COLLABORATION
BETWEEN
HEALTH AND PERSONAL SOCIAL SERVICES

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by

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PREFACE

This report is supplementary to a larger project undertaken at the Centre for Social Research at the University of Sussex into the proposed reorganisation of the National Health Service.

The main project originated in an application to the King's Fund from the South East Metropolitan Regional Hospital Board in 1970 for support for a study to see how the proposed unification of the NHS may be made to work at area level. The project was approved by the Fund's Management Committee in December 1970 and a sum of £13 000 was allocated towards the cost of the project over a period of two years. It was to be related to the Brighton and East Sussex area and to be conducted under the direction of Dr. P.J. McEwan, Director of the Centre for Social Research.

The project started in January 1971 with the appointment of Dr. John Powles as Research Fellow and was guided by a steering committee consisting of:

Dr. K.R. Porter (chairman)	Senior Administrative Medical Officer South East Metropolitan Regional Hospital Board
Mr. R.W. Alderton	Group Secretary, Brighton and Lewes Hospital Management Committee
Mr. D. Allen	Director of Social Services, East Sussex
Mr. K. Barnard	King's Fund Centre
Mr. C. Brady	Regional Officer for Health, Department of Health and Social Security (observer)
Mr. M.C. Hardie	King's Fund Centre
Mr. H.N. Lamb	Secretary, South East Metropolitan Regional Hospital Board
Dr. P.J. McEwan	University of Sussex
Miss A. Mead	Senior Lecturer in Sociology, Middlesex Polytechnic
Dr. J. Powles	University of Sussex
Mr. J. Simmonds	University of Sussex
Dr. J.A.G. Watson	Medical Officer of Health, East Sussex

Initially nine 'first phase' advisory groups were convened to consider problems in the integration of services at 'fieldworker' level. The subjects covered by the groups were:

1. Preventive services and the promotion of health
2. Primary health care services
3. Centralised health care services
4. Birth control and maternity services
5. Child health services
6. Services for the elderly
7. Services for the mentally and physically handicapped
8. Psychiatric services
9. The consumer and the health service

This series of advisory groups reported in March 1972 and their reports were published by the Hospital Centre in May 1972 (88 pages: 50p). The reports served as basic documents for a second phase of advisory groups, which were convened in April 1972, to consider the administrative arrangements necessary to secure the effective coordination and management of services. There were six such groups:

1 The Area Health Authority
2 Organisation at district level
3 The professions and management
4 Consumers and the health service
5 The organisation of information services
6 The organisation of supporting services

An interim version of the information services report was forwarded to the Secretary of State's Management Study Group, at their request, in May. The final reports of these second phase groups were published by the Hospital Centre in November 1972 (61 pages: price 50p).

Early in 1972 it was decided to include as part of the project a study of the future relationship between the health services and the social services after the 1974 reorganisation. For this purpose, Miss Adrianne Mead was appointed as Research Fellow at the Centre for Social Research to undertake this work. Her report was completed early in 1973 and is presented in the following pages.

It is hoped that the report may be of help to members of joint liaison committees and others concerned with collaboration between health and social services, both now and in the future.

Miles Hardie
Director
King's Fund Centre

May 1973

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INTRODUCTION

"Unification offers solid advantages to the individual and the family, because their needs for health and social services are not divided into separate compartments. A single family, or an individual, may in a short space of time, or even at one and the same time, need many types of health and social care, and these needs should be met in a co-ordinated way" - The White Paper

The concern of this report is to review some of the problems involved in the future collaboration between the health services and the personal social services, after NHS reorganisation in 1974: in particular to highlight certain specific issues which seem to warrant more careful and detailed consideration.

The problems of future collaboration are discussed within the framework of the proposed new NHS structure: that is, at Regional, Area and District level. In each section selected issues of common concern are outlined and various viewpoints considered. Attention is primarily focused on problems of cooperation and coordination between the statutory health and personal social services. This is not meant to obscure, however, the important role played by the voluntary health and welfare organisations, and attention is directed towards these at the end of the study.

Adrianne Mead

May 1973

SUMMARY

Problems of future collaboration between the health services and the personal social services are discussed at three organisational levels: regional, area and district.

Regional Health Authorities

On the local government side there is no geographic unit corresponding to the regional health authority. Further, the power of the central department is different with respect to the two services: it has more control over the health service. The sources of revenue differ: the NHS is funded from the central exchequer while local government is partially rate-funded. The styles of government and the forms of public accountability vary for the two services.

It is hoped that these organisational differences will not impede collaboration between the two services at regional level, especially with respect to coordinated planning. It would seem crucial to view the 'health' and 'social' needs of a region in conjunction with each other. It is assumed that the personal social services and other local authority services will be represented on the RHAs.

Area Health Authorities

The fact that the existing tripartite structure of the NHS is to be replaced by a more unified service, and that the new AHAs will be coterminous with local authority areas is to be welcomed. However, although the areas will correspond geographically, the two services will be administered by separate organisational structures so posing problems of integration.

The two authorities will have statutory obligations placed on them to collaborate, and this will be effected through joint consultative committees. In view of the potential importance of the JCCs, it is felt that their exact function needs careful consideration.

There is a need to coordinate planning between the health and personal social services at area level, in particular a need for closer cooperation in handing over responsibility for patients discharged from NHS hospitals to the local authority community services. The latter require strengthening and this will necessitate resources being diverted from the NHS to local government. Closer inter-service links are also urged between the local authority housing and education services and the health services; this is particularly important in view of the inter-relationship between health and other social problems.

Due to the administrative separation of the health services and the local authority social services, a strong plea has been made for increased liaison through joint committees. A note of caution is added - this proliferation of committees may have disadvantages in that they will be administratively costly to operate and will be time-consuming, and possibly frustrating, for the members involved.

Three specific topics of related interest have been selected for more detailed discussion: (i) The future of the hospital social worker, (ii) The provision of hostel accommodation, (iii) Seebohm reorganisation of social service departments.

Health Districts

A crucial issue in terms of operational efficiency at this level is the mismatch between health service and local authority districts; health districts based on district general hospital catchment areas will contain populations from 200 000 - 400 000, while local authority districts will be from 75 000 - 100 000. Whenever possible it is hoped that health district boundaries will be drawn along local authority district boundaries.

It is envisaged that the multi-disciplinary team approach will be a central concept in the new reorganised health services, this is welcomed as a practical attempt to provide comprehensive care for the individual. One fundamental problem that needs further consideration and investigation is the difference in ideology and culture between the medical and social work professions. Medicine as it has become more highly scientific and technological has focused on the disease entity within the patient, social work by contrast has broadened its perspective to look at the individual within his social situation, focusing attention on groups of individuals such as the family and the community. These differing orientations have implications when members of the two disciplines are expected to work together to solve 'common problems'. There is an urgent need in the training of health and social work professionals to prepare them for inter-disciplinary cooperation.

Two further related issues are discussed in some detail: (i) The involvement of social workers in health centres and group practices, (ii) collaboration between the statutory health and social services and the voluntary organisations.

Conclusion

A plea is made for a greater dissemination of knowledge concerning health service-social service collaborative schemes, both in this country and abroad. In particular, it is hoped that future research will study the new system, not only from managements' perspective downwards but also from the recipients' viewpoint upwards. In Sir Keith Joseph's words ".....the purpose behind the changes is a better, more sensitive service to the public".

REGIONAL HEALTH AUTHORITIES

This is the first tier of the new NHS structure. Regional Health Authorities (RHAs) will be responsible for general planning in each region, for allocating resources between the Area Health Authorities (AHAs), and for coordinating and monitoring their activities. Their aim will be to ensure that national and regional objectives are achieved, and that desired standards of service are provided. The new health regions will be based on the existing hospital regions.

On the local government side there is no geographic unit corresponding to the RHAs. This has a number of implications; two seem of particular importance and are interrelated: (i) the lines of control between the local government areas and the central department are different to those for the NHS, and (ii) the main source of revenue and types of accountability are different.

The White Paper states clearly the difference with respect to the personal social services:

> "There is a difference between the local authority and its matching health authority. Where statutory responsibility for the administration of a local service is placed on independent local authorities, the Minister's responsibilities being correspondingly limited, it is right that the local authorities should deal directly with the central Department. The personal social services, where the DHSS has central responsibility, are an example of this. But the NHS is in a different position. Parliament has placed full statutory responsibility for the service on the Secretary of State and holds him accountable for the money spent on it - nearly all of which comes from central sources."[2]

The Power of the Central Department

The main problem arising from this situation is the different degrees of control by the central department over the two respective services. In effect, the Secretary of State 'runs' the NHS, while he can only 'advise' and 'guide', but cannot direct, the local government personal social services. Thus, there is a disparity of power running down the two channels - the Secretary of State has considerably more control over the health services than over the personal social services. This could be particularly crucial should there be conflicts between the two services which could not be resolved within the proposed organisational framework.

Most significantly, the styles of government are different for the NHS and the local authority social services; the members of the regional and area NHS authorities will be appointed whilst their local government counterparts will be elected representatives. It is anticipated that the former will be more responsive to 'direction' from above - the central department, while the latter will be more sensitive to 'pressures' from below - the electorate.

Sources of Revenue

Sir Keith Joseph in his foreword to the White Paper states that one of the existing gaps in the health services is the provision for non-acute cases:

> "It is well understood.....that the domiciliary and community services are under-developed - that there is a need for far more home helps, home nurses, hostels and day centres and other services that support people outside hospital."[3]

While a unified health service can go some way to filling the existing gaps, it will fall short of its aim unless community facilities are developed and resources are available to the local authorities for this purpose. The difference in source of revenue for the NHS and local government is an issue which affects collaboration at all three levels, and only the main features will be discussed here. The essential difference is that the NHS derives its funds from the central exchequer, while local authorities are partially rate-funded; the NHS is ultimately accountable to the community through the central government, while local authorities are more directly accountable to their electorate.

The difference in source of revenue is particularly significant when there is a transference of responsibility between the health services and local authorities with respect to certain groups of patients. In the past decade there has been a growth in community care for a whole range of patients, in particular the mentally ill, the mentally subnormal, and the elderly. Some of these patients are cared for in small residential units in the community, while others are looked after at home by their families. This undoubtedly puts increased physical, financial and emotional strains on those providing care who, in turn, require help and support from a whole range of local authority services - the housing department, the social services department (SSD), with their home helps and other supporting services.

Coordinated Planning

A stated function of the RHAs is to "develop stratetic plans and priorities based on a review of needs identified by AHAs and on its judgement of the right balance between individual areas' claims on resources."[4]

It would seem crucial that 'health' and 'social' needs are viewed in conjunction with each other, and that strategies for dealing with these are coordinated. The problem arises, however, that the RHAs will be required to deal with a number of local government areas where views on social policy and planning priorities may vary.

It is assumed that the personal social services and other local authority services will be represented on the RHAs. This would seem of extreme importance if the comprehensive care of the individual, whether his needs be 'health' or'social', is to be effectively planned, coordinated, and monitored. At the same time, the RHAs will need to have particularly close links with their AHAs so that planners do not become too remote from the people they serve. In this way two types of integration are envisaged: horizontal

integration of the health and other social services, vertical integration of the various tiers of the health services.

The advisability of having a regional tier within the NHS is accepted, but it is debatable however whether such a 'supra' body is necessary on the local government side. On the one hand it can be argued that a strong regional authority, responsible for overall planning, might be able to minimise some of the wide variations that exist in local authority social policies and provision. For example, they might encourage 'Scrooge Areas' to be less parsimonious with respect to services provided, and, by introducing 'positive discrimination', could focus attention on priority areas of need so that minimum national standards could be achieved.[5, 6, 7] On the other hand, it is important that local authorities retain a certain amount of autonomy so that they can regulate their policies in accordance with changing social needs and can be responsive to local demands.

The results of the DHSS's recent request to local authority social service departments to prepare 10-year plans may show to what extent the long-term policies of the respective authorities differ. While an undoubted advantage of such an exercise is to force SSDs to think and plan ahead, a disadvantage might be a retreat into 'departmentalism' - a more concerted and coordinated approach to social problems would be preferable which involved health, social services and other local authority departments coming together in a joint planning exercise.

AREA HEALTH AUTHORITIES

It is not felt appropriate here to go into the long debate on the 'pros' and 'cons' of having the health and social services within one administrative structure. The second Green Paper of the Labour Government firmly rejected the idea of the NHS being under local government control, and since then it has been accepted that the new NHS authorities will "administer the unified personal health services and in partnership with reorganised local government will coordinate them with personal social services". (Our underlining).[8] It will perhaps suffice to say that recommendations for alternative arrangements have frequently been put forward. For example, the Radcliffe-Maud Report suggested that the NHS should come under the reorganised local authorities, so ensuring closer coordination of health and personal social services without the necessity of special arrangements having to be made. It would also follow that under such an arrangement the health services would be subject to more democratic control than exists at present.[9] An alternative proposal put forward by the Liberal Party suggests that Area Health Boards should be democratically elected (with adequate professional and staff representation) and should be responsible for the whole range of health and welfare services within their area. The local authorities would continue to administer the welfare services but as agents for the Area Health Boards.[10]

Given the proposals embodied in the present Government's White Paper and Bill, it is at area level that collaboration between the health services and the personal services will be most readily effected. The fact that the existing tripartite structure of the NHS is to be replaced by a more unified service, and that at area level the health unit will be coterminous with local authority areas is to be welcomed. However, although geographically there is correspondence between the two area authorities, other important differences still remain: (i) management styles, (ii) community provision and the need for liaison, and (iii) arrangements with other local authority services.

Management Styles

The health services on one hand and the personal social services on the other now seem to be evolving different management styles and approaches. For example, the NHS is adopting a policy of devolution of responsibility downwards: the basic management level which has now emerged is the district. The local authority, on the other hand, does not usually delegate so far down (geographically) and responsibility is concentrated at the county, or metropolitan borough, level. This means that the agency running the personal social services covers a larger area with different types of control at district level, than the one running the health services. (There may be some tendency now, however, for SSDs to be devolving more power outwards to their area offices and teams.)

Community Provision and the Need for Liaison

The present trend towards community provision and away from long-term care in large hospitals is likely to continue in the future, so putting increasing demands on local authority services and facilities. However, the rate at which this trend is increasing is causing concern in some quarters. A recent report published by a tripartite committee of the Royal College of Psychiatrists, the Society of Medical Officers of Health and the British Medical Association concludes that it would be impossible to

plan the closing of existing institutions for the mentally ill and handicapped, until and unless alternative community services have first been provided.[11] The committee stress in their report the necessity for compulsory provision for liaison between the NHS and local authorities at all levels. In support of this imperative they state:

> "....we firmly believe that nothing short of this will ensure against unilateral action - or no action at all - and consequent waste of resources by one of the bodies concerned."

Arrangements with Other Local Authority Services

The provision of short-term residential and community care naturally evolves on local authorities; this includes supply of such facilities as transit and rehabilitation hostels, day centres, 'boarding out' arrangements, training facilities and centres. All require suitable physical accommodation and links with the housing departments are vital. Further, the provision of adequate accommodation for those being cared for in their own homes is often a responsibility of the housing departments and the supply of adequate housing may seriously affect the rate at which patients can be discharged from hospital.

Joint Consultative Committees

The White Paper proposes that:

> "....the NHS Reorganisation Bill should contain a general obligation on the authorities concerned to collaborate; should give them the fullest possible powers to provide each other with goods and services; and should make it obligatory to set up joint consultative committees."[12]

While the general principle of statutory collaboration between the health service and local authority services would seem reasonable, details as to how the joint consultative committees (JCCs) are to operate requires careful and detailed consideration.

The fact that the AHA members will be appointees of the RHAs, while most local authority members will be elected representatives will be significant in terms of their respective responsibilities, and the relationship they have with their respective authorities.

Function of the Joint Consultative Committees

The White Paper seems evasive as to the exact function of the JCCs, the Collaboration Study's first report was more explicit:

> "The function of these committees would be to examine jointly needs of each area, the plans of the two sets of authorities for meeting their needs and the progress made towards meeting them; and to advise on both the planning and the operation of the services in matters of common concern. The objective would be to secure genuinely collaborative methods of working throughout the process of planning, and close and continuing cooperation between the offices on the two sides."[13]

The Collaboration Study poses the questions as to what are to be the exact powers of the JCCs. Are they to be given 'teeth' - that is some financial control over the policies of their respective authorities in matters of joint concern, and possibly statutorily defined responsibilities to prepare joint plans, or, are they to become merely 'talking shops' with a more shadowy function? It appears that the 'consultative' function of the JCCs envisaged by the White Paper falls somewhere in between these two extremes. They will "examine jointly the plans of the authorities and to advise on the planning and operations of services in spheres of common concern."[14]

Issues of common concern

The assumption that there is a consensus between the two services as to areas of 'common concern' warrants careful consideration. Both services, at the most general level, would ascribe to a common goal - to provide services and care for those with medical and social needs. But, differences may exist as to the ways in which these needs are identified and satisfied. For example, differences may be emerging between the two services as to the most appropriate 'unit' for treatment. Medicine, with its emphasis on unique pathology, stresses the importance of the individual as the focus for therapy. Social work stresses more the dynamic inter-relationship between variables and may favour a wider unit as a focus for "treatment" - the family or the community group. These differences may affect fundamentally the choice of priorities of the two services, areas of 'common concern' may be so general as to be meaningless from the point-of-view of practical policy-making.

It is suggested that the community physician might be an appropriate person to identify areas of common concern and to form a bridge between the two services. His training in epidemiology and community medicine alerts him to the significance of environmental factors in the aetiology of disease, and his position in the community (like that of the general practitioner) places him in an excellent position to coordinate the efforts of the health and social services in a joint frontal attack on medico-social problems.[15]

Cross-Representation

In addition to JCCs, the White Paper recommends:

> "....each AHA will include in its membership members of the corresponding local authority; and local authorities will be strongly recommended to coopt to their relevant committees members or officers of the AHA."[16]

Again, the precise function and accountability of these respective members is vague. It appears that the Collaboration Study could not reach agreement on this issue.[17]

It would seem that if cross-representation is left to the discretionary power of the two authorities, this will not only contribute to confusion, but also serve to reinforce regional variations in social policy formulation and implementation.

Inter-service Links

As pointed out in the White Paper, not all local authority services are administered according to the same geographical units:

> "....personal social services by the non-metropolitan counties, the metropolitan districts and the London boroughs; education by those authorities except in central London where the Inner London Authority is responsible; environmental health and housing by the non-metropolitan districts, the metropolitan districts and London boroughs."[18]

Housing

As pointed out above, the fact that the health services, the personal social services and housing services are administered by three separate bodies requires machinery to be set up to ensure coordination and cooperation between the three, if an integrated approach is to be achieved towards the citizen's needs. This need is re-enforced by the realisation that some individuals and families suffer from a 'multiple-problem syndrome', where illness is only one manifestation of a whole range of inadequacies and deprivations suffered by the individual. The causes of such problems are often multiple, inter-related and cumulative. For example, the inter-relationship between such factors as unemployment, economic instability, poor housing, large or one-parent families, poor educational attainment, and illness is well known. The vicious 'poverty cycle' is often difficult to break, and it seems essential that an integrated approach to the problems be attempted. The administrative separation of the services may encourage a situation where these problems are viewed in isolation from each other.

Education

The fact that the School Health Service is to be the responsibility of the NHS is welcomed. However, it seems important that the inter-service links between the health service, the personal social service and the education services be strengthened. These are especially important in the case of the educationally backward and subnormal where the child may be suffering from a number of associated problems such as physical illness, emotional stress and family pathology and instability. Most often these children, and their families, are known to the social services and it is important that adequate channels of communication exist between the three services so that dissemination of information is

maximal and as wide a perspective as possible is gained on the problems. This would seem particularly important if preventive measures are to be taken, for example 'backwardness' at school may be an early-warning sign that the child may be suffering from incipient physical or emotional problems. (It should be pointed out that the Working Party on Collaboration has looked separately at the School Health Service.)[19]

The need for social work advice in schools is now generally acknowledged, and a recent suggestion that the educational welfare officer might perform this function deserves serious attention.[20] It seems that the EWO is in an excellent position to provide a preventive service, which has real opportunities for intervening in the recurring cycle of deprivation. The relative merits of the EWO remaining within the education department or joining the SSD would have to be considered. Whichever arrangement was decided upon, it would be necessary to create formal liaison arrangements between the AHAs, the SSD, and the education department.

The Proliferation of Committees

In the foregoing section a plea has been made for strengthened administrative machinery to allow effective cooperation and collaboration between the health services and the various local authority services. While the aim of such liaison machinery would be to provide comprehensive care for the individual, it appears, given the present administrative separation of the services, that the solution lies in instituting a complex system of committees and sub-committees. This proliferation of committees may, unfortunately, have certain disadvantages - they will be time-consuming and thus frustrating for the members involved; minutes and documents will have to be written, circulated, read and reported on. The administrative, and personal costs, of the proposed complex structure of committees required for 'integration' should not be overlooked.

The Future of the Hospital Social Worker

This question is considered of particular importance and is, therefore, discussed in some detail.

The Labour Government's second Green Paper stated:

> "....the decision is that the health authorities will be responsible for services where the primary skill needed is that of the health professions, while the local authorities will be responsible for services where the primary skill is social care and support."[21]

This statement introduced the notion that medical social workers in hospitals, at present employed by the NHS, should be transferred to local authority social service departments; arrangements being made that they should be 'seconded' back for hospital service. The debate as to whether the medical social workers should 'stay in' or 'go out' has continued ever since. It seems that the Executive of the British Association of Social Workers is in favour of hospital social workers merging with local authority social workers, but there is a vocal group of hospital medical and psychiatric social workers within BASW who strongly oppose this suggestion.

The Collaboration Working Party who have considered the 'pros' and 'cons' at some length, came down strongly in favour of the medical social workers being employed by local authorities, with special arrangements being made for hospital coverage.[22] The Secretary of State announced in April 1973 that after the reorganisation of the NHS it will be the responsibility of local authorities to provide a social work service to hospitals. This has settled the issue, but it may help to improve future understanding and cooperation to summarise some of the main points put forward for and against the employment of medical social workers by local authorities.

Disadvantages if medical social workers are to be employed by the local authority social service departments

(i) The medical social worker (MSW) will be asked to serve two masters - the hospital and the social service department - she (or he) will suffer from a divided allegiance and responsibility.

(ii) The MSW has worked hard to establish herself as an accepted member of the medical team, it is feared her employment outside the hospital, and return only on a seconding basis, might interfere with this relationship. Both patients and medical colleagues may suffer if she is not in the hospital full-time. It is feared medical colleagues will fail to refer cases in need of social work help.

(iii) The presence of the MSW on the medical team is seen as providing an important 'humanising' element. There is anxiety about the fact that high technology modern medicine, with its inevitable specialisation, has become too disease-orientated and is not sufficiently aware of the personal and emotional problems of the patient. If the MSW was employed outside the hospital, it is feared her influence on the medical profession would diminish.

(iv) MSWs now have access to confidential matters concerning patients, it is feared hospitals might not be prepared to divulge information to staff who were employed by another authority and over whom they had less control.

(v) One significant practical problem arises: patients in district general hospitals (DGHs) in the future will be drawn from a wider geographical area (population 200 000 - 300 000). DGH catchment areas may not correspond to local authority boundaries and thus the patients may come from a number of local authority areas. This poses several problems: (a) MSWs employed by the local authority in which the DGH is located will be dealing with patients from possibly a number of local authorities. If the distribution is very uneven, some form of reimbursement for

her services will be necessary. (b) She will be required to deal with a number of local authorities beside her own, which may entail complicated liaison arrangements and divided responsibilities for the patient's care. These problems will be particularly acute in the specialist regional hospitals where patients may be drawn from a nation-wide catchment area. (Interestingly, if the smaller Community Hospitals were reintroduced, possibly run by general practitioners (GPs), the above problems would not arise because the catchment area would be smaller and patients likely to come from the same local authority. However, these hospitals are only likely to cater for a small proportion of all in-patients).

(vi) There is a fear on the part of the MSW that her specialised knowledge will be diluted if she becomes a member of the SSD's 'generic team'. Because of the general shortage of staff and ever-increasing demands in most SSDs, she will be called upon to carry a 'mixed' case-load which will give her less time to devote to hospital patients. It is feared that the somewhat disorganised SSDs (after Seebohm) will not be able to cope with the added burden of therapeutic and clinical work the MSW, and especially the psychiatric social worker, does now. (This of course applies if MSWs are not seconded back to hospitals on a full-time basis).

(vii) It also should be mentioned that many MSWs now employed in hospitals do not have professional qualifications, this might pose problems of status for them in the reorganised SSDs.

(viii) It is pointed out that much of the MSWs work is involved with helping patients who are in a 'crisis' situation and who need prompt support and help; if the MSW was not in the hospital full-time, this would be more difficult to provide.

(ix) MSWs have expressed concern over the fact that Directors of SSDs vary in their attitudes to hospital social work which may influence the amount of manpower and resources they are prepared to channel in that direction.

(x) Finally, if MSWs were to be employed by the local authority but transferred back to hospitals on a full-time or part-time basis, there seems to be great ambiguity as to the precise nature of her role and accountability. Terms most often used are: 'attachment', 'secondment', and 'outposting'. ('Joint appointments' and 'liaison schemes' are also suggested, these are discussed below). It would seem important to have clear definitions of these various terms as these may have serious implications with respect to the authority structure in which the MSW will work and her various role responsibilities. We give below some helpful definitions offered by the Institute of Organisation and Social Studies, Brunel University.[23]

Definition of Terms

Attachment

> "When a specialist function exists at different levels of an organisation a junior specialist may be required to service under the command of a non-specialist, while at the same time remaining the subordinate of a specialist superior. The junior specialist thus has two superiors who are together accountable for his work to their common superior. This situation is described as attachment."

Outposting

> "A subordinate may be posted to work in a division of the organisation which is functionally or geographically separate from that of his manager. When the original superior remains fully accountable for the work of the subordinate, the situation is called outposting."

Secondment

> "A manager may transfer one of his subordinates to work for another manager for an agreed period of time or for the duration of a project. When the second manager to whom the subordinate has been transferred is accountable for all the subordinates work the situation is called secondment."

Advantages of medical social workers being employed by local authority social work departments

(i) The present distribution of MSWs within the hospital service is very uneven, for example:

(a) Many more MSWs are employed in teaching hospitals than non-teaching hospitals.[24] It has been estimated that about one-third of qualified and practising MSWs are concentrated in about one-tenth of the hospitals employing any MSWs at all.[25]

(b) Large, long-stay, geriatric and mental hospitals are particularly poorly served by MSWs.[26]

(c) There are vast regional inequalities in the distribution of hospital social workers. The Collaboration Study cites the following evidence:

> "....taking as a measure the ratio of hospital beds to social workers, the variation was 219 in one London region to 798 in a provincial region - the average being 484. The figures for psychiatric social workers

in proportion to beds for psychiatric patients varied to greater extremes, from 175 in one London region to 3 029 in a provincial region - the average being 1 030."[27]

(ii) The time hospital workers spend with different types of patients has also been found to vary greatly. One study observed that MSWs were concerned with the after-care of 75% of the maternity patients but less than 15% of other patients.[28] Another study which followed up geriatric patients after discharge from hospital, found that only 18% had been seen by a MSW while in hospital.[29]

(iii) One of the aims of NHS reorganisation is to unify the existing branches of the health services so that greater continuity of care will be achieved. The employment of hospital social workers outside hospitals would help in achieving this aim. It should be pointed out that hospital admission usually only constitutes a short period in the patient's illness "career". The social services and other local authority services may be helping the patient before and after his hospital admission (especially if he is suffering from the 'multiple problem syndrome' mentioned earlier) and it is important that his care is not fragmented by unnecessarily handing over to other persons.

(iv) Hospital social workers are tending to want to develop community ties and to be more active outside hospital on their patients' behalf. But, in doing this there is a danger they may overlap with local authority social workers and so waste resources. Efforts should be made to counteract the 'dualism' that often exists at present between hospital and community care - if social workers were able to move freely between the two services they could be a powerful force in integrating the hospital service, the old local authority health services and the new social work departments. Of course the introduction of 'joint appointments' in some areas have been a useful attempt to bring such integration about.

(v) The HMSO survey "The Handicapped and Impaired in Great Britain" estimates that more than 3 million adults living at home are physically or mentally impaired and almost one and a quarter million of these are described as seriously handicapped. Of these 80 000 are living alone, more than half of whom have no regular contact with local authority health and welfare services.[30] Thus, a strong case is put forward for strengthening medical social work in the community and removing it from its exclusively hospital-based location. At present patients, especially in teaching hospitals, have some chance of receiving specialised medical social work help, but patients receiving domiciliary medical care within the community have much less chance of this kind of help. Although such supportive services as home helps, district nurses and health visitors are available for the patient at home, skilled social work assessment of the situation which is often vital, is not easily available.

In a recent study of a full-time social worker attachment to a London group practice, it was stated that "although most of the patients referred to the social worker had serious and often prolonged social and psychological difficulties, most (70%) had not been in touch with any other social-work agency."[31]

(vi) At present hospital social workers have no financial resources at their disposal, if they were within the SSDs they would have greater access to resources and could exert more influence on behalf of their clients. MSWs need to make use of local authority social service facilities, for example day centres, rehabilitation units, etc. It would make it easier for them to gain access for their clients if they were operating from within the SSD. Further, in planning improvements for the local authority social services it would be an advantage to have the voice of the MSW within rather than outside the local authority SSD.

(vii) If the MSWs were within the SSD this would indeed be in the spirit of the Seebohm Report. Many of the duties of the hospital social worker are identical to those of the local authority social worker (it is argued only the site is different), for example such duties as ensuring social security benefits are paid to a family, helping the family with its housing and other personal problems, advising them on work problems, etc. It can be argued that these functions can just as well be done from the SSD, rather than waiting until the patient is admitted. Further, the MSW located in the community can more effectively detect 'early warning' signs of potential problems and therefore act in a preventive capacity.

(viii) It would be naive not to mention the financial advantage for MSW were they to transfer to local authority SSDs. This, together with the professional support from social work colleagues could contribute to an all-round greater job satisfaction. In fact, the trend has already been observed for MSWs to be leaving the hospital services in favour of working in SSDs.[32]

(ix) Finally, a solution that has been suggested to overcome the unequal distribution of MSWs in areas and different types of hospital, is to introduce statutory powers to ensure more comprehensive coverage.

Liaison Hospital Social Workers

Discussion of such a scheme operating in Coventry will be found in Appendix A.

Hostel Provision

Another area of special concern which deserves detailed consideration is the provision of hostel accommodation.

Both the Consultative Document and the recent White Paper have remarkably little to say about future plans for hostel provision at area level. This seems surprising in view of the important role they have to play in the transition of patients from hospital in-patient care to community care and in view of the long-term support needed for many of these patients. This is of particular significance in view of the reported increase in numbers of patients suffering from various forms of 'mental disorder' requiring the attention of the health services. A central question is, who should be responsible for running the hostels? Richard Crossman in the second Green Paper recommended that institutions should be administered by local authorities wherever the 'primary skill' is social care and support, and by area health boards when the primary skill is of a medical nature.[33] The Crossman distinction suggests that there would be a division between hostels where residents require constant psychiatric (ie medical) supervision and those hostels where residents do not require such care. If the idea of hostel provision is to receive more than lip-service, it seems essential that more be known about the present government's policy with respect to the appropriate service to provide such care.

Different types of hostel provision

A distinction which those both studying and working in hostels consider should be made, is the difference between the 'rehabilative' and 'compensatory' hostel.[34] The former acts as a 'stepping stone' for patients who have left hospital but who require a transition period to allow them to prepare themselves for an independent life in the community. The latter, compensatory hostels, provide a permanent home for certain categories of mentally ill who, because of the nature of their illness, could never be rehabilitated (for example the chronic but quiescent schizophrenic). It seems essential that a clear distinction be made between the two types of hostel; their therapeutic functions are very different, they cater for different types of mental patient, they require different staff and facilities. (However, it is possible to put forward an alternative argument that differentiation of this kind could lead to some hostels becoming second-class 'dumping grounds' providing inferior facilities, etc.)

One criticism that is frequently heard is that the hospital staff and local authority hostel staff operate with very different policies with respect to the admission of patients. Hospitals, owing to staff shortages and other reasons are often anxious to discharge patients quickly to hostels in the community, hostels on the other hand wish to exercise caution and discretion as to whom to admit. Such variations in admission policies may hinder the easy flow of patients from hospital to community, so causing 'blockages' to develop in the system. The local authority social workers are usually in touch with all hostels in their area, whether provided by the local authority or the voluntary organisations, and it has been suggested that the social workers could play a more positive role in liaising between the hospitals, the hostels, and other community support services. (Joint-user posts have been advocated). If this were to be implemented, it might go some way to providing a more integrated service for the mentally ill and handicapped.

The demand for hostels

Despite official statements in the recent past that a large increase in hostel accommodation for the mentally ill and subnormal is needed, relatively little progress

appears to have been made.[35] A recent government report believes that 120 000 people in England and Wales are severely handicapped, however, a large proportion of these who do not need specialist medical or nursing care could be cared for in the community if there were adequate provision. The paper sets out to explain "....why the present services need to be extended and improved, and the shift in emphasis from care in hospital to care in the community accelerated".[36] Much attention is given to the need for closer cooperation between hospital authorities and local authorities, especially with respect to joint planning and coordination of progress. Special emphasis is placed on the need to expand residential homes and adult training centres, and it is also appreciated that increased numbers of social workers, home helps, play-group organisers and similar staff will be needed. Surveys of hostel provision for both the mentally subnormal and the mentally ill reveal that there are wide variations throughout the country, some local authorities providing no hostel provision whatsoever.[37]

Recruitment and training of staff

An important factor in providing adequate hostel accommodation is the supply and training of staff. The following should be borne in mind:

(i) The demand for hostel provision is increasing and this is likely to continue indefinitely. Thus, in order to recruit sufficient staff of the right calibre, attractive work situations and career prospects are necessary, combined with appropriate training schemes.

(ii) Just as different types of hostel are needed to cater for a range of need groups, similarly a number of different tasks have to be performed within hostels: administration, nursing, social work etc. Supervisory and other skills are needed for the efficient running of a hostel combined with the all-important need of providing a warm, emotionally secure, environment for the residents. This requires time, understanding, and a commitment on the part of those involved. It would seem naive to think that all these skills could be found in one person, and more attention should be given to the wide range of personnel needed for the successful running of a hostel, and especially that resources are provided for in-service and college-based training courses for those recruited.
The recent discussion document put out by the Central Council for Education and Training in Social Work is welcomed. This makes proposals for "bringing residential work into the mainstream of the social services". It recommends two types of training at different levels; a Certificate of Qualification in Social Work, and a Certificate of Qualification in Welfare Work. The report cites the fact that of the present 65 000 residential staff, only 4% are trained in residential work and 62% are totally untrained.[38]

(iii) It would seem important that more research is directed towards evaluating the relative merits of different types of community provision for the mentally ill, for example, 'boarding-out' schemes, sheltered housing, patients' communes, etc.

The New Seebohm Social Service Departments

There is much discussion but a paucity of published empirical research on the outcome of Seebohm reorganisation. (A useful appraisal of some of the areas of concern is to be found in K. Jones (Ed.), The Yearbook of Social Policy in Britain 1971, Part 1, "After Seebohm".)

Below some general comments are made about the current situation:

(i) There appears to be no clear national picture yet about the reorganisation of the social services. However, the point is frequently made that time is required before an accurate picture can be obtained, and it is important to differentiate between the short-term disturbances caused by reorganisation, and the more serious long-term structural and organisational problems that are likely to emerge.

(ii) One fundamental problem is the shortage of social workers. Like the demand for medical services, the need for social services is continually rising. It has been estimated that the demand on the SSDs since reorganisation has increased by 20%, this demand has not been matched by a corresponding increase in the supply of social service personnel.[39] The Butterworth Committee estimated that there was a shortage of about 1 000 establishment places for all grades of local authority social workers.[40]

(iii) One criticism of the Seebohm reorganisation is that it has meant that social service departments are now 'top heavy', many of the specialist field workers having been promoted to managerial positions, leaving a vacuum of 'expertise' in the lower grades. There is some criticism also of 'generic social work' training courses (which have replaced the previous specialised courses) in that they do not equip students with enough detailed knowledge to cope with specific cases where, for example, detailed knowledge of the law is required. Staff in departments often lack confident knowledge of the law and administrative procedures for particular situations with which they have not previously been concerned.

(iv) There is much debate as to whether the new SSDs are comprised of 'generic individuals' or whether they are more likely to be 'generic teams'.[41] There appear to be variations between departments and between area teams - many of them working out independently the lines along which they feel 'specialisms' should

emerge (rather than the old administrative ones of child care, mental health and welfare). This would seem a very important area for planned research and controlled experiments; in particular looking at the various alternatives with respect to the benefits for the clients. Assuming that the social service departments will continue to grow in size, some division of labour is inevitable. The crucial question is, what are the criteria to be used for the allocation of clients to social workers, and what are the most important skills required of social workers?[42]

(v) Some social workers feel that the success of Seebohm depends on the 'top management' within the departments. The social services are faced with an ever-increasing pressure of work, in order to cope with this it is necessary to have an order of priorities to decide what is feasible to tackle and what, reluctantly, will have to be left undone. If these dilemmas are faced and clear decisions made and responsibility for them are delegated downwards, then the social service departments would seem to have a chance of coping with the current situation. If however, these measures are not followed, the departments soon become swamped with applications for help, chaos ensues and apathy sets in.

(vi) A criticism from the medical profession, especially from general practitioners (GPs) is that post-Seebohm they have lost the personal contact with particular social workers which had existed before. Rather than dealing with one social worker for certain problems, for example the mental welfare officer, they are now expected to liaise with a number of different social workers and communications are now more complicated and time-consuming. (For example, GPs mention the frustration of trying to establish telephone contact with social workers in large departments where lines are always engaged and valuable time is wasted). Some SSDs have attempted to overcome this problem by appointing a special liaison social worker to deal exclusively with requests from GPs. Many GPs are aware of their lack of knowledge of the full range of statutory and voluntary agencies available to help their patients, they appreciate knowing a 'friendly' social worker who they can quickly contact for such advice and regret the fact that she may now be more difficult to find. Such complaints, however, should perhaps be treated with some caution. While it is true that contact with specific social workers, such as the mental welfare officer, may be more tenuous under the new arrangements, contact with a whole range of other social workers should be easier due to the fact that there is now "one door on which all can knock" - an advantage to clients and their medical practitioners. As the Seebohm Report noted:

> "Survey after survey has shown that many family doctors do not seek help from social workers nor use social services that are available: they often do not know about them, or do not understand or value them".[43]

(vii) Another criticism from the medical profession is that certain groups of patients have suffered as a result of social service reorganisation. Those most frequently mentioned are the blind, also the elderly and the mentally subnormal. GPs complain that there is insufficient 'after-hours' cover for patients by social workers, not only in emergency situations but patients are often not free to visit SSDs until after their working hours.

HEALTH DISTRICTS

It is believed that this, effectively, is where maximum interaction between the health services and the personal social services personnel will take place. For example, the Health Care Planning Teams are each to include a consultant, a GP, a nurse, an administrator and a social worker for such major need groups as mental health, child health and the elderly.[44]

This section will begin by discussing some general problems likely to be encountered at district level.

The mismatch between health districts and local authority districts

A crucial issue in terms of operational efficiency at this level is the mismatch between health districts and local authority districts. Health districts, based on DGH catchment areas will contain populations of between 200 000 - 400 000, local authority districts typically cover populations of between 75 000 - 100 000. (A criticism of the health districts based as they are on DGH catchment areas is that boundaries are drawn for administrative convenience rather than according to population distributions and community needs.) It has been strongly suggested that, wherever possible, health districts should be drawn along local authority boundaries and they would then naturally include a number of local authority districts, rather than health districts cutting across these boundaries. While this correspondence would benefit cooperation between the health service and the personal social services at the planning level (ie SSDs), it would be of less help at the delivery level (ie social service area teams) as the latter cover somewhat smaller populations - Seebohm suggested between 50 000 - 100 000. (This problem is discussed in more detail in the Working Party Collaboration Study[45]). It is important therefore that links be planned between the DMT and the Director of Social Services for planning purposes, and between the envisaged health care teams and social service teams for operational purposes.

The mismatch of boundaries has another important implication, there is an increasing need for accurate statistical information about the demographic and other characteristics of an area. Unfortunately, due to the fact that the DGH's catchment area does not correspond to local government boundaries, important data such as that derived from the census cannot be easily used. This indicates an urgent need for 'small area' data which could be aggregated according to DGH or local authority boundaries, so allowing comparisons to be made between health service and social service 'units'.

Multi-disciplinary teams

The multi-disciplinary team approach is to be a central concept in the new reorganised health services. The Management Study proposes that health teams should be set up according to certain 'need' groups: Children, Maternity, Mentally Handicapped, Elderly, etc., and for different types of health care: Primary, Secondary and Prevention.[46] These teams are to include medical, para-medical and other associated professionals, thus an inter-disciplinary inter-professional approach is envisaged, which aims to provide comprehensive care for the citizen, whether he be 'patient' or 'client'. (There may be a danger that these plans run contrary to the spirit of Seebohm, that is that the needs of the family as a unit may be lost once more if attention is focused on the needs of individuals.)

While it is easy to accept the need and desirability for a broader and more integrated approach to health to cope with the multifarious needs of individuals, it is essential to consider some of the practical problems involved in implementing these ideas. Possible problems likely to be encountered will be discussed below with respect to the medical and social work professions, similar and other difficulties may be found between other professional groups.

Inter-disciplinary working relationships

Some of these problems were clearly elaborated by the Seebohm Report:

> "It is a paradox that cooperation between workers in medicine and the other social services should often be poor when both are so dependent on communication and they are so involved in common concerns. Medicine and social work share responsibilities in the field of disturbed personal relationships and social maladjustment. They are both much involved in helping with the consequences of poverty and deprivation. The problems of living with the chronic diseases (which dominate the practice of medicine today) often are medical-social. The physical, mental and social difficulties of old age often have to be considered as a whole in order to offer appropriate help. But doctors have been slow in coming to terms with the new social work "helping professions" that is growing so rapidly alongside them."[47]

It would seem that insufficient attention is paid to the fact that the ideological bases of medicine and social work may differ. The two professions have developed different 'cultures' and see the same problems from different perspectives. While, ideally, the two approaches should be complementary, health and social problems being two sides of the same coin, often there may be fundamental disagreement as to the 'causes' of problems and how these are to be best solved. This difference can lead to conflict and misunderstanding between the two groups; one resolution of which would be to try and move the two professional cultures nearer together.[48]

Not only the knowledge-base, but the professional training of medicine and social work is very different. Medicine, as it has become more highly scientific and specialised, has focused on the disease entity within the patient. Social work, by contrast, has broadened its perspective, looking at the individual within his situation, focusing attention on groups of individuals such as the family and the community. These different approaches obviously have serious implications when members of the two disciplines are expected to work together to solve 'common problems'. Often there is a lack of knowledge about the respective training and abilities of the two professions, in particular the medical profession frequently being unaware of the training and range of skills possessed by social workers. This lack of understanding on the part of the medical profession is easy to appreciate - the social work profession is young and striving to gain respect and independence. This makes it particularly sensitive to misrepresentation of its proper function and wary of dominance by the older and more prestigious profession. These attitudes tend to hinder, rather than help, understanding and inter-disciplinary working relationships.

In order to break down these barriers, it has been suggested that there is a need for more inter-professional education; for example, a common basic training for medical, nursing, para-medical, and behavioural science students.[49]

Not only may the basic ideologies and outlooks of the professions be different, but the situation is further complicated by the fact that the health and social services are organised within two separate administrative structures, so increasing the need for effective 'bridges' to be built between the two services. The physical placing together of health and social service personnel in one team should go some way to surmounting these barriers, but it has been pointed out that this closer physical contact may, rather than improve understanding, exacerbate problems - increased contact may lead to increased conflict'. Ways of resolving these will have to be carefully and sensitively worked out if positions are not to become entrenched and the respective groups retreat back into their narrowly defined professional 'enclaves'.

As Seebohm has shown, it is relatively easy to change organisational structures and to give people new titles and roles, but it is much more difficult and time-consuming to break down old practices and ways of thinking and for new expertise to develop. The multi-disciplinary team members will require time to adapt, to be 'socialised', into new roles and, unless training is brought into line with practice some may never have the intellectual apparatus to change to the new situation and tasks confronting them. Medical training, in particular, is a lengthy process and attitudes and perspectives built up over these years cannot be easily altered. The recommendation of the Todd Report to include more behavioural science courses in the medical curriculum is to be welcomed.[50] However, it seems important that integration of the two sciences is demonstrated in a practical way, students from both disciplines working together to solve shared problems. The vocational GP training programmes might be a place where this approach could be profitably tried, young GPs and social workers coming together for this purpose.

Practical suggestions for closer training and working schemes between medical, para-medical, and social work personnel are being developed by a number of interested observers.[51, 52] Increasingly, these 'experimental' schemes are being discussed in the medical/social work literature.[53]

A fundamental dilemma which faces both the medical and social work profession in the reorganised health and social services is that both are more likely to find themselves working within larger organisational units, subject to bureaucratic constraints. The hierarchical authority structure found in such bureaucracies is likely to pose problems for those accustomed to a certain amount of professional autonomy.

The involvement of social workers in Health Centres and Group Practices

The number of health centres and group practices are increasing. As one writer points out:

> "....about 30% of general practices now have the services of health visitors and it seems rational to extend the concept of the 'health team' to include a social worker. In a few areas this is done but it is at a nascent stage."[54]

It is indeed true that some practices do have part-time or full-time attachments, although such arrangements seem relatively infrequent. More practices are now exploring the possibility of having a liaison arrangement with the local SSD, whereby a social worker 'calls in' on the practice on a regular basis, discusses cases with the GP which might suitably be referred to the SSD, but does not actually see clients at the practice.

(Two alternative schemes, (i) a full-time attachment, and (ii) a liaison arrangement which have been tried out in Scotland are discussed in Appendix B.)

Implicit in the discussion above on multi-disciplinary teams is the belief that there is a need to clarify the function and responsibility of the social worker (and other members) within the group. Studies which have looked at the involvement of social workers in primary health care teams have generally found that the social worker's function falls into three broad categories: (i) diagnosis and assessment, (ii) the provision of links with social agencies, (iii) casework. One study suggests a fourth function, that of helping to secure the patient's cooperation in medical care.[55]

Sometimes it is found that the social worker's conception of her own role and function differ from that held by her medical and para-medical colleagues, so causing misunderstandings, frustration, and possibly friction. One problem facing the attached social workers is the way in which clients are 'introduced' to her. Should she see patients/clients only referred by the general practitioners - so running the danger that they may, from her point-of-view, disregard or misrefer certain cases? Alternatively, should she have an 'open door' policy, whereby patients/clients are free to refer themselves - although this may cause the GPs to feel that their traditional responsibility for the patient is being usurped?

The attachment of social workers to health centres and group practices is increasingly being urged by the medical profession, but it seems important that more attention should be given to experimenting with alternative types of attachment so the 'best' methods can be found for different types of practice situation. (Relatively little published material is available on this topic.) Understandably, the medical profession often conceives of social work attachment as something similar to nursing, or health visitor, attachment schemes. However, because of the very different training and function of the social worker, alternatives role-relationships and conditions of work will have to be developed. The possible overlap between the health visitor's and social worker's role is often a very sensitive area for those concerned in 'experiments'; the health visitor may feel threatened by the arrival of a social worker in the team, and it seems important that the two roles are clearly differentiated while at the same time emphasising the complementary nature of the two roles.

Finally, it should be pointed out that, while many GPs would like to have social workers attached to their practices on a part-time or full-time basis, the recently reorganised SSDs are often strongly against this on the grounds that they have insufficient manpower to make such appointments. One possibility that seems to have received little attention is for the hospital social workers to move into general practice. In this way they would retain their close, and valuable, contacts with the medical profession, would be part of the local authority SSDs but be 'seconded' to general practice, would be in a strategic position to help patients with their problems before they went into hospital and after discharge, and could even retain their contacts with hospitals by doing weekly

'out-patient sessions' when patients/clients were seen and/or discussed with hospital colleagues. In such a way they could forge a valuable link between the hospital and community health services and the social services.

Issues to be considered

Below are outlined some questions which need further consideration:

(i) Is the employment of social workers in health centres and group practices to be on an 'attachment', 'secondment', 'outposting', or 'liaison' basis?

(ii) What is likely to be the estimated volume of work in an average practice, and does this warrant full or part-time appointments of social workers?

(iii) If the social worker were to be attached on a full time basis, would this cause her to become professionally isolated from her social work colleagues in the SSD? Would she become too influenced by the medical perspective, which might prevent her using her social work skills to the best advantage?

(iv) Will the attached social worker have sufficient agency and financial resources at her disposal to maintain a strong position in the team with respect to the amount of help she can give her clients?[56]

Collaboration with the voluntary organisations

There is an awareness of the increasingly important role to be played by the voluntary organisations in the future in the provision of health and welfare services. Certain implications of this trend are discussed below:

(i) There is a need for better channels of communication between the voluntary organisations and the health services. Health personnel are often only vaguely aware of the full range of voluntary services in their area. A comprehensive and up-to-date directory is needed in which it is easy to recognise at a glance the range of alternative services available for any particular need group. Existing directories often seem to be compiled according to 'provider' rather than 'consumer' needs.

(ii) If wider knowledge is made available as to the potential usefulness of the voluntary organisations, they can expect an increased demand for their services. It is important that they are in fact ready, willing, and able to meet these demands.

(iii) Attempts are being made to rationalise and coordinate the work of the various community voluntary organisations, and this move is welcomed. This seems particularly important if these agencies are to play a major part in the proposed community health councils. Many hospitals are now employing salaried voluntary help organisers - a similar post is now being created by some local authorities and this practise could be accelerated further. It has been suggested that there should be a voluntary work liaison officer in every social service area team office.

(iv) It is suggested that more research is needed into the concept and philosophy of voluntary work in contemporary society, for example:

(a) The tendency for voluntary help to be drawn from all strata of society nowadays, rather than predominantly from the middle-classes as before. Also the trend for more young people, especially school children, to be involved in voluntary work.

(b) The whole question of the motivation of the voluntary worker - the 'manifest' and 'latent' satisfactions to be derived from such work perhaps warrants closer scrutiny. The dilemma posed by the fact that volunteers give their time and energies free, yet there is a need to organise and control their services if the help is to be truly useful and dependable.

(c) A question which needs careful consideration is whether voluntary work should become more 'professional', that is whether more and better training should be provided for voluntary workers?

The setting up of a National Volunteer Centre in London is very much to be welcomed. It is hoped that this will encourage much needed research in this area.

Conclusion

At first sight this report may appear negative in that it concentrates exclusively on the anticipated problems arising from reorganisation of the national health service, rather than its potential benefits. However, while appreciating the basic aims of the White Paper to unify the health services and to bring these more closely together with the social services, it is felt that there is an urgent need to consider these proposals in some depth and it is to this end that this review is addressed.

Collaboration between the health services and the personal social services is not a new venture, many formal and informal arrangements are now in existence. It would be helpful if such collaborative schemes were more widely publicised and discussed so that their value to others could be assessed. Little attention seems to have been paid

to international comparisons. The Scandinavian, Communist, and other countries, whose health and social service provision has similarities to that in the UK, have both implemented and experimented with different organisational arrangements. It is felt that much could be learnt, both on the positive and negative side, from the experience of these countries.

It appears that there has been a great deal of discussion to date on devising better methods of delivering health and social care looking at the situation from the management downwards. A much more difficult, but equally important, task would be to look at the new system from the recipient upwards, that is, the way in which the reorganisation of the services affects the individual in need of help. Certain questions remain to be answered. Will the consumer have more or less choice in the new system? What control will he have effectively over the way in which his taxes are deployed, and the manner in which the services are delivered to him? As Sir Keith Joseph states in his foreword to the White Paper "....the purpose behind the changes is a better, more sensitive service to the public". This surely can be achieved only by a thorough and on-going analysis of the proposed new structure from all points-of-view, but remembering nevertheless that we may be trying to find an answer to an insoluble equation:[57]

Consumer wants ⁂ Professional needs ⁂ National resources

APPENDIX A

Liaison Hospital Social Workers

The discussion in the main body of the report was largely hypothetical as to the advantages and disadvantages of local authority employment of MSWs. In some areas alternative arrangements have been tried and, below, is discussed one such scheme operating in Coventry. There social workers have been transferred to the employ of the SSD which is responsible for providing a service to hospitals on an agency basis - the hospital management committee pays for the service. [57]

Functions of the liaison hospital social workers

(i) There is at least one liaison social worker in each hospital acting as an initial point of contact with hospital staff.

(ii) Community-based social workers come into the hospital to deal with difficulties of patients already known to them.

(iii) The hospital liaison social worker deals with most other referrals, particularly short-term crisis work appropriate for the social workers working in hospital with her knowledge of illness and relationships with hospital staff. Some long-term work will be passed to the area from the beginning or when the patient leaves hospital, the hospital social worker retaining long-term cases in the area to which she is attached.

(iv) Patients living outside Coventry receive social work help while they are in hospital and if they need ongoing help on discharge they are referred to a social worker in their district.

Some general comments on the Coventry scheme [59]

(i) Advance warning is needed to prepare hospital staff for the changeover and to explain the new system.

(ii) There is a danger of loss of personal contact between individual consultants and social workers since social workers are working on a geographical basis rather than a hospital unit. To avoid this, social workers are being attached to consultants and medical teams with the aim of improving cooperation between area teams and consultant staff.

(iii) There is need to improve communication between social workers and all hospital staff.

(iv) If secondment (or some other arrangement) is to be tried it is important to experiment with different types, conditions and length of secondment. It is suggested that secondment should be for at least 2 years.

(v) Poor relationships between hospital employed medical social workers and local authority social workers have led to delays in handing-over responsibility for cases and often result in an adequate exchange of information. It appears more rational and economic if there is one social worker dealing with the patient/client, whether he is in or out of hospital.

(vi) 'Non-detriment' conditions of service have to be worked out (superannuation terms, etc.) for hospital social workers transferred from the NHS to the local authority.

APPENDIX B

Social workers in health centres and group practices - alternative schemes

Description of a full-time attachment in East Kilbride, Scotland[60]

(i) The medical centre which comprises two group practices provides medical care for 15 000 people. A full-time social worker is attached to the medical centre. The social worker works with one group of GPs who have a total patient roll of approximately 10 000.
It would appear that this social work provision is too small, particularly as the policy has been that the social worker should be involved with the broad range of social problems and not just those which are the direct result of illness.

(ii) All cases for the social worker are referred directly through the GPs and, as far as possible, the attached social worker retains these cases but, in some instances, it is necessary to use other members of the departmental social work staff or a student unit which is attached to the medical centre. In such cases the attached social worker should be responsible for liaison between these other workers and the GPs.

(iii) There is a referral system operating in the social work department which ensures that copies of new referrals are made available for a brief discussion by senior staff at a case conference the following morning. Allocation is carried out afterwards by the senior worker in each unit. Referrals received by the attached social worker in the medical centre go through this process and, although the question of allocation rarely arises, as has been indicated earlier, it is useful for senior staff to see the whole range of referrals that are coming into the department. There is a central index system for all cases, including those referred to the attached worker. The social worker maintains his own files in the medical centre.

(iv) The GPs and the social workers meet weekly to discuss relevant cases and the social worker has available to him all relevant medical information regarding his cases.

(v) No formal links were created between the social workers and other health staff but it would appear that the staff, particularly health visitors, are using the social worker more and more as a consultant. Generally speaking, cases are not referred from health staff in the clinic but from the GPs who have quickly understood the role of the social worker and make appropriate referrals.
Considerable preparation was carried out in discussing attachment with the GPs prior to its implementation. These discussions were valuable for clarifying problems such as confidentiality, the nature of social work accountability, etc.

(vi) The attached social worker uses the reception and telephone services which are provided for the health department staff. At present, limited clerical assistance is made available - this situation will probably have to be reviewed.

(vii) It is essential that formal links are created whereby the attached worker maintains his contact with the social work department. In fact, the attached social worker is under the general supervision and jurisdiction of one of the units and is involved in the normal meetings which take place within this unit. He does, of course, have the availability of the senior social worker of the unit for case consultation where necessary and evaluation of work which is considered to be an important part of the senior's role.

Description of a liaison scheme in Clackmannan, Scotland [61]

(i) The policy that has been followed in relation to social work in health centres is one of providing a liaison social worker through whom the clients and staff of the health centre can have access to the full range of social work department resources.

(ii) The social worker concerned visits the health centre regularly once a week for discussion which takes from one to one-and-a half hours, with the general practitioners and with the health visitors. The rationale behind this policy is that so many of the problems which may be picked up by the GP and which require either the services of a social worker, or access to some of the resources of the social work department, may not be specifically of a medical social work nature.

(iii) To allocate one worker to the health centre who would themselves take all the cases referred to them from that centre limits the service those clients receive to the skills and abilities of that one worker. The liaison method also enables the social work department to make the most effective use of workers with specialist skills.

(iv) The liaison worker in her discussions receives information from the doctors relating to clients they may wish to refer to the department. This information he feeds into the allocation procedures and, either the social worker who may already have contact with members of that client's family or another social worker whose skills are felt to be most appropriate, are allocated the case. In some instances of course the liaison worker is the worker allocated to the case. In the discussions the social worker can feed in information to the doctors in relation to other cases known to the department and, importantly, can in some instances act as a consultant to the health centre staff without needing himself to be involved in seeing the actual client.

(v) The particular health centre concerned has 3 doctors who are members of one practice, with a total list of some 7 000 patients.

(vi) The liaison workers carry generic caseloads within the full range of the department's functioning but the liaison arrangements make use of their particular skills, training and experience.

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