King Edward's Hospital Fund for London

King's Fund Centre

'UTILISING JAY' - THE SCOPE FOR LOCAL INNOVATION

Report of a conference held at the Centre on the 10 May 1979

BRINGING MENTAL HANDICAP CARE IN FROM THE COLD

This was how the Chairman, David Towell, defined the object of the conference. It was concerned with the creation and exploitation of opportunities for innovation. The massive response to the announcement of the conference showed its importance.

Three years of work had gone into the Jay report, which set out ideas about fundamental aspects of care. The debate which it had opened was wide and heated. It was unlikely that any radical change could come without conflict, but he hoped there would be respect for each other's views.

Jay Committee Members Speak- 1

PEGGY JAY: 'Change is Inevitable'

The Chairman of the Jay Committee, Peggy Jay, said that the six-month consultative phase - at the start of which people had unfortunately not been able to get hold of the whole report - was vital. There had been a phenomenal amount of interest - she had had 40 invitations to speak and her colleagues had had many others.

The Committee had been appointed in 1975. It was interesting that four to five months was spent on the members getting to know each other - and there had been no feeling of 'social workers versus the nurses'. Seven nurses signed the main report; there was only one minority report, although there were additional statments by other individual members.

'Change had now become inevitable,' stressed Mrs Jay. 'The new Briggs pattern for nurse training will simply not permit the new professionalism so needed by staff themselves in mental health work. A second influence is the EEC. We are the only country in Europe to employ nurses to care for the mentally handicapped.'

Another part of the background to the setting up of the committee was that people were conscious that all was not well with mental handicap. There had been seven or eight public enquiries into conditions in long-stay hospitals.

The committee held a large number of meetings and made many visits. It received 613 written pieces of evidence and was the first such committee to base its findings very largely on the results of its own questionnaires to staff. The nurses felt that their present training was of a custodial nature which constrained the individual. And there were doubts that the main stream Briggs nurse training could offer the more specialist training in mental handicap residential work.

The Office of Population, Censuses and Statistics Survey showed that only six per cent of staff wanted to keep the large mental handicap hospitals and very few wanted a separately funded specialist service.

'There have been criticisms of local authority services, but we are not proposing a take over by the local authorities', stressed Mrs Jay. 'We say there should be a reduction of hospital beds, that facilities should b small and local. We are asking to set up a service which will be split between hospital and local authority settings'.

The committee had a great deal of discussion on the need to build up support for families, particularly where a mentally handicapped child was living at home. The committee also called for improvement of the ante-natal services, to prevent the birth of handicapped children. The regional and class differences here were wider than in other countries.

It wanted to avoid for parents the horrendous choice of having to send a child to a long stay hospital when he or she reached the age of 8-10. Small and local facilities were required, physically integrated into the community. The adaptation of private houses was suggested.

'We made a particular point of recognising the work of existing staff in long stay hospitals', said Mrs Jay. 'The kind of model we are putting forward is based on the actual needs of the mental handicapped and the actual wishes of the staff themselves. We are looking to a doubling of the staff. For every one person doing the job today, you would have two.'

The committee looked at the sex balance of those working for the mentally handicapped. At present seventy per cent of the senior nurses were men, whilst among the auxiliaries only sixteen per cent were men.

In the small unit concept, the committee strongly emphasised the position of the unit head who would orchestrate a multi-disciplinary service. Many nurses and supervisors said: 'If only we could have more responsibility and get things done' '.

In the proposed course there would be a common, generic element, and a specialist element. There would be separate modules for the care of children and of adults. The committee was particularly concerned that there should be training in child care. There was criticism that many children's wards and units were in charge of staff who had no training in the residential needs of children or, indeed, of child development of any kind.

One of the reasons the committee decided against the GNC and in favour of the Central Council for Education and Training in Social Work was that the GNC was not geared to training for residential care. Despite the recent revision of the mental handicap nurses' curriculum, there were some serious shortcomings in it.

Mrs Jay noted that people who criticised CCETSW in public meetings came up to her afterwards and said privately: 'We're on a CCETSW course - and it's very good'.

The committee stipulated that there should be a special group within CCETSW in which the GNC should take part. Mrs Jay felt that CCETSW was moving into a phase of specialisation, against the previous emphasis on the generic.

An advantage of the Jay proposals was that they would provide a unified career structure. The committee envisaged a staff fifty per cent of whom would be qualified and fifty per cent non-qualified but in-service trained. The qualified staff would be able to rise to the top branches of senior managment. The committee anticipated a deputy director of social services having oversight for the mental handicap services. In the NHS, although the mental handicap services officer would not be a member of the area team, he would advise it.

Statutorily no individual could suffer from a change in career structure as a result of her committee's recommendations, Mrs Jay underlined. 'No one is saying that a nurse who is now qualified should be retrained. What we hope is that opportunity will be given for study days and refresher courses and reorientation, opportunities to study the report.'

From an agreed date no one would come into the qualified branch who had not taken the new training.

Mrs Jay agreed that some impetus would have to be given to local authorities. There were actually some who had not provided a single place for children, for instance. There would have to be at least two units for each local authority area. 'In order to get this off the ground there will have to be earmarked funds', declared Mrs Jay. The DHSS, she indicated, strongly supported this. Funds would also have to be voted to set up training courses, which would inevitably cost more than the existing nurse training courses.

In 1966-67 mental handicap services cost less than five per cent of the revenue expenditure of both local authorities and NHS, and less than six per cent of the capital budget. All that the Jay committee asked was that these percentages should be increased to seven and eight per cent.

Jay Committee Members Speak - II

DEREK THOMAS: "A New Professional Training is Needed"

To relate training to practice it was necessary to identify the settings in which practice would take place and to begin to identify the new professional performance that would be expected of residential care staff, said Derek Thomas, a psychologist member of the Jay Committee. In discussions on Jay, and in the detailed design work that must go into the new courses, this was best done locally.

The GNC syllabus offered a framework but it was often difficult to find what kind of learning and practice opportunities would be available to students. The curriculum might say: 'Placement in children's wards, ' for instance, but this did not indicate what learning opportunities there would be there.

People were expected to practice in the setting of handicapped people with a very wide range of individuals needs. Those who were going to work with children should have experience not only in the wards of hospitals for the mentally handicapped but in family group homes for non-handicapped children. And some of the staff of those homes would be required to work with the handicapped.

In addition to the small local homes there might be need for more specialist, back up homes. The Jay Committee also envisaged people practising in the community, as well as in hospitals.

'The Jay Committee did not recommend all NHS services should be taken over by social service departments,' declared Mr Thomas.

Referring to some of the new demands, Mr Thomas mentioned the challenge of working with parents. 'When we brought parents into the group, neither nurses nor teachers had met parents in their own home,' recalled Mr Thomas. There was a complete missing

dimension in their training. There was going to be a lot more interaction between parents and professional carers.

These also had to work with a network of other professionals. In a mental handicap hospital the nurses rarely met a paediatrician or health visitors. There was dissatisfaction among heads of homes at their lack of participation in things like case conferences. Care staff should be contributing to individual planning and might need training in how to do so. 'We are talking about staff taking on a teaching role as central to the residential caring task and not as an extension to nursing', he said. This was additional to providing the personal care that most handicapped people required. It was a very large and complex task. It would need a new professional training.

Mr Thomas rejected the claim that the committee's proposals would lead to a loss of professional identity. The committee laid down that training was of great importance. It stated that trainees should not be regarded as part of the staff complement - as they were are present. Both local authority and NHS staffs needed the training: the committee did not accept that there were two types of caring - one for those who needed 'medical and nursing' care in 'hospitals', and those who needed just 'care'. The generic training should be with other care staff, not with other nurses.

'We want specialism in training. What we are trying to say is that the Certificate in Social Service should be used as a framework. We are not simply uncritically accepting the CSS as it is at the moment. What we recommend would be the required professional training for mental handicap work.

Advantages of the CSS were that it was modular, so that people would take different parts of it at different times; that it had a strong practice base; and that there was scope for specialisation. Its very newness had certain attractions. It was not just a 'better' RNMS.

Answering his own question: 'What could we do now?' Mr Thomas said the first task was to develop new services. Ward sisters and heads of homes should learn to develop programmes within units, through the support of other people, such as physiotherapists and psychologists. A start should be made, with the help of the experience of education authorities, in the development of LA/NHS training strategies. Priorities must be defined. To develop joint strategies, joint planning mechanisms must be created. He reminded that CSS was constituted, and worked, on a local basis.

Discussion Period

DISCIPLINARY BODY - EARMARKED FUNDING

June Norfolk, District Nursing Officer, Dartford and Gravesham Health District, said the report mentioned the need to set up some professional body to monitor in the same way that the GNC monitored the disciplinary training, and to take disciplinary action.

Mrs Jay replied that in order to be accepted as a profession there must be a disciplinary body. How a body with disciplinary powers should be set up was not spelt out and would need further thought.

Harry Button, District Administrator, Basildon and Thurrock Health District, wanted to know the extent of the earmarking of funds.

Mrs Jay said the committee stated that funds must be earmarked to get the new training off the ground. 'In my view, which is shared by some other members of the committee, there must be national government initiative to bring laggard social service departments up to scratch', she added, Mr Thomas regarded training finance as concerning both social service departments and health authorities.

Innovations

ISLINGTON: WORKING ALONGSIDE PARENTS

Colin Groves explained that his background was that of a psychiatric social worker, now Assistant Director of Social Services running the research and development branch. His other field was geriatrics, which was not so specialist as mental handicap.

In Islington there was no residential basis for the services for the mental handicapped. The large hospital was Harperbury, where the problems of admission and liaison were well known. This new innovation was a truly remarkable concept by a group of parents of mentally handicapped children. Whilst the local authority was debating, Barbara Castle, as Secretary of State for Social Services, introduced joint funding - and suddenly money became available. And there was a disused hospital in the middle of the Borough, the Liverpool Road Hospital.

The Social Services Committee proceeded from the philosophical base that it should attempt to care for the severely handicapped in its community.

'The skills I have had to learn are those of negotiation and co-ordination', said Mr Groves. On the project team the parents were represented, and his own department, AHA staff and also the Local Education Authority Without the thrust of the elected members, it would not have happened.

The unit had eight places for severely mentally handicapped children. No one felt that using a former hospital was ideal, but there was a strong concensus that here was an opportunity which could be made to work.

With joint funding the unit had been brought into being from scratch in two years flat - it was a crash programme. The unit had an elaborate programme of working with parents. This was not the tradition of the NHS and much had to be learned about how to do it. 'Staff, parents,managers and elected representatives, along with colleagues in education, worked to overcome problems.

There had been ripple effects. The project was planned in a situation where Islington Social Service Department and the AHA had to be very practically involved. A local authority, Mr Groves pointed out, could not just dive in at the deep end and accept responsibility for the care of the severely handicapped children without looking ahead to what happened when they became adolescents and then adults. One of the lessons was that a joint area strategy had to be hammered out with local and health authorities.

ROTHERHAM MERGING ROLES

Hugh Firth said he was a psychologist involved with AHA hostels and small hospital units. Rotherham, he explained, had no mental handicap service prior to 1974. In the ¼m. population there were 800 mentally handicapped adults and children. 'We now have a range of services - we in the AHA provide a lot of things that we hope the social services will provide'.

The residential services were integrated with hospital and community. At the Beechcroft Hospital Unit 32 adults lived permanently. Two short term care beds were maintained, and there were beds for some ten children.

'The building could take a larger number, but we will not take more than the nursing staff can adequately look after', stressed Dr Firth. 'We are a team of people and we stick together'.

In the short term the restrictive admissions policy caused heartaches, but in the long term it had paid off. They were now getting the extra staff. The principle was finally accepted that quality was more important than quantity, and that for quality of life there must be adequate numbers of staff. The on-duty ratio was one staff to three or four residents in the day. In the hospital unit domestic and caring staff were separate. In the hostels they were integrated.

A good overall quality of life for residents, however severely handicapped, was the aim. A great deal was due to the initiative of those in charge.

There was a continuing in-service training programme for care staff.

Dick Barrows took up the story of the merger of roles of catering and basic care staff. It started in 1978 in a limited way. Detailing the hurdles and strategems, Mr Barrows revealed that personnel had told him it was 'total rubbish, lad' and an ANO said she could see every advantage but would like to wait to find what Peggy Jay had to say when the report was published.

What were the benefits? It enhanced the homely atmosphere. It greatly increased the responsibility of the charge nurse. It built up the team spirit. And it reduced absence to as little as five per cent. In the children's unit, sixteen staff between them had only ten days of sickness absence in a year'.

Because of the increased emphasis on training the residents, everyone could see great results for their efforts. People were able to cook their own breakfast. For charge nurses who mostly came from ordinary NHS settings, it had opened up new vistas.

'The most important lesson I have learned is that change can be brought about, despite opposition from everyone involved', concluded Mr Barrows. 'That is very important in the context of the Jay report'.

THE PROSPECT FOR TRAINING

Dan Williamson, a Jay Committee member, looked at in-service training. This was of three types: Induction training for staff at all levels. Refresher training for most staff and also formal courses in management for people already in post. Basic training for basic care staff.

The induction explained the aims and working methods, gave information on the management structure of the employing authority, how to register complaints, where and how to get advice. It should also include some formal elements, such as visits by trainees to appropriate units.

In the past nursing assistants and care assistants suffered from lack of systematic training. Yet in fact, certainly in large hospitals, it was they who had most contact with residents, and their attitudes and ability reflected the life style of the residents. It was therefore most important that in-service training should be relevant to the day-to-day needs of residents.

Qualified staff should see there was integration between the job instruction on the ward and the formal element of instruction.

The authority should provide at least two weeks training for basic care staff. Mental handicap staff should be aware of social and psychological requirements. They should know that if a child was physically ill, he would require treatment by a paediatrician. The isolation of mental handicap units had been exaggerated by the unwillingness of the ordinary medical service to care for these people.

Nurses required post-qualifying training. The Jay Committee had recommended that the GNC and CCETSW should collaborate. At present the majority of people who cared for the mentally handicapped were taught in schools of nursing by nurse tutors or clinical nurse tutors. Social workers, on the other hand, were taught in educational establishments. Both teaching disciplines should be used.

'Our training model is quite different from existing training,' Mr Williamson explained. 'It seems from our evidence that senior managers are quite receptive to change and are optimistic about it, but inevitably there is resistance lower down the ladder.'

BUILDING ON ASPECTS OF CURRENT TRAINING

Ken Barnes had resisted change. 'When CCETSW took over I fought like mad to resist the change from the Training Council for Teachers of the Mentally Handicapped', he confessed. Now after much heart searching he was convinced. In his opinion for too long the mentally handicapped had been isolated.

The Jay report stated that staff working with the mentally handicapped had educational and training needs which were common to all residential workers. Many residential workers were already being trained in CSS and there was much expertise in training in normal residential care already in the colleges. There was also a body of expertise in the field of mental handicap available, which could be added to by the knowledge and skills of hospital staff.

CSS was a new form of training which was a partnership between employing authorities and colleges. Provision was made for training new entrants to a profession. Never before had so much joint planning gone into a course of training as into CSS.

In the day care field when transfer was envisaged CCETSW set up a working party which identified learning objectives for the training of staff in that field. A similar exercise could be undertaken to identify areas of learning and behavioural objectives for residential work with the mentally handicapped.

Each CSS scheme would then break down those learning objectives into areas of knowledge and skill which could be taught in colleges and practised in the agencies. CSS had a modular structure with three units of study - a Common Unit, a Standard Option and a Special Option.

The common unit covered areas of knowledge and skill which were common to all working in the personal social services and could be extended to cover the health service. This included a study of normal human growth and development, structure of the services, similarity with the needs of all handicapped people, basic skills of working in the social and health services, sociology, etc.

There was a choice of four standard options - children and adolescents, adults, elderly and communities.

The specialist options concentrated on the specialist skills of working with the mentally handicapped.

'CSS is an integrated scheme of training spread over the whole period, not just the special option', Mr Barnes explained. CCETSW had decided that a scheme could be completed in two years or extended over five. Formal study for the common unit must be between 240 and 300 hours, as with the standard option. There was no limit stated for the special option.

Students could train alongside other people who were training to work with normal children and adults and other handicapped people. At West London College there was astrong health department and a thriving special education department, with an ESN(S) teacher training course. These resources could be called upon to offer their expertise to students working with the mentally handicapped, who would be members of the social studies department. It was hoped to plan a number post-qualifying courses.

'Standards of training are high in CSS and external assessors appointed by CCETSW make sure that these standards are maintained'.

Innovation:

SKELMERSDALE: AN EXPERIENCE IN ORDINARY LIVING

Ann Walter and Chris Washington described the Dr Barnardo's experiment in Skelmersdale New Town to demonstrate not only that mentally handicapped children could be cared for in ordinary houses that they would benefit from the more stimulating environment which this provided.

The Development Corporation offered two adjoining council houses on a new estate which could be adapted to form a home for six mentally handicapped children. Following the Nebraska project, it was decided to provide an alternative living cluster round the small children's home, which was called the 'mother unit'. This further development was also supported by the Development Corporation. It was decided that the total number of children in the project should be limited to 14 - six in the 'mother unit' and the remainder in four alternative living units. Four ALUs were now in operation.

The whole project is directly managed by the superintendent (Chris Washington). There are four child care staff, including Chris, in the 'mother unit', which generally means a ratio of one staff to three children.

In each ALU there is a manager and an assistant, giving at least a ratio of one to two children, allowing for staff off-duty and holidays. One part-time member of care staff provides additional cover for all ALUs. A second part-time member will be employed now that the fourth ALU is opened.

Each ALU is only a few minutes walk for the 'mother unit'. As far as possible they are run as autonomous units. Managers have responsibility for their own monthly budgeting and liaise directly with other professionals involved with their children, such as social workers and GPs.

When the project started very few staff had any experience of working with mentally handicapped children. Most were child care trained. Since the project began two staff formerly employed as cooks in the 'mother unit' had transferred to the child care staff, one becoming a ALU manager.

Early on staff received some support from the local educational psychologist, who advised them how to deal with one child's problems using behavioural modification. Staff found this useful but limited as it only dealt with one specific technique. It had now become possible to train staff in devising and implementing individual programme plans for children aimed at increasing their developmental skills.

The 'mother unit' had required some adaptations which in no way affected the outside appearance of the house: sixty per cent of the capital outlay had been for fire protection and detection. The ALUs required no modification from ordinary houses.

'In line with our philosophy we furnish all the homes with everyday furniture such as you would find in any normal home'.

The children came from a variety of backgrounds. Four were from mental handicap hospitals, three came direct from home breakdowns, one from a short term foster home breakdown and the other five from other residential facilities. Apart from one, all were severely mentally handicapped. Three had little or no speech, three were doubly incontinent.

The development of the children when they moved to their ALUs had been both impressive and surprising. Behavioural problems had diminished almost entirely. They went into the street and played with neighbours' children. They went to the cinema, sports centre, Scouts and Guides.

One of the most important aspects of the work was the increased contact with the children's own families. Parents were encouraged to become part of the caring team, wherever possible.

The immediate community showed children and staff the utmost consideration and there had never been an incident which could be described as community non-acceptance. The children were regularly taken to local shops.

In thinking for the future the question was being asked: If children developed better in the ALUs, shouldn't all the children be in ALU situations? So they were looking at ways in which they could move the remaining six children from the 'mother unit' into smaller houses. The former could then be used as a short stay home for both children in ALUs and for children at present living at home with their parents in the area.

QUESTION AND ANSWER

There was a strong feeling in one group that there was over-emphasis on cost and money in the Jay report. As important, surely, was the change in attitudes and action of the new model of care for the mentally handicapped, both now and in the future. This group believed that much could be done about changing attitudes of staff.

Mrs Jay replied that nothing would have sunk the report quicker than not to have gone into detail about cost. The committee would have been labelled 'wooly headed idealists'. The cost was in fact small. She agreed about staff attitudes.

Harry McCree said that already costs were rising. 'What we are in danger of doing is getting more of the same. 'The cost of hospital care was becoming very expensive: it was £20 plus per day. If the government did not make an early decision on Jay, the inflexible planning system would continue to grind out solutions which were inappropriate. There were so-called "small" units being built with 120 beds.' Mrs Jay added that Archway House was in the pipeline, costing £1 m.

Betty Nicolas, a member of the General Nursing Council for England and Wales and of the Jay Committee, said that more money was needed for nurse education.

Who was to say that any change for the better took place: was there not need for interdisciplinary monitoring?

Mrs Jay said thought was being given by the new government to an inspectorate for the NHS. The National Development Team clearly wanted strengthening, when one thought of Normansfield and other reports.

Mr Thomas said that monitoring of standards was a complicated issue.

In reply to further question, Betty Nicolas revealed that there were constant negotiations as to waht constituted conduct which should lead to erasure from the nurses' register. Mr Thomas pointed out that psychologists did not have a register. Mr McCree noted that the theory of the GNC's disciplinary power was that it protected the public. 'But I am not sure it has been very successful in doing that in the past', he added. There was a debate at the annual representative meeting of the Royal College of Nursing, and a great deal of concern elsewhere about the fact that the investigating committee decided there was no case

to answer by the nurses named in the Normansfield enquiry report.

Would the young person come into mental handicap nursing at the moment, knowing that they were being relegated to second class citizenship?

Mrs Jay: 'How can you say that? We are providing a much taller ladder for the mental handicap nurse. The latest official figures show that recruitment is in fact going up'.

Questioner: 'I am talking about realities, not figures'.

After the panel answered further questions, Mrs Jay concluded the conference.

JAY PROPOSALS A CHALLENGE, NOT A THREAT TO NURSES

'Firstly, there will always be jobs and careers for people working in mental handicap', said Mrs Jay. 'Secondly, the nurses themselves have spoken in very clear terms of their dissatisfaction with their existing training. You may say it is a silent majority, but it was certainly a majority of the written evidence which my committee received.

'When you add to that the problems of Briggs and the EEC directives, you see that change there must be. Nurses, our proposals are not a threat. They are a challenge. Please accept them that spirit'.