when valuing should be clear and the base for costs should be used consistently. Current concern is with public expenditure but if researchers become obsessed with that point of view their studies can give some very curious results. Some studies have come to grief because bases for costs have been mixed up and the result is a confused mess. In Mr Wright's opinion, the value of the economists' view - looking at the resources of the whole community - is that it can be used consistently across departmental boundaries. Care should not depend on how money flows between different organisations.

Measurement of effectiveness

Mr Wright reaffirmed that measurement of effectiveness was exceedingly tricky. Few researchers are working on this topic. This is partly a problem of the sheer difficulty of the questions, partly because of the length of time needed to develop and test methods and also because of a general shortage of research funds. There is often a longitudinal element to the research, for example following up a cohort over quite a long period to pick up changes in their condition, and, as Albert Kushlick demonstrated, this requires considerable research input. In the Community Care study there seems to be a criticism that researchers have not undertaken studies of effectiveness. Mr Wright felt that there were also grounds for researchers to complain to sponsors that it was very difficult to obtain funds for this type of work. Funding bodies see this kind of project as long-term, high risk, speculative work.

Interpreting the findings of cost-effectiveness studies

Mr Wright then summarised the findings of studies using fairly straightforward bases. These studies show that the costs of major institutional care are a great deal higher than residential care or the cost of care at home. For example, the basic cost of caring for a patient in a group home may be in the order of £38 per week compared with about £150 per week in the local psychiatric hospital. The difference in cost between hospital and residential care could theoretically be spent on help for patients and clients in the community. The more help that is provided in the community, the more expensive community or residential care becomes. The cost and also the effectiveness of community care depend on the amount of help provided to patients in the community. If they receive regular visits from social workers, attend day centres or visit a hospital for occupational therapy, then gradually the difference in cost is whittled away.

Most cost-effectiveness studies have concentrated on care of the elderly and there are problems in interpreting their results. For example, Opit's work in Birmingham[15] shows that because of the amount of help required, about 20% of the sample cost more to care for in the community than in hospital. The London Boroughs' study[16] found quite the reverse - a lot of people are being maintained in the community at costs below that of residential care. But this may be because the levels of service they receive are so low - 'cheap but nasty'. Once basic living expenses are taken into account, the difference in cost is a function of how much help is provided. But this overlooks issues about the quality of care.
Mr Wright felt the need was to define standards of care within a limited budget so it could be made clear that community was less expensive and more effective; equally costly and more effective; or, if a real commitment was to be made, more expensive and more effective. All these outcomes would be acceptable from an efficiency point of view. It would then be possible to experiment, for instance, with social workers holding budgets to buy in help for their clients, particularly from the informal sector. Another idea is to increase weekly allowances that put the cash either with the helper or with the client directly, so that it can be used as they wish. These are ways, said Mr Wright, that cost differences could be used to try and achieve the best possible buy for a client. Given in cash, rather than in service packages, it could be more flexible and allow people to buy the help they feel is right for them.
Mr Wright thought these were exciting experiments which could offer a lot of hope for the future and for cost-effectiveness.

In conclusion, Mr Wright said that cost-effectiveness is not an academic economist's exercise. It had to be a multidisciplinary exercise, carried out in an experimental setting, with clear definitions of cost and effectiveness in order to compare the outcome of two options in practice. This is in contrast to the desk exercises of the past which were often unilluminating and left too much to the interpretation of those doing the analysis.

Questions and discussion

Mr W Laing, Health Studies Officer, Royal Institute of Public Administration, drew attention to the absence of any consideration of the role of the private sector, although he felt that many of the issues that had been raised pointed to the possibility of people buying in 'packages of care'. He asked whether any of the speakers felt there would be anything to be gained in the long-term by stimulating appropriate private services as a complement to public services. Mr Wright said he felt this would certainly give more flexibility and he would like to see the development of cash-based benefits rather than service help. He realised, however, that this approach did raise problems about clients knowing what was good for their own welfare. Dr Kushlick commented that in relation to the client group he was particularly interested in - severely mentally handicapped people - he knew of no private health system that took any interest. Private, non-profit making trusts (the formal voluntary sector) had made major contributions to innovations in care, but in a country with a National Health Service, opportunities for research and development should be taken within the NHS. Mr Gilroy felt there was a case for experimentation, especially to find the most effective mechanisms for injecting the money.

Dr Castleton thought it was very misleading that the private sector had not been considered, especially in relation to care of the elderly. Mr Gilroy replied that the private sector was important in providing residential care for the elderly but its role in providing community care appeared to be minimal, therefore it had not been considered in the study. Mrs Williams, Hampstead DHA, asked whether it was true that private residential care for elderly people was a good deal less expensive than local authority care. Mr Wright said there was evidence that care was cheaper in privately run institutions but he was concerned about how costs were estimated. There is doubt, for example, about the private sector's use of GP services and drug prescribing. It is not at all clear which costs fall on the institutions and which on other services. However, Mr Wright felt there was a case worth investigating about why differences in cost between private and public sectors appeared to be so great. Dr Kushlick pointed out that there were simple ways of measuring the quality of life in residential homes and it is certainly worthwhile, especially where costs are very different, to investigate why this might be the case. He advised conference participants to see how many people in a residential home were actively participating at any time of the day. Is the home the kind of place you would like to live in yourself ? Would it support the kinds of activities you like to do ? Dr Kushlick said there was good evidence that a home where people did nothing but look out of the window all day could be run much more cheaply than a home where activity was encouraged in a stimulating environment.

Reports from discussion groups

After lunch conference participants divided into three groups to discuss in more depth some of the issues raised in the morning session. Possible questions had been suggested for each group to consider and these are listed at Appendix I. After tea, a plenary session was held, in which a rapporteur from each group listed the main points and conclusions from their discussions.

Group 1

The group first considered the question 'What are the limits to community care in terms of either cost or effectiveness ?' It was felt that currently service organisation was determined by finance rather than client needs although it would be preferable to see this reversed. 24 hour care can be provided outside institutions, but someone - a facilitator - is needed to cross boundaries and link the branches of the different services necessary to provide community care. Cost-effectiveness analyses show that it is possible to suggest optimum provision of services but the group thought that the absence of mechanisms to coordinate provision of community care and lack of financial control had hindered progress.

The group then considered 'How is it possible for field staff to take account of cost-effectiveness in the delivery of care ?' and 'Does it matter if they do ?'. Problems were identified which stemmed from the facts that budget holders did not control access to services or their use; and that little was known about the effectiveness of current service provision. The group recognised that it is easy to criticise poor institutional care but there is great tolerance of poor community services. They felt that those who delivered care should be concerned primarily with effectiveness even though this could be difficult to assess.

Group 2

The group considered the formal voluntary sector under four headings:

The shortcomings of the voluntary sector.

i) Money: The voluntary sector has constant difficulties of fund-raising and an obsession with building. There is also the problem of independence and the origin of funds: if too great a proportion of financial support comes from statutory sources, then there is a danger of losing independence and possible interference with a voluntary body's pressure group role. The precarious hand-to-mouth existence of voluntary organisations may affect staff morale.

ii) The volunteers role. A tendency to paternalism was noted by the group, which also recognised that this was not limited to the voluntary sector. There may also be a tendency to confuse volunteer and staff roles which is often seen as a threat by professionals. Volunteers are often seen as 'unreliable'.

iii) Gaps in provision. Unpopular client groups are not well-served by the voluntary sector, for example alcoholics, one parent families. The voluntary sector experiences particular difficulties, for example trying to form self-help types of organisations in less prosperous areas. There may be duplication of activities by narrow interest groups and developmental difficulties, especially when an organisation has been funded by one person.

What can be done to improve things.

Five 'needs' were identified:

i) better liaison and communication with statutory agencies
ii) volunteers with the same social and local background as clients

iii) training for volunteers and careful selection for tasks
iv) imagination
v) education for NHS managers about volunteers and what they can do.

Advantages of voluntary organisations.

Voluntary organisations can generally do things that would be impossible within the statutory sector. They are less formal and volunteers have local and personal knowledge of clients.

Reconciling pressure group roles and service roles.

The group thought that a dual role was possible and could have advantages, but the two roles should be kept separate. The potential of CHCs was discussed - they could set up voluntary bodies as pressure groups as temporary measures. A voluntary body could also be seen as a stage in obtaining statutory service provision. Professional reactions to criticism from voluntary bodies tended to be mixed. Members of the group also admitted holding ambivalent attitudes towards the voluntary sector.

Group 3

The group considered how changes in the balance of health service resources might be achieved. They discussed the type of life-style that should be aimed for in the community, in terms of the maintenance of dignity and how this could be achieved. The group found it difficult to think about realistic long-term goals when currently services are so constrained by finance. One particular problem is the reluctance of social services departments to commit themselves to jointly financed projects. The group thought that to improve services locally, it was necessary to have both cooperation and the will to work together and clear objectives and goals. The possibilities for community care are constrained by finance and attitudes, and the group felt that trial schemes to identify successful projects should receive more careful scrutiny.

Chairman's summary

Professor Webb began his summing up by asking who the audience was for messages from the DHSS about the development of policies for community care. He observed that there was evidence that the Department was not very effective at communicating with health authority members on this topic - the approach tended to be mechanistic and failed to get across the essence of community care policy. The 'Community Care' study was an attempt to overcome these difficulties but, despite its good intentions, the generality of the document tended to give the impression of well-meaning platitudes.

The Chairman underlined earlier comments to the effect that the study would have been even more valuable if it had acknowledged the possibility of failure and had addressed questions about what should be avoided when providing community care. A more critical stance also would have enabled consideration, for example, of the point at which resources become so constrained that it has to be admitted that a policy of community care has been abandoned. Professor Webb felt that present policies were so elastic that there was no point at which we could say they had been abandoned. Packages of care were not being costed and there was little appreciation of what was possible or impossible under certain resource constraints. Without costings, precise guidance on implementing policy cannot be given. Professor Webb observed that perhaps we should not be surprised that the study did not consider the possibility of failure or the limitations of community care: Ministers, of course, are never happy to advertise the shortcomings of favoured policies.

The Chairman concluded by saying that nevertheless the DHSS stocktaking exercise had been valuable. It had encouraged and provided information for discussion about the future of community care.

Jane Hughes
King's Fund Centre
February 1983.

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Discussion Group I. Possible Questions

I. How is it possible for field staff to take account of cost-effectiveness in the delivery of care ? Does it matter whether they do ?

2. What sorts of constraints should be placed on people's actions in delivering services ?

3. What are the limits to community care in terms of either cost and/or effectiveness ?

Discussion Group 2. Possible Questions

I. How can the voluntary services best make use of the resources in the statutory sector ?

2. What, in the experience of members of the group, are the shortcomings of the various segments of the voluntary sector ?

3. What seem to be the most potentially fruitful opportunities for mutual collaboration and development ?

4. Are the information sources available to the statutory sector adequate to enable services to be planned to "dovetail" into existing informal sources of care ? If not, what else is needed ?

Discussion Group 3. Possible Questions

I. What are the major constraints placed upon service providers in ensuring quality of care ?

2. What is the impact on health services of increasing constraints on local authority resources ?

3. Is there a case for shifting resources from the N.H.S. to the personal social services ?

4. How may changes in the balance of health services resources be achieved ?

5. What opportunities are there for effecting a shift in the way care is provided for the boundary groups ?

Appendix II

KING EDWARD'S HOSPITAL FUND FOR LONDON

King's Fund Centre

COMMUNITY CARE

Study day on Thursday 22nd July, 1982

Attendance List

Mrs A ALDER	Secretary	West Essex and District Community Health Council
Mr R AMBURY	Regional Training and Development Officer	Assoc. of Crossroads Care Attendant Schemes Ltd.
Mrs P M ARTHUR	Administrator	D H S S
Mr A BLACK	Assistant Secretary, Policy and Information Services	Newcastle Health Authority
Miss I BROMLEY	District/Superintendent Physiotherapist	Royal Free Hospital
Dr P E BROOKS	Specialist in Community Medicine (Social Services)	Cheltenham D H A
Ms S BROOKS	Mental Handicap Co-ordinator	Islington Community Health Services
Mrs M BURFOOT	Member	Eastbourne C H C
Mrs S M BURGESS	District Occupational Therapist	Whitchurch Hospital
Dr B A CASTLETON	Senior Registrar in Geriatric Med.	Frimley Park Hospital
Mr J B CHAPLIN	Chairman	East Herts. C H C
Ms J CHARLES	Reporter	General Practitioner
Ms C CLARK	Secretary	Waltham Forest Dist. CHC
Mrs F M COLEMAN	Principal Social Worker	Horton Hospital
Mr P COULTER	Vice Chairman	Haringey C H C
Mr G DARVILL	Development Officer	Volunteer Centre
Ms L DAVIDSON	Reporter	Therapy Weekly
Mr M T ELSE	Asst. Regional Treasurer	North East Thames R H A
Mrs E ENNALS	Member	Richmond, Twickenham and Roehampton C H C
Mr M B FOLEY	Acting Divisional Nursing Officer	Horton Hospital
* Ms A FOSTER	Project Officer - Planning	King's Fund Centre

Mr W J FRASER	Administrator	King's Fund College
Mrs A FRENCH	Member	N W Surrey C H C
* Mr D GILROY	Principal Social Work Services Officer	D H S S
Mr G F GOODALL	Secretary	Darenth Park Steering Group
Mr S HALPERN	News Editor	Health and Social Services Journal
Mr D HANDS	Assistant Director	King's Fund Centre
Mr M A B HARLOW	Principal	D H S S
* Mr N HINTON	Director	National Council for Voluntary Organisations
Ms C HOWIE	Reporter	Nursing Times
Mrs E HUDSON	Chairman Mental Handicap Group	North West Herts. C H C
Ms J HUGHES	Project Officer - London	King's Fund Centre
Dr D J HUNTER	Research Fellow Department of Community Medicine	University of Aberdeen
Mrs K M JENKINS	District Physiotherapist	South Glamorgan H A
Ms J JONES	Principal Research and Planning Officer	Westminster Social Services Department
Mr B KAT	Principal Clinical Psychologist	Northumberland District Psychology Services
* Dr A KUSHLICK	Director of Research	Health Care Evaluation Research Team
Mr W LAING	Health Studies Officer	Royal Institute of Public Administration
Dr J LEACH	Asst. Administrator Community Serv.	North Manchester H A
Dr M McCARTHY	Senior Lecturer Department of Community Medicine	University College London
Mrs D McCORMICK	Assistant Secretary	North East Essex C H C
Mr P MERRY	Editor	Health and Social Services Journal
Mr J METCALFE	Social Work Services Officer	D H S S
Mr M J NAYLOR	Planning Officer	Cheltenham & District H A
Mrs C OSBORN	Member	Islington C H C

Mrs P OSBORNE	Chief Executive Officer	Assoc. of Crossroads Care Attendant Schemes Ltd.
Mr P PARKER	Reporter	Times Health Supplement
Mrs C PARTRIDGE	Honorary Research Fellow Health Services Research Unit	University of Kent
Dr M PURKISS	Senior Registrar in Community Med.	Lewisham & N Southwark H A
Dr J C A RAISON	Community Physician	
Dr G T REID	Information Officer	Sheffield H A
Ms M REYNOLDS	Assistant Administrator	N.A.H.A.
Mrs R RIGDEN	Boarding-Out Social Worker	Netherne Hospital
Mr W ROBIN	Member	East Herts C H C
Miss A M SEELIG	Nursing Officer	D H S S
Mr D SMITH	Senior Research Officer	Westminster Social Services Department
Miss B J SUTCLIFFE	District Physiotherapist	Westminster Hospital
Mr R C TAYLOR	General Administrator (Services Planning)	North East Thames R H A
Mr P M TOPHAM	Secretary	Canterbury & Thanet C H C
Mrs M H TRAVIS	Head Occupational Therapist	Llanfrechfa Grange Hosp.
Mrs M TUCKER	Deputy Divisional Administrator	Horton Hospital
Mr N TURNBULL	H E O Community Services	D H S S
Mr G R VANCE	Principal Officer	London Borough's Training Committee
Mrs C WATSON	Member	Dartford & Gravesend C H C
* Professor A WEBB (Chairman)	Professor of Social Administration	Loughborough University
Miss G WILLIAMS	Vice Chairman	Hampstead D H A
Mr G WISTOW	Research Fellow Social Sciences	Loughborough University
* Mr K WRIGHT	Senior Research Fellow Institute of Social and Economic Research	University of York

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Mr R C TAYLOR	General Administrator (Services Planning)	North East Thames R H A
Mr P M TOPHAM	Secretary	Canterbury & Thanet C H C
Mrs M H TRAVIS	Head Occupational Therapist	Llanfrechfa Grange Hosp.
Mrs M TUCKER	Deputy Divisional Administrator	Horton Hospital
Mr N TURNBULL	H E O Community Services	D H S S
Mr G R VANCE	Principal Officer	London Borough's Training Committee
Mrs C WATSON	Member	Dartford & Gravesend C H C
* Professor A WEBB (Chairman)	Professor of Social Administration	Loughborough University
Miss G WILLIAMS	Vice Chairman	Hampstead D H A
Mr G WISTOW	Research Fellow Social Sciences	Loughborough University
* Mr K WRIGHT	Senior Research Fellow Institute of Social and Economic Research	University of York

* denotes speaker