is 659. I cannot see that list being abolished in the near future.

Future arrangements of local authority health and welfare services should bring general practitioners and local health authority staffs together. The conditions of general practice are changing, and we have to change with them. It is not always easy because there are not as many nurses and health visitors as there are general practitioners. On the proposals for area health boards, I doubt whether they are going to result in the release of any new amounts of money for specialized man-power for the social services. I am not against change but our trouble is that in postulating escape from difficult circumstances we do not want to admit that administrative change will not suddenly unlock some hitherto hidden and undisclosed resources in money and man-power.

In management, and I am after all a manager of a large scale health and welfare service, we need to define our objectives and determine the resources in money and man-power that we can command to fulfil those objectives. The task of management is to see how these things can best be brought together. Therefore the question arises as to how we ought to proceed. What I would like to know from you is, are we using the money that the government allows us to spend, in the right ways and at the right time?

Mr W. E. Allison (*residential services officer*)

First and foremost is the question of who should and—probably even more important—who should not be in an old people's home. The Act says 'Local authorities shall not provide services of a kind normally only provided by admission to a hospital'. That wording was settled well before 1948, when there was no National Health Service, and the great changes since then, in what is normally provided in hospitals have changed the rôle of old people's homes. One simple example is the development of warning systems, which have progressed from one of the residents banging on matron's door with a walking stick to the employment of night attendants supported by electronic devices and internal telephones. Cost has also progressed. For Kent County Council homes the percentage of total running costs paid to staff has risen from 44 per cent in 1953 to 60 per cent in 1967. The current division of responsibility between local welfare authorities and hospitals is laid down in a Ministry of Health memorandum dated 15 September 1965. Paragraph 5 reads:

> The elderly people whom local authorities may need to admit or retain in homes can broadly be defined as, those who are found after careful assessment of their medical and social needs to be unable to maintain themselves in their own homes, even with full support from outside, but who do not need continuous care by nursing staff. They include (1) people so incapacitated that they need help with dressing, toilet and meals but who are able to get about with a walking aid or with the help of a wheel chair; (2) people using appliances that they can manage themselves or without nursing assistance; (3) people with temporary or continuous confusion of mind but who do not need psychiatric nursing care. They also include residents who fall ill whether for short or long periods whose needs are no greater than could be met in their own homes by relatives with the aid of the local health services. Where the illness is expected to be terminal, transfer to hospital should be avoided unless continuous medical or nursing care is necessary. Some incontinent residents other than those with intractible incontinence and other disabilities may also be manageable in a residential home.

It is necessary to stress one simple but vital fact. The whole can be greater than the sum of its parts; for instance, if the condition of one dependent person is tested against the standards of responsibility and found to be just within the compass of an old people's home—then a second and third and so on. The pressure on the staff force which can be employed at an acceptable cost can build up so that the facilities become saturated well below the total number of places in the home unless there is a fair proportion of relatively capable residents. At the ordinary type of home such as we have in Kent for about 40 people, experience is that just about one quarter of the total number of residents can have extensive physical infirmity provided there is not

also severe mental failure. As Dr Elliot said, to provide services for a higher proportion of dependent people we have developed a special type of home which for economic reasons has to be rather larger, about 60 places. A recent survey we did on our ten homes of this type showed that 24 per cent of residents needed night care, involving two attendants every night of the week, while 16 per cent were incontinent by day and 18 per cent every night of the week. Only 38 per cent were reported as having no cerebro-vascular change. We plan to have about one special home to four ordinary homes in a given area. Even with higher numbers, the cost of staffing special homes is greater. For instance in 1966–67 the staffing cost for the ordinary homes was 107/4d. per resident per week and for the special homes, 125/10d. Incidentally, these figures are well above the national average. Then additionally we have specialized accommodation, exclusively for persons with such extensive mental infirmity—they constitute about ten per cent of the total—that their behaviour would cause undue distress to their fellow residents who have retained their mental faculties. My third point is on staff ratios; in our special homes we have about one staff member to 3.6 residents and in the ordinary homes one to five. These figures are near the 4.3 estimated in "Health and Welfare Services in 1975". Paper no. 22, National Institute for Economic and Social Research. They are certainly higher than the national average of 6.3.

As Dr Elliott said, voluntary organizations play a useful part in residential care of old people, accounting for about ten per cent of our total provision. The needs of physically-handicapped younger persons have until now been exclusively provided by various specialist voluntary bodies. This is an area of specialized care in competition with the great number of old people in need of help, which must be considered in conjunction with the development of services for the physically handicapped such as day centres. All welfare authorities have Ten Year Plans and the national aim is approximately 21 places per 1,000 population over 65; this is very much of an average as our own experience shows. Two localities in Kent provide an interesting contrast; one has 26 per cent of the population over 65 and yet our calculations show that we need only about 6.5 places per thousand of the elderly population, whereas another locality with a population of persons over 65 as low as 9.8 per cent requires about 22 places per 1,000.

All these building programmes are based on full development of the hospital and domiciliary services, and the voluntary organizations. The council gives considerable financial grants to voluntary bodies to provide such things as home-meals services, day centres for the housebound with facilities including bathing and meals as well as the normal social activities. These range from the normal social club that is open seven days a week to one held every third Thursday in the village hall. A development of some significance is a system of giving the local old people's welfare committees a grant to employ an organizer for visiting schemes and, it is hoped, finding accommodation. All our grants are based on the belief that home visiting is probably the most important service that can possibly be provided by volunteers.