

University of Sheffield

THE HOME HELP SERVICE

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ABSTRACT

This thesis is a study of the role of the domiciliary home help and community auxiliary nursing services in England and Wales. The origins of the two services, interwoven as they are with political, social and demographic changes, are traced. Factors in the development of the services such as the effects of war, infant mortality, the professionalisation of nursing and medicine, the low status of domestic service, the role of voluntary organisations and the policies of successive governments in particular since 1948, are discussed.

The parallel development of both services since 1948 is analysed. The increase in the numbers employed in the auxiliary nursing field, since the separation of nursing and the home help service in 1972, and its effect upon the role of the home help is examined. The concern at the possible duplication and overlapping of a role, because of the independent development of the two services since 1972, is also discussed.

In an attempt to identify the actual tasks carried out by both groups of workers, I carried out a large study of the role of each group. A postal questionnaire, listing 110 tasks was completed by 1037 home helps in 20 Local Authorities and 1368 nursing auxiliaries in 81 District Health Authorities. The completed questionnaires were analysed under the headings of: Professional Nursing; Basic Nursing; Administrative; Domestic; Personal; Advisory; Escorting and Miscellaneous Tasks.

The data collected on the role of the home help and auxiliary nurse is examined and areas of potential overlap discussed, along with an analysis of the perception that each group has of their role. The variation in practice in differing authorities is also discussed. The thesis is concluded by a summary and conclusions.

In the appendices each group of tasks is analysed, in tables, by frequency, perception of role, age, sex, time in post, marital status, qualifications, political affiliation of each authority and type of authority. A comparison of the number of tasks and the percentage of staff carrying them out in each authority is also included.

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In postscript, I hope that the findings of this research will make some contribution towards improving the status and image of the home help service and a recognition of the valuable work carried out by them.

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INTRODUCTION

Domiciliary Home Help and Community Auxiliary Nursing Services: A Neglected Field of Study.

The impetus for this study arose out of the experience of the author of working in a number of social service departments as a middle and senior manager with responsibility for social work, domiciliary care and health service liaison. The home help and community auxiliary nursing services are a key component of community care; the service supports more elderly people than the residential services and hospitals combined (Isaacs 1979: 25). To manage the service effectively it is necessary to have a clear understanding of the roles of the workers involved. At present the range and boundaries of tasks carried out by home helps make it difficult to get a clear definition of their role (Bond 1982: 20). Despite this lack of clarity, the home help service in particular is often referred to as the backbone of domiciliary community care services (Hillingdon L.B. 1975: 1, Goldberg and Connelly 1978: 27). The work of home helps is clearly recognised in new innovative social service schemes (Hadley and McGrath 1979, Cooper and Stacy 1981, Whitehouse 1982, Seyd, Tennant, and Bayley 1984) but in many traditional social service departments they are accorded a marginal status (Parsloe and Stevenson 1978). More money is spent on this service in England and Wales than any other community based service; national expenditure on

home helps accounts for approximately 70 per cent of Social Service Department net expenditure. As the Audit Inspectorate argue, "on expenditure grounds alone, the home help service is a major contributor to the value-for-money of SSD services to the elderly" (Social Services: Provision of Care to the Elderly 1983: 42). In view of its importance in the community care debate, why should the service be afforded such a marginal status? Why have two separate groups of untrained workers, home helps and auxiliary nurses, evolved to provide domiciliary support to families and individuals in their homes?

Since 1974, a number of issues relating to the role of the two groups have been raised. Is the home help role overlapping with that of the auxiliary nurse? Is the home help service substituting for the auxiliary nursing service (Bond 1982, Latta 1980)? Despite the role of the auxiliary nurse being unclear (Nursing Mirror 1982, Nursing Mirror 1983, Nursing Times 1982, UKCC for Nursing, Midwifery and Health Visiting 1982) their numbers have increased rapidly from 1,184 in 1971 to over 4,500 by the early 1980s (Hardie and Hockey 1978: 78, Audit Inspectorate 1983: 70). The role of both workers are unclear and blurred (Audit Inspectorate 1983, 70), in particular, recent studies comment upon the uncertainty and lack of clarity of the role of the home help (DHSS 1981b, West Berkshire Health Authority 1980, Latta 1982, Simons and Warburton 1980, Dexter and Harbert 1983). By their nature, professional groups tend to be isolated from one another, each profession or group tends to view its own function as central to the care of clients with the other performing subsidiary roles. There may therefore be a need to define their respective responsibilities and roles, otherwise overlaps and omissions occur (Amos 1975: 20). These

recent studies raise questions as to the necessity of separate roles for each group of workers in the light of increasing centralisation of services.

It is clear from the literature that there is a debate concerning the definition and role of the home help and auxiliary nurse. Some of this discussion has centred on the issue as to whether there is any 'overlap inefficiency' between the two groups. There is literature highlighting the concern about the National Health Service - Personal Social Services Split at macro level (Herbert Report 1960, Brown 1979, Hill 1982, Wilding 1982, Walker 1982, Klein 1983) but little has been written about the effect of this split at micro level. It is my intention to examine one aspect of this local interface - the relationship between home helps and auxiliary nurses. I wish to examine the tasks carried out by both groups, in as many authorities as possible, to analyse their role and identify any area of overlap.

In the first six chapters of this thesis the history and origins of both services are discussed in order to highlight some common trends and to identify the relationship between the two groups of workers. In the remaining chapters the data from the empirical study, which set out to analyse the present tasks carried out by both groups, are discussed. Any areas of overlap will be highlighted. The variations in the type of tasks carried out in differing authorities are examined as are the perceptions that home helps and auxiliary nurses have of their role.

The origins of the identity of a role lie as much in history, as in the expectations which others have of the practitioner at work. Therefore, in order to consider the range of variables which might have exerted an influence on the role-identity of the home help and auxiliary nurse, and

upon the acceptability of those roles, both historical and contemporary perspectives are examined.

Issues in the early history of the 1834 Poor Law services are raised in the first two chapters, to provide some answers to these questions. The absence of adequate statutory domiciliary services in the 19th century and the emergence by the beginning of the 20th century of the philosophy that the state should support the family in certain situations had an effect upon the development of domiciliary services. The origins of the two occupations, home help and community auxiliary nurse, are to be found deep in the history of the Poor Laws, voluntary movements of the 19th century, and the emergence of the concern for the health of the mother and child. The foundations of the modern home help service were laid in the middle of the 19th century. Nursing at the early part of the 19th century was at a low ebb; the majority of nurses were drawn from the servant class, working conditions were often appalling, and drunkenness was common. Charles Dickens' depictions of Sara Gamp and Betsy Prig in *Martin Chuzzlewit* were considered to be fair representations of the typical nurse of the early 19th century, a stereotype only now being questioned (Davis 1980, Versluysen 1980). The first scheme to train women to work specifically as district nurses was set up by Rathbone in 1862; by 1873 district nurses were attempting to professionalise their field of work. The National Association for providing 'Trained Nurses for the Sick Poor in London and Elsewhere' indicated the dangers of amateur nursing of the sick and the need for skilled, trained women of "good education" (Kratz 1982: 80). The introduction of a trained community nursing workforce aroused the suspicion of the medical profession. In 1878 the *Lancet* argued that

professional nursing was not suitable for ladies delicately brought up, but rather for properly trained women of the lower classes who had been accustomed to dirty work from their youth (Stocks 1960). The evidence which points to antagonism between district nurses and the Medical Officer of Health and the resulting effect upon the home help service is discussed (Stocks 1960).

Changes in the role of nurses (discussed in chapter five) should be seen in the context of the bifurcation of labour that permeates the health industry. Doctors and, in particular, surgeons, have been elevated in terms of salary and prestige. Doctors increasingly delegated skilled tasks to trained nurses who are in turn happy to transfer routine nursing tasks to others (Cang 1978, Cang and Clarke 1978). As the nursing 'profession' struggles for the status of a profession, moves are in hand to remove the title 'nurse' from all but the professionally trained, retitle those with less training as 'care assistants' and therefore place them as manual workers under the responsibility of the Ancillary Staffs Whitley Council. This move is prompted in part by the trained nurses reluctance to accept the auxiliary as a "real nurse" (Nursing Mirror 1982: 5, Nursing Mirror 1982a: 27, Nursing Times 1982, UKCC for Nursing, Midwifery and Health Visiting 1982: 6). This situation pertains even though no study to date has examined in detail what an auxiliary nurse actually does. It is therefore important to identify what tasks she carries out and if these tasks are compatible with those of a 'manual' worker such as a 'home help'?

Because of the manner in which the two services have developed there are some aspects of both roles which may overlap and cause possible confusion [in the client's mind] which is compounded by the division

between the 'health' providers of care and those who deliver services from a 'social' perspective such as home helps. Should clients and their families in principle have one service which meets both their social and health needs? If so, it might be that such basic nursing and domestic activities could be delegated to one person who would work under competent supervision. The problems of communication between groups such as home helps and health care personnel may be exacerbated when they belong to different organisations. As Hill points out, this problem of communication was one of the arguments for the unification of the personal social services in 1972 and the health services in 1974 (Hill 1982: 72). Wilding puts the argument concerning the present system thus:

"one of the most damaging divisions in our social welfare system is the division of responsibility between health and personal social services... It is the direct result of the relevant professional groups insisting that services be organised around their skills rather than around patient need" (Wilding 1982: 25).

Others have described this split between health and social services as the "most serious impediment to the rational development of priority services" (Brown 1979: 218). Jaehnig argues that

"because professionals control, and seek to control, their own work territory, no one can ensure that an integrated, coordinated package of services is delivered to the consumer. Each professional tends to see his role as crucial and assumes that someone else, somewhere else, is doing any necessary coordination" (Jaehnig 1979: 6).

Wilding believes that lack of co-ordination is the price to be paid for professional control of a field of work and the organisation of services according to provider rather than the client's needs (Wilding 1982: 27).

What effect does this situation have upon the home help service? The effect on the home help service of being controlled by other workers is analysed in chapters two and three, in particular the nursing

profession's efforts to rid itself of the 'domestic' aspect or their role in the late 19th and 20th century. The rapid increase in the numbers of auxiliary nurses employed since 1972, when the responsibility for the home help service was removed from nursing and medical control, is discussed and its effect upon the home help service analysed. Was this phenomenon an attempt by the nursing profession to employ a 'home help' under their supervision and also to control the work of an untrained 'assistant'?

The home help service has always been predominantly a female workforce. How has this affected the development of the service? Some evidence is available to suggest that it has had a profound effect upon the service and this is discussed (Bond 1982) to shed some light on the present day service. It has been argued that the ordinariness of the tasks involved in the home help and auxiliary nursing service, in the sense that it is assumed that any relative, particularly wife or daughter, can manage them, has led to a lowered view of the worth of the service (Bond 1982). If it is of such low status, how will the recognition of the service be brought about (Dexter and Harbert 1983)? A recognition of just what tasks home helps carry out might open up discussions as to the worth and place of the service in relation to other professionals. Information on how home helps view the tasks they carry out could also contribute to that discussion.

It was not until the Second World War that concern for the elderly led to changes in the organisation of the home help services. This period could be said to be the watershed of the service after which it was orientated away from mothers and young children towards the elderly. The reasons for this are discussed in chapters three and four, as is the

effect upon the service of the growing number and needs of an increasingly dependent population. The effect of the slow development in the service and the emphasis upon residential care in the 1940s and 1950s is highlighted. During the 1950s and 1960s the service was perceived as mainly a domestic one but the efforts of some who saw greater potential for the service in such areas as basic nursing or training of families is highlighted in chapters three and four.

Hunt's study of the home help service in the late 1960s hinted at a possible shift of emphasis from domestic to a personal service, a trend which may have increased since the home help was removed from nursing and medical control in 1972 with its placement in the new Social Service Departments. How did this move and, in particular, the reorganisation of the Health Service in 1974, which placed the community nursing service in the health authorities, affect the development of the two services? These issues are discussed in chapter five. Since the home help service was removed from nursing and medical control the number of community nursing 'assistants' has increased dramatically. Are these 'assistants' or auxiliary nurses carrying out tasks that previously were the role of the home help?

The possible convergence of the role of the home help and auxiliary nurse is discussed in chapter six against a background of new methods of providing domiciliary home help or home care services. The swing towards a more personal care service is examined and evidence which might support the supposition that the service may be moving from a domestic to a personal caring service is discussed. Is domestic support still a priority service in the 1980s or does the home help service see personal care as a priority? Data from local research projects is

discussed in order to throw some light on the matter [chapter five and six] but an overall or average national role of the home help service is difficult to picture from these local studies. Local studies, discussed in chapter six, examines different aspects of the home help role and use differing criteria as to what constitutes a particular task.

Within the hospital nursing service work had begun in the late 1960s on identifying qualitative measures of nursing care as a basis for standardising manpower requirements (McFarlane 1970, Ryhs Hearn 1972) but these developments were not matched in any way within auxiliary nursing or the home help services.

The DHSS (1981a: 49) expressed the view that there was some evidence to suggest that there might be some overlap of role between the home help and auxiliary nursing service. No evidence or identification of this overlap was offered but nursing auxiliaries in particular were thought to be performing tasks that were indistinguishable from those performed by home helps. In so far as this situation has developed, it may be a reflection of the extent to which there is a lack of understanding between health and social services (DHSS 1981b: 49, West Berkshire Health Authority 1980, Latto 1982: Simons and Warburton 1980, Dexter and Harbert 1983, Audit Inspectorate 1983). Should a person in need of care be divided into a 'health' or 'social' component? Is it economical to assign two workers to a client, who may be carrying out similar tasks, where one carries out only 'basic health' tasks and the other 'social care' ones?. Are social, environmental and health needs at the basic level inseparable?

The issues discussed in chapter six raise a number of questions. Do

home helps see themselves as domestic workers, do auxiliary nurses carry out such tasks or do they see their role as basic nursing? Is the home help and auxiliary nursing service a rehabilitative service; does either group carry out administrative tasks such as recording and planning care programmes for clients? Do the working practices of the home help service make it difficult for close collaboration with other workers? Do home helps carry out personal and basic nursing tasks and do they perceive these tasks as their role? What tasks do home helps and auxiliary nurses actually carry out in the 1980s for their clients? How do the two groups of workers perceive their roles? Do they carry out differing tasks in differing authorities? To attempt to answer these questions I carried out an empirical study in a number of home help and health authorities, of the tasks that home helps and auxiliary nurses say they carry out and how they perceive their roles. The data collected is analysed and discussed in chapters eight to eleven. The methodology of the empirical study is discussed in chapter eight; the home help and auxiliary nurses' responses are analysed in chapter nine, in chapter ten the variation in practice between differing authorities is examined and chapter eleven is concerned with an analysis of the perceptions that each group have of their role.

Notes on Source Material.

I carried out an extensive review of relevant secondary literature as well as government files at the Public Records Office and also files at the Department of Health and Social Services not yet transferred to the Public Records Office. Files of particular interest were those of the periods 1914 to 1918 and the 1940s, both periods which could be

described as watersheds in the development of domiciliary services. Material relating to the home help service in the years between the two World Wars was difficult to trace but the Journal 'Mother and Child' was a source of relevant data on the home help service at certain periods in the 1930s. Much of the material relating to the development of the domiciliary services was written from a medical or nursing perspective. The available literature indicates that domiciliary care managers (Home Help Organisers) published little material relating to their services. Burr who wrote some articles in the late 1940s and early 1950s was an exception but it should be remembered that although she was a Home Help Organiser she was in fact also a qualified community nurse.

I was allowed access to files of relevant voluntary organisations, in particular the Womens Voluntary Service and the Jewish Board of Guardians. Data in the archives of the J.B.O.G covering the years 1895 to 1905 illustrating the development of the 'Sick Room Helps Society' in the East End of London was particularly useful. Unfortunately the archives were incomplete and most of the information in them came from secondary sources such as Annual Reports and evidence submitted to the Committee On The Poor Law and Relief of Distress in 1909. WVS archives illustrated the part played by that organisation in the development of the home help service during and after the Second World War. The archives of the Institute of Home Help Organisers, which began in the late 1940s, would have perhaps yielded much information but unfortunately only files relating to the evidence given to the Seeborn Committee in the middle of the 1960s survive. The available data did however give an insight into the perception that Home Help Organisers had of the service during the 1960s.

The lack of primary data on the home help service during the early years of this century were constraints which forced me to rely on secondary sources. As I have previously mentioned, much of this data had a nursing or medical perspective which made the information gleaned from J.B.O.G, WVS and the Institute of Home Help Organisers archives particularly important.

Public Records Office files consulted related to the period just before and after the First World War providing evidence of Civil Service and government attitudes towards the development of domiciliary services as did the DHSS files for the period 1940 to 1948. Because of the 30 - year rule no government files were available after 1952. For the period 1950 to 1980 data was obtained from professional journals, government papers and relevant publications. Sources used in the empirical study (Chapter 7 to 12) are discussed in chapter 7.

CHAPTER ONE.

Background to the Origins of the Home Help and Community Nursing Services; the 19th Century.

1.1 Introduction and Summary.

The roots of the present home help and auxiliary nursing service have many diverse strands linked with the development of the New Poor Law, voluntary organisations, the medical and nursing professions; the decline of domestic service, the demise of the 'handywomen', specialisation, infant and maternal mortality and the increasing tendency of the state to intervene in the sphere of family responsibility. In relation to the development of the home help and auxiliary nursing service, other important themes also emerge: the changing patterns of infant and maternal mortality and professionalisation of the medical and nursing professions. These are touched upon in this chapter and expanded in chapter two,

This chapter examines the background from which the modern community nursing and medical services developed. The social, economic and political system of the late 18th and 19th century that led to the development of domiciliary medical and nursing services for the sick in

their own homes is discussed. Events leading up to the New Poor Law are examined and the effect upon the lives of the sick poor analysed. The New Poor Law and its effect upon the emergence of out-door nursing is examined in the light of the seeming lack of interest in developing services in this field among local poor law authorities which, in many parts of the country, led to the emergence of voluntary effort by individuals and groups to fill the gap. The ideological importance of charity during this period is discussed as are the attempts by groups, such as trade unions, friendly societies and sick clubs, to provide support to certain sections of the population. Attempts by voluntary and statutory authorities to develop services were hampered by the lack of trained personnel particularly in the nursing field, a situation which led voluntary bodies to organise training programmes.

The inadequacy of the 1834 Act in dealing with economic and social tragedies such as famine or high unemployment is highlighted and the events which led the Poor Law Inspectors in 1871 to encourage strict adherence to the regulation that medical relief to the sick poor should not be provided in their own homes. The isolation of medical reformers by senior civil servants is discussed and reasons for this stance examined. Reports such as Booth's on poverty, which began to question if the Poor Law was becoming increasingly irrelevant to the needs of an urban society, are examined and reasons for the development of concern for the welfare of the elderly are discussed.

Some argued that wealth had made many of the upper classes more concerned with respectability and materialism and that they held the view that indiscriminate help for the poor resulted in the undermining of a person's character (Young and Ashton 1956). The competitive nature

of the economy led to a concern to maximise worker efficiency and less productive members of society began to be excluded from the workforce, which gradually led to the notion of 'retirement'. This combination of events is discussed against the growing pressure from Trade Unions, employers and others for pensions for the aged.

The growing number of elderly on out-door relief led to criticisms of the relief system by Royal Commissions and Select Committees in the latter part of the century. Growing dissatisfaction with the working of the 1834 legislation led to calls for reform of the system and consequently a Royal Commission on The Poor Laws was finally appointed at the beginning of the 20th century. The evidence given to this commission is discussed to highlight the concern about the need for a more effective community nursing and medical service. Evidence to the 1909 Commission is also examined to throw some light on the attempts of the emerging nursing profession to control untrained personnel working in the field.

1.2 The New Poor Law 1834.

The Poor Law cast a long and dark shadow over attempts to provide statutory domiciliary services. Many writers have given vivid pictures of community medical and nursing support for the sick poor in their own homes during the early 19th century (Report of the Royal Commission on the Poor Laws (RCPL) 1909, Hodgkinson 1967, Rumsey 1856, Bickerton 1936, Rathbone 1890, Webb S and B 1963, Chamberlain 1981). However, before a discussion of these services is entered into it is necessary to set the scene in a broader context in terms of the general economic and social

conditions of the poor and the structure of state, voluntary and community services of the period. Of towering importance to all this was the Poor Law.

The workhouse continued to be the most common institutional refuge for the poor but throughout the 18th century, outdoor relief was the staple element of the Old Poor Law. The money to finance the system was raised by a parish rate levied on property holders and administered by Overseers of the Poor (Blaug 1964). Much of the work of the Overseers of the Poor was supplemented by the work of charities and individuals in a society where charity was seen as an obligation and duty. The recipients of this support were usually the 'deserving poor' or 'industrious labouring classes' as distinct from the paupers who were seen as the responsibility of the Poor Law (Baly 1980: 72). The custom of visiting the poor had very old traditions. "Scripture urged the practice and Christians, from Bishops to working women, carried out the biblical prescription" (Prochaska 1980: 97). Parochial charities added variety to the help available in some areas but charities were unevenly spread and they varied enormously according to the wishes of the living benefactors and the bequests of the dead (Hennock 1973). The late 18th and early 19th century was probably the classical period of the work of locally organised charities, many of whose origins lay in the pre-industrial society (Owen 1965, Nightingale 1973). Charity was of ideological importance enabling the middle class to justify its privileges. This philanthropy has been called a bridge between the reformers' religious consciences and their commercial dealings. "They sought to instil into the poor good principles and a desire for independence, and to raise their moral standards" (White 1978: 10).

However, Nightingale has pointed out that the charitable responded to quite different moral incentives at different periods in history. It has been argued that in the 18th century the charitable, afraid of depopulation, gave to create a well-nourished populace (Nightingale 1973:106). It was also an expression of a well-ordered society; the rich were offered a reminder of their status, and the poor kept firmly in their place; in order to receive, the poor had to behave acceptably and with due deference. The rich man enjoyed his privileges, yet these also bestowed certain obligations upon him. He had a social duty to give to the poor and to provide for them when they were in distress, which meant that much charity was far from impersonal; it represented a complex web of social relationships. Prochaska argues that the giving of charity and visiting the poor was designed to put the establishment in closer touch with the working classes as a means of averting social unrest (Prochaska 1980: 102); others view the motive as genuine philanthropy and a determination to perform what the upper class believed to be their duty (Lascelles 1934: 347). It took some time for the Lady Bountiful to become synonymous with objectionable grandeur and condescension, Towards the middle of the 19th century, charity began to get a dubious name; it was said to rot the character and encouraged the feckless to breed (de Schweinitz 1943: 140-153, Rose 1971: 116, Nightingale 1973: 109).

The eighteenth-century view of poverty was that it served a purpose: it drove the labouring poor to work (Cooper 1983:11). Taxes for poor relief had risen steeply since about 1760 and by 1832 were over six times the 1760 amount, a burden which fell unequally on householders, whereas the increase in wealth was in the manufacturing areas. The places where the poor lived were seldom the parishes where the rich resided.

Consequently, the communities with the greatest need were often the communities least able to pay (de Schweinitz 1943: 114).

Alongside the long years of dissatisfaction with the administration of the Old Poor Laws arose the theories of a new group of economists. Increasingly, people listened to these critics of the old poor law who disapproved of the more generous out-relief system and argued that the poor man ought to be forced to look after himself, making provision through friendly societies for periods of emergency by adopting a more frugal standard of living and limiting the size of his family (Rose 1971: 43-46). The principles of the 1834 Poor Law were designed to redeem the pauper from his own moral baseness; the "new poor law carried Malthusian principles as far as common sense and common humanity permitted - moral rather than political reformation was the best remedy for most social ills" (Pinker 1976: 56). Workers were left to find their true market value.

The average working wage in the early 19th century was barely sufficient to sustain the worker even in good times (Chamberlain 1981: 99). In the 1830s, rural life was as appalling as urban life for many. For example, on the Marquis of Aylesbury's estate, conditions exhibited "a violation of all decency, althogether filthy and disgusting", with, in extreme cases, 12 persons in one room and "depravity which the towns could scarcely have rivalled" (Thompson 1958: 128). Agricultural labourers remained badly paid and discontented which led to rioting in a number of rural districts in 1830. The Whig Government severely suppressed the revolt but some of its members realised that this was not enough to solve the problem. The fear of revolution coupled with the bitterness and rancour which surrounded the many years of debate on electoral

reform ended only after the riots and the Reform Act of 1832 (Rose 1971: 25, Baly 1980: 73). A reformed Parliament announced the appointment of a Royal Commission for Inquiring into the Administration and Practical Operation of the Poor Laws. The Commission was determined to stop the allowance which supported wages and dealt with pauperism. The main tenet of the Commission's philosophy was to "cut off the disease of pauperism at its roots" (Baly 1980: 74), and to carry out this policy they provided support which, when given, would make the applicant's situation on the whole not "really or apparently so eligible as the situation of the independent labourer of the lowest class" (de Schweinitz 1943: 123). This formed the basis of the 'work house test' by less eligibility that was to underlie most social policy for nearly a hundred years. The poor were to live under the shadow of an institution which became essentially penal (de Schweinitz 1943: 124). The 1834 Act reflected the attitude towards poverty traditionally held; that it was largely the result of individual behaviour that was at best unwise and at worst morally reprehensible. The Act recognised that extra workhouses would be needed, the expenditure being justified by a reduction in the number of 'idlers and scroungers'. The workhouses not surprisingly became the objects of bitter resentment, hatred and dread (Parry, Rustin and Satyamurti 1979: 1-20).

The New Poor Law (1834) never denied that it had an obligation to support the destitute sick although the correct principles for dealing with the sick poor were more difficult to determine. The 1834 Report excluded medical treatment from the principle of 'less eligibility', a development which caused tension between 'less eligibility' on the one hand and 'free' medicine on the other. Although apparently unplanned,

the middle of the 19th century witnessed the birth of a patchy and inadequate yet recognisable health service, which in time came to serve poor and non poor alike (Rogers 1889: 250) - a development explained by some as a result of the flexibility and financial strength of the new poor law unions (Flinn 1976: 49). Levey argues that the only practical and effective remedy against "utter destitution of the working-class family in the contingencies of sickness and death was destined to be the Friendly Society" (Levey 1944-45: 142). Others hoped that the sick poor would remain independent by membership of sick clubs, which through payment of a weekly subscription, provided for medical attention and in some case hospitalisation. The earliest Friendly Societies have been traced to the 16th century but the mid-18th century saw their development on a large scale. Granted legal status in 1792 and encouraged by the state as an alternative to Poor Law Relief, they sprang up in many communities. In some cases relief was denied to those who subscribed to the Societies or who were thought capable of subscribing (Webb S and B 1913: 47). It was, however, only the better-off skilled worker who could afford to pay the subscriptions - a number estimated by 1857 to be 4,000,000, which represented, as the 1875 Royal Commission on Friendly Societies stated, about half the male population of working age only a fraction of the total (Chamberlain 1981: 104). To obtain benefits, members' contributions had to be paid up to the date of a claim. Ward in his diary in 1820 writes of a man who had paid twenty pounds in subscriptions over a 26 year period but was excluded from benefit because of his incapacity to pay his arrears;

"thus he lost the provision of sickness and old age which his foresight had made. He is a labourer, and told me feelingly that he was not so strong as he had been, for last winter's starving had pulled him down"

(Bell 1909: 267).

Some contemporary writers argued that Friendly Societies were 'useless thrift' because of the insecurity of the society (Levey 1944-45: 148). Friendly Societies were not a 'good buy' as far as illness was concerned. Clubs provided sickness benefit only to subscribers - working men not their families; compensation for loss of wages rather than medical treatment; many categories of benefit were often excluded: midwifery and certain other serious diseases such as tuberculosis, serious surgery and mental illness (Chamberlain 1981: 106, Thompson 1968: 456-469, Levey 1944-45: 159). Once the worker received his benefit from a Friendly Society, assistance out of the poor rate was often denied him. It was not until 1894 (Outdoor Relief Friendly Societies Act) that Boards of Guardians were legally empowered to ignore, if they thought fit, the fact that applicants for relief had a Friendly Society allowance (Levey 1944-45: 147). Some trade unions, particularly craft unions, paid out large sums of money in welfare benefits; however, craft unions were not typical of trade unions as a whole (Hanson 1975: 247). Relatively little is known about the medical condition of the poor during the years immediately following the 1834 Act. The Home Secretary was aware of the need for new forms of provision to support the growing numbers of the contagious sick (Pinker 1976: 60). Although there had been no attempt to include the sick under the 'less-eligibility' test in the 1834 Act, a person had to become pauperised before being eligible for treatment. The Poor Law Commission refused to provide fully for the sick poor as it might have tempted "the industrious labourer into pauperism" (Poor Law Commission 1841: 11). A point was often reached at an early stage of illness when the assistance of the Poor Law had to be

invoked, and the extant data highlight the pauperising influence of illness. The sick, where classified, always formed a prominent element in all relief lists. Between 1842 and 1868 from 40 to 50 per cent of those in receipt of outdoor relief were sickness or accident cases (Rose 1972: 18). As Flinn has demonstrated, the Poor Law for more than three decades after the enactment of the 1834 statute, failed to guarantee many of the impoverished victims of sickness competent standards of outdoor treatment. No attempt was made to establish a uniform code of medical practice within the framework of the Poor Law until 1842 (Flinn 1976: 48). Even then, the positive gains remained small. Partly, this stemmed from the cumbersome nature of the relief mechanism itself: the District Medical Officer had to await instructions from the appropriate relieving officer to treat a patient. The District Medical Officer, who by 1844 numbered over 2,800, was the key figure in the service (Flinn 1976: 49) and his role was to

"attend duly and punctually upon all poor persons requiring medical attendance, and supply the requisite medicines whenever he may be lawfully required by an order of the Guardians, or of a relieving officer, or of an overseer" (Fowle 1906: 125).

Medical relief was not uniform. The exercise of local discretion led to different levels of service;

"no two officers take the same views as to the nature of their duties or the best way of performing them; and, what is worse, no two destitute persons under similar circumstances can be at all sure of being dealt with in the same way" (Fowle 1906: 126).

The slow development of the medical services owed much to the contemporary obsession with economy which resulted in the Poor Law medical service being starved of funds. There was a fundamental gap between the needs of the poor and the willingness of the ratepayers to pay (Flinn 1976: 51, 54). One of the greatest developments made under

the Poor Law Board in the late-19th century was, according to Hodgkinson, the establishment of a trained nursing service which was linked with the evolution of the Poor Law Infirmary (Hodgkinson 1967: 556). The 'indoor' sick poor were cared for in conditions that "were mostly a standing reproach to a nation which thought of itself as civilised" (Flinn 1976: 55).

In theory, outdoor medical relief was to be granted in preference to indoor relief but in many cases the principle of 'less eligibility' was applied to the sick as well as the poor. As a consequence, workhouse infirmaries found themselves accommodating numbers of sick poor beyond their original capacity, with few trained staff (Chamberlain 1981: 101). In 1886, there were only 111 paid nurses in all of the London metropolitan workhouses together. By 1893, this number had risen to 784 (Barton 1913: 150). Workhouse infirmaries were a double charge on the ratepayers in so far as they called for both capital and current expenditure. The writings of Dickens (1860), Cobbe (1861), Rumsey (1856), Rathbone (1890) all highlighted the inadequacies of the workhouse nursing system. It was never the intention of the Poor Law Commissioners that large numbers of sick should be confined in workhouses; but, as Baly points out, they had not appreciated the extent to which sickness and poverty go hand in hand (Baly 1980: 75). Sickness has always been a cause of poverty: as Flinn postulates, the more advanced the forms of social and economic organisation the more acute the problem of poverty becomes. The Industrial Revolution, by polarising rural society, and by increasing the proportion of urban dwellers made new demands on society's resources (Flinn 1976: 45).

The revolution in both hospital and community poor law nursing came with

Florence Nightingale but there had been attempts to reform nursing before the Crimean War. Louisa Twining in the 1850s campaigned against the inadequacies of poor law nursing and the lack of training given to those who nursed the poor sick (Twining 1858). Twining has been accused of arguing for the professionalisation of nursing, the "replacing of the gifted amateur with the full time professional" (White 1978: 21). Also, at this early stage in the development of the nursing profession some members of the medical profession defended the status quo arguing that training was "superfluous" (White 1978: 24). The attitude of the poor towards the workhouse tainted the Poor law and acted as a barrier to reform, which may account for the development of voluntary services and their use by many of the population. Religious bodies in towns such as Liverpool had assisted and nursed the sick poor; in 1840 Elizabeth Fry established a nursing society to nurse the poor in their own homes (Baly 1980: 47); and the better off members of society employed nurses to look after the sick (Rathbone 1890: 24, Abel-Smith 1979: 2).

1.3 The Development of Community Medical and Nursing Services.

The Poor Law Commission did not begin to issue General Orders on out-door relief until 1841. All previous orders had taken the form of 'Particular Orders' (which did not have to be submitted to the Home Secretary or laid before Parliament) issued to individual unions or parishes. Before its demise in 1847 the Commission had issued two General Orders concerning outdoor relief which were concerned with maintaining the principle of 'less eligibility'; but up to 1847 no policy had been formulated as far as the maintenance of the sick was

concerned although the practice seemed to allow for outdoor relief in the form of food or clothing. Meat, milk, wine and porter could also be granted by the local authority on the recommendation of the medical officer (Webb, S and B 1913: 47, 48, Glen 1898: 442-449). The Poor Law Board took office in 1847 and in order to provide more central control, issued a third Order on outdoor relief in 1852 which covered the sick and aged as well as the able bodied. However, it indicated that after one week's support the indigent poor person had to be received into the workhouse (Rose 1971:146, Webb, S and B 1913: 116). Indignant Boards of Guardians protested at this interference with their powers of discretion; the Order was amended later that December and included exceptions such as the sick and aged. A second 1852 Order stipulated that outdoor relief might be given in cases of sickness even if the head of the family was simultaneously earning wages (Rose 1971: 146, Hodgkinson 1967: 271). As a consequence of the panic caused by the cholera epidemic of 1866 the Guardians were empowered to provide whatever sustenance and clothing might be required, irrespective of 'destitution'.

It was not until 1869 that the Poor Law Board classified the causes of destitution under four headings:

"(a) old age or permanent disability; (b) death or absence or desertion of husbands or fathers; (c) temporary sickness, or want of work of male heads of families or single men; (d) single women in receipt of outdoor relief" (Hodgkinson 1967: 270).

Using this classification, in London in 1870 the total outdoor poor were classed by percentages: 31 per cent were in category a, 34 per cent in each of categories b and c and only 0.8 per cent were single women. Over the whole country 30 per cent of indoor and 13 percent of outdoor

poor were actually on the sick list (Hodgkinson 1967: 270). In the early-19th century the concept of medical care to poor persons in their own homes was of the simplest. Beatrice Webb wrote;

"The fundamental failure of the Poor Law with regard to the sick lies in its very nature. It is inherent in any poor Law that it is confined to the relief of the destitute; until the man stricken with disease had become so ill as to be unable to go to work he is not destitute. But when the disease has gone so far as this, it is usually too late to prevent its ravages" (Webb 1909: 4)

It was usually the relieving officer, not the medical officer, who diagnosed sickness in the first instance. Appointed under the Poor Law to assess individual cases of destitution and award relief as appropriate, they also judged claims for sick relief (Griffin 1861: 376, Hodgkinson 1967: 288). Medical officers insisted that relieving officers were not competent to judge whether an applicant for relief genuinely needed treatment or not. Relieving officers, on the other hand, backed by the Guardians, claimed that medical officers took too little account of the many moral and economic factors involved in determining whether or not an applicant was a fit recipient for the proceeds of the poor rates (Flinn 1976: 47). Diagnosis was usually based primarily on an assessment of the applicant's income. To have done otherwise would, it was thought, have opened the floodgates of medical provision for all. As the Poor Law Commission itself commented in 1841:

"This superiority of the condition of the paupers over that of the independent labourers as regards medical aid will encourage a resort to the poor rates for medical relief and will thus tempt the industrious labour into pauperism" (Flinn 1976: 8, Hodgkinson 1967: 288).

By 1853 nearly all medical officers had security of office and by 1854 the cost of medical relief stood at four million pounds (White 1978: 20). Even so, doctors were provided on the cheap, were overworked and, until 1858, often appointed with little regard to qualifications

(Chamberlain 1981: 101). Drugs and dressings were not provided out of the Poor Rate, a situation which hampered the work of many doctors as did the absence of trained nursing assistance (Hodgkinson 1967: 287).

By 1865 Boards of Guardians were encouraged to provide quinine, cod-liver oil, and "other expensive medicines" to the sick poor (Webb S and B 1913: 117), a change in policy which was the outcome of a long campaign by the medical profession supported by Members of Parliament and the Lancet (Webb S and B 1913: 117). In 1867, Poor Law dispensaries, ensuring a regular supply of medicines and appliances, were operating in London (Webb S and B 1913: 118) - a reform condemned by Poor Law Inspectors after the 1871 crusade against outdoor relief (Webb S and B 1913: 207-8).

Parallel with these reforms ran the development of district nursing, which marks the beginning of public health nursing in England, supplementing as it did the existing system of poor law medical relief. In district nursing reform, as in workhouse nursing reform, Liverpool was to lead the country (Rathbone 1890). Trained nursing support, as distinct from medical services for the sick poor in their own homes, had been discussed since about the 1850s. In his 'Essays on State Medicine' Rumsey recommended that "one or more Midwives duly qualified and licensed, should be appointed in each subdistrict, for attendance on destitute women" (Rumsey 1856: 53). Rumsey was one of the first to put forward that nursing the poor was an important task and not one for the untrained who were "equally low in habits and depressed in circumstances" as the poor themselves (Rumsey 1856: 411). One of the first attempts at providing a trained district nursing service was organised in London by the Sisters of Mercy, an Irish Catholic Society,

who in 1839 set up a house from which they set out to nurse the sick poor in their own homes. A similar establishment (organised by the Sisters) was in operation in Liverpool by 1843 (Bickerton 1934: 203).

However the development of such services was still only of localised character by the end of the 19th century (Rathbone 1890: 6). In many parishes the elderly and sick poor were living in extreme poverty and supported only by "aged women" (the handy-woman) who went out "charing and nursing". It is clear that much community support came from neighbours and untrained women (Booth 1894: 108, 116, 120, 140, 158, 160, 206).

As discussed earlier, for the working class population, access to medical or nursing support was through either the Poor Law, charitable institutions or Friendly Societies but these services were limited and selective. It was thought by some members of the medical profession that hospitalisation of the sick poor was in their interests as many homes were unhygienic and unsuitable to allow proper nursing care. Rathbone, however, set out to educate the public that the poor sick might be better off nursed in their own homes. In particular, he felt that those suffering from chronic or incurable illness might benefit from home nursing and he argued that there were psychological benefits to be gained from having familiar surroundings and family and friends at hand. He was the first to point out that keeping the patient at home could be cheaper than treatment in hospital (Rathbone 1890: 7, 14, 121).

Rathbone was writing in 1890 from many years of experience of community nursing services. His wife had died in 1859 but in her last months had been looked after by a very skilled nurse, Mary Robinson. Having seen and experienced the benefits of her services, he engaged her for three

months to nurse poor patients in their own homes (Bickerton 1963: 205). She received much support from Rathbone who wished to extend the service but the shortage of skilled nurses delayed the introduction of an extended scheme. Arising from his experiences, he came to the conclusion that

"among the less fortunate - the poor - untold misery, lasting disability, and death itself must ensue in cases where these comforts and appliances, as well as skilled nursing are almost altogether wanting" (Rathbone 1890: 15, 19).

In order for workhouse and community nursing to develop, the reluctance of the guardians to pay for nursing services had to be overcome. Rathbone overcame this hostility (in the early 1860s) in Liverpool by offering to put a team of trained nurses into the infirmary at his own expense. At the end of three years the Guardians accepted the cost of training and retraining nurses (Fraser 1976: 63).

In order to provide the skilled and trained nurses for community work he also helped organise the Liverpool Training School and Home for Nurses whose objective was to provide trained district nurses for the poor in their own homes. On completion of training the nurse was expected to spend at least eight hours a day nursing the sick and keeping their home clean.

A nurse working with the sick poor in their own homes at this time had a varied nursing and domestic role. She was expected to do

"whatever was necessary for the patient and but for her would be left undone. In the home of the sick poor this includes, of course, many things which are not generally supposed to come under the title of nursing at all, but which, in their case, are most important accessories to it; such offices for example, as cleaning the sickroom of lumber and unnecessary furniture, sweeping floors and lighting fires" (Rathbone 1890: 28).

1.4 Community Nursing in the 19th Century. Nurse or Domestic?

The district nursing system was taken up by voluntary organisations in other parts of the country. Despite these attempts to extend the service it was noted in 1874 that the

"deficiencies of nursing in London - both as to the number of nurses employed, and the character of the nurses - were far greater than had been imagined, that most of the attempts to supply these deficiencies had been unconnected and unsystematic, and that the number of really skilled nurses employed was very small" (Rathbone 1890: 48).

The newly established Metropolitan and National Nursing Association set out to remedy this situation by establishing Local Nurses' Homes which lodged up to six nurses who served the sick in the locality. They set very high standards as it was felt that community nurses were in positions of greater responsibility than nurses who worked in hospitals under supervision. The effect of this was to raise the status of the district nurse in the eyes of the public and as a consequence Queen Victoria in 1887 donated a large part of the Jubilee Fund to the founding of the Queen Victoria Jubilee Institute for Nurses. This Institute, under the direction of Florence Nightingale, set out to establish throughout the country a national association of district nursing (Rathbone 1890: 114).

Towards the end of the 19th century a substantial part of the district nurse's role was concerned with domestic and cleaning duties, although skilled nursing was very much part of her task; her responsibilities were wide indeed. Miss Lees of the Metropolitan Nurses Association outlined what she saw as the nurse's role in the homes of the sick poor:

"Upon entering a close, unventilated room, too often in an indescribable state of filth and vermin, the nurse's first duty is to see that the bed of the patient is so arranged as to have the greatest amount of air, light, and space possible, which in most cases,

necessitates a total rearrangement of the furniture in the room. That done, the nurse washes and arranges the patient, makes the bed, applies any dressings required, then dusts the room, ventilates it, empties and washes all utensils, dirty glasses, etc, and when necessary disinfects utensiles and drains, sweeps up the fireplace, fetches fresh water and fills the kettle. With helpless patients, she takes the necessary precautions against the formation of bedsores; and in serious cases, or when desired to do so by the doctor, takes a strict note of the variations in the disease which a nurse ought to know and observe" (Rathbone 1890: 56-57).

Florence Nightingale writing in the Times in 1876 argued against the trend of using trained nursing staff for duties other than nursing:

"A nurse is, first a nurse. Secondly, to nurse the room as well as the patient - to put the room into nursing order. That is to make the room so that a patient can recover in; to bring care and cleanliness into it and to teach the inmates to keep up the care and cleanliness. Thirdly, to bring such sanitary defects as produce sickness and death, and which can be remedied by the public, to the notice of the public officer whom it concerns. A nurse cannot be a cook though sweet Jack Falstaff says she is a relieving-officer, district-visitor, letter writer, general store - keeper, upholsterer, almoner, purveyor, Lady Bountiful, head dispenser, and medical comforts shop" (Nightingale 1876).

It is obvious from these descriptions of the role of the district nurse that much of her time was taken up by unskilled tasks which could have been carried out by a less qualified or unskilled person, which in turn could have freed the nurse to carry out more specialised tasks. Even at this early stage in the evolution of the nursing profession, domestic or cleaning duties were not thought by some to be normally part of the skilled nurse's role. This state of affairs, however, did not go unnoticed and by the end of the 19th century many nurses and doctors were pointing out that there was much misuse of the trained nurse and others questioned if some other form of worker could best carry out the non-skilled jobs. The beginning of attempts by the nurses to strive for the status of a profession can be identified in their moves to delegate tasks to untrained workers and control those groups. Miss Dowding in 1894 wrote that there was much "strong and deep rooted prejudice"

against the development of the nursing assistant grade in some trained nurses. She, however, felt that there was a role for the untrained nurse assistant to be seen not "in rivalry, but as subordinate to due authority " (Dowding 1894: 163).

Fears were expressed by many nurses that the system of district nursing would become a new system of distributing relief among the poor. The supply of medical comforts was allowed only when absolutely necessary so as not to create competition between the relieving officer and the nurse (Nightingale 1876, Rathbone 1890: 31). The Matron "possessed a valuable power of control over the selection of cases to be nursed, and over the methods of nursing to be employed. She kept the nurses to their appropriate work, and checked any tendency which might exist to allow relief-giving to take the place of nursing" (Rathbone 1890: 36). Those poor who were in receipt of relief during this period were supposed to be visited frequently by the relieving officer. Authorities were willing to consider granting outdoor relief to sick persons who refused to enter the workhouse and in 1878 the Local Government Board were in favour of supplying the sick poor not only with medical attendance but also skilled nursing attendance in their own home, a view arrived at under medical pressure. The lack of trained nurses was to render impracticable for some time the general "application of the system of paid nurses in the treatment of the poor in their own homes" (Webb S and B 1913: 210). Some writers like the Webbs inferred that there was internal conflict within the Local Government Board, who, although expressing encouragement of the use of trained nurses in the home, nevertheless did not issue an Order allowing their employment until 1892. However, the nurse could only attend upon the poor in their own homes if the

relieving officer had granted medical relief in the first place (Glen 1898: 181). The District Nurses Order of that date was merely permissive and in the minds of some commentators did not go far enough in encouraging or allowing the widespread use of nurses, appointed by the guardians, in the homes of the poor. The circular accompanying the Order ran

"it can only be under exceptional circumstances that a sick pauper, whose illness is of such a character as to require that the services of a nurse should be provided by the guardians, can, with propriety, be relieved at home. At the same time it appears... where circumstances render it desirable the nurses employed in such attendance should be duly appointed officers of the guardians, having recognised qualifications for the position, and being subject in the performance of their duties to the control of the guardians, and the Board have consequently decided to empower boards to appoint such officers " (Webb S and B 1913: 211).

By 1893 it was alleged that only about a dozen Poor Law nurses for the outdoor sick were in post (Webb S and B 1913:211). However, it should be remembered that many guardians paid elderly women to nurse the sick in their own homes (Booth 1894: 156). Inspectors in 1897 and 1899 reported few Unions appointing District Nurses but some Guardians had attempted to provide support to the sick in their own homes by requiring trained Workhouse Nurses to take on the task of working in the community by taking turns on "district duty, visiting all the outdoor sick, for two months at a time" (Webb S and B 1929: 338).

White points out that the justification for this in many cases was to prevent admission to the workhouse infirmary (White 1978: 69). Other Unions paid a subscription to District Nursing Associations to provide a service, a system seen by some as contributing to the slow development of the statutory services (Webb S and B 1929: 336). The 1909 Poor Law Report, however, found that over a large part of the country, the sick

in their own homes were unprovided for, "For the most part...with regard to the nursing of their outdoor poor, Guardians have shown themselves strangely apathetic" (Webb S and B 1929: 338).

As discussed earlier in this chapter the Metropolitan Poor Law Act 1867 allowed Poor Law Unions to introduce a hospital system and by 1891 about 16 percent of Poor Law beds were in specially designed hospitals (Baly 1980: 139). The main provisions of the 1867 Act allowed for separate institutions to be erected for the insane and for those with infectious fevers (Baly 1980: 80). The substitution of indoor for outdoor relief for the sick was being supported on grounds of medical efficiency.

The transformation of many of the workhouses into what the Poor Law Inspectors called 'State Hospitals' contrasted with the inadequate and insanitary conditions in which many of the sick poor lived. In 1897 The Local Government Board issued an Order defining what qualifications and experience workhouse or Infirmary nurses should possess (Glen 1898: 434-438, Abel-Smith 1979: 46). However, by the end of the century many authorities still employed unqualified nurses; indeed, Beatrice Webb accused many workhouses of employing 'mentally defective paupers' in the role of nurse (Chamberlain 1981: 110). One important outcome of the Act was a change in attitude towards the sick poor. The Guardians were pressed to form Sick Asylums exclusively for the sick, and the poor were persuaded to enter these institutions "where their medical needs could be adequately met" (Webb S and B 1929: 324).

1.5 Poor Law Reform.

The Poor Law by the middle of the century had begun in some cases to show a less inhumane attitude which mitigated some of its unpopularity, but by the 1870s a sterner attitude on the part of the officials brought a return to 1834 principles. The significance of this development for the domiciliary nursing and domestic services was a stifling of the initiatives of the 1860s by a return to the strict 'less eligibility' of the 1870s. The Poor Law now became an instrument of social control through the exercise of local power. Its inadequacies became increasingly exposed; famine in parts of the country had shown the futility of the Poor Law in the face of high unemployment. Between 1871 and 1921 the population in England and Wales rose from 22.7 millions to 37.9 millions; the birth rate dropped from 35.4 per 1,000 to 13.5 per 1,000. The trend towards an older population was confirmed: in 1851 the age group 15 to 64 showed a return of 598 per 1,000 but in 1911 it was 639 per 1,000 and for the age group over 64 the respective figures were 47 per 1,000 and 53 per 1,000 (Stern 1962: ch2). The Lancet revelations of 1865 highlighted the state of the sick poor in the workhouse; but most alarming to many was the fact that a number of Boards of Guardians were giving out small sums of money to relieve able-bodied paupers and leaving them to bring their allowances to subsistence level by begging, stealing or working at ill paid jobs (Fraser 1976: 222). With the appointment of a New President of the Poor Law Board by Gladstone in 1868 and the setting up of the Local Government Board a sterner attitude towards the administration of relief was ushered in. Goschen as president of the Poor Law Board continued

with this attitude towards the administration of relief. His minute on poor relief in London in 1869 condemned the practice of giving outdoor relief in aid of earnings and suggested greater co-operation between Boards of Guardians and charitable agencies (Rose 1971: 226). Goschen's successor at the Local Government Board, Stansfeld, shared his anxieties and issued a circular to Inspectors in 1871 encouraging them to impress upon Guardians the need for a much stricter adherence to the regulations and thus a reduction in the number of recipients of out-door relief. Many Boards were willing to carry out these instructions (Webb S and B 1929: 351, Rose 1972: 230). Lambert, one of the Joint Permanent Secretaries of the New Local Governemnt Board, was a great believer in the principles of 1834; he also disliked medical specialists and believed that policy formation was the prerogative of the layman. He consequently launched a campaign against out-door relief and isolated the medical reformers (Lambert 1963: 523-524). de Schweinitz argues that the Poor Law was under the influence of the same trends in thought that had determined the development of the charity organisation movement - "an aggressive individualism, reinforced by the conviction that the doctrine of the survival of the fittest could be successfully applied to human society (de Schweinitz 1943: 156). H. Longely, a London Inspector, succinctly stated the policy of the campaign: "indoor relief shall be the rule and outdoor relief the exception" (Poor Law Commissioners 1874: 169). In many Unions everybody asking for relief was offered the workhouse" (de Schweinitz 1943: 157) - a policy not however implemented without criticism by some Guardians (Rose 1971: 239-252).

The observations of the Inspectorate and others had shown that many Boards of Guardians had no informed or constructive policy for meeting

the needs of the poor. Many of the reformers of the period, such as Octavia Hill, were drawn from the philanthropically minded who felt that any form of Government expenditure and activity was dangerous, and threatened the moral character of the poor and destitute. As the Webbs later pointed out, these reformers were very successful. The number of persons receiving relief in 1877-1878 was lower than any year since 1849 (Webb S and B 1929: 1042-1043). This hardening attitude on the part of the Inspectorate found support in the form of the Charity Organisation Society. Charities in London had been spending nearly twice as much as the Poor Law expenditure in that city (Pinker 1976: 74). Many of the members of the Charity Organisation Society became Guardians and enforced their principles. However, others such as Booth and Rowntree were beginning to show, by their dispassionate enquiries, that the causes of poverty were low wages, unemployment and old age - situations over which the individual had little or no control. They showed that the Poor Law had made few attempts to tackle the causes of poverty and their findings raised doubts as to whether the Poor Law was the proper agency to relieve poverty. Allegations that it was irrelevant to the needs of an urban industrial society became increasingly widespread. Particular criticism was directed at the treatment of the aged and children (Rose 1971: 23). The individualistic philosophy of the first half of the 19th century was slowly giving way to a more collectivist way of thinking and a feeling that the state had a responsibility for the weaker sections of the population.

The large proportion of the elderly receiving indoor relief as a result of the 'reform' of the Poor Law in the 1870s caused concern. The criticisms of the Royal Commission on The Aged Poor in 1895 and the

Select Committee on the Aged Deserving Poor of 1889 led the Local Government Board to recommend that the aged poor be treated with greater sympathy (Rose 1971: 252). The elderly poor became a widely recognised social problem in the late 19th century. Why was this so? The mid-19th century was the peak of migration, many young left the countryside for the towns leaving behind ageing rural communities (Thane 1982, Horn 1976). Horn graphically illustrates the plight of the rural aged poor during this period (Horn 1976: 198-218). By 1905, 80 per cent of England's population was dwelling in towns and cities (Rose 1985: 13). Old people who had no family looked to charity, the philanthropic agencies which grew in the late 18th and early 19th century, or to the Poor Law. The opportunity for self help expanded with the development of Friendly Societies and Trade Union Pension Schemes but these existed mainly for men (Gilbert 1964). However, the passing of the Unemployed Workmen Act of 1905, it has been suggested, alarmed those members of the Local Government Board and Charity Organisation Society who were hoping for a stricter system of poor relief. The 1905 Act could encourage the tendency for able bodied to present themselves for relief (Rose 1971: 263). Pressure was brought to bear on the government to reform the system. A prominent source of that pressure was J.S. Davy of the Local Government Board who was imbued with the ideals of the 1870s. The Conservative Government of Balfour in its last month of office agreed to set up a Royal Commission to inquire into the working of the Poor Laws. The overall composition of the Commission was biased towards those who might be expected to support the deterrent principles (Pinker 1976: 80). The late-19th century also marked the development of working class organisations as an important force in English life. Membership of

unions expanded with an explosion in growth from one-and-a-half million members in 1890 to nearly four million by 1913 (Halsey 1972). The 1880s and 1890s also saw the emergence of working class political organisations, some of which came together to form the Labour Party in the early 1900s. During the first 10 to 20 years of this century the Labour Party and trade unions were vociferous in demanding social reform in such specific areas as free education, old age pensions and the provision of a health service (Hay 1975: 27).

1.6 Royal Commission on the Poor Laws, the State of Domiciliary Nursing and Health Services.

There was general agreement in the Majority and Minority Report that the Guardians should be disbanded and be replaced by Local Authorities; that deterrence and 'less eligibility' should be abandoned; that more should be done to give positive help to those in need, especially old people, children and the unemployed; and that the disfranchisement of those in receipt of relief should be limited. There the agreement ended. The Minority Report recommended the break up of the Poor Law, the Majority Report wished to rename it 'Public Assistance'. The Poor Law and private charity were to be retained; the Report made it clear that there was to be no changes in principle but only improvement in machinery. The Majority's proposals for medical care were not very ambitious. Its recommendations, it has been argued, were no more than a muddled Medical Assistance Committee under the Public Assistance Authority, with contributory 'Provident Dispensaries' for all below a certain wage level (Bruce 1968: 205). The Minority Report was largely the work of the Webbs

and made a great impression on its publication.

"It insisted that destitution, not pauperism, was the problem, that conditions of life for so many people were such that they could not unaided escape extreme poverty and that the remedy lay not in relief but in prevention" (Bruce 1968: 206).

What they suggested was a mobilisation of the community's resources as;

"would prevent anyone, at any age, from falling into destitution. Children were to be properly cared for and educated, adults were to be protected against sickness, disablement and unemployment, the elderly were to be assured modest income. There was, in short, to be a recognised 'national minimum' below which no-one was to be allowed to fall, 'the provision, for the citizens, of whatever was called for in the public interest' " (Bruce 1968: 206).

Much was said in the evidence given to the Commission about Poor Law medical services and the state of district nursing and domestic support in the homes of the poor in the last century and the first few years of this century. Very little co-ordination or co-operation existed between the various Nursing Organisations and the Boards of Guardians who in general had appointed outdoor nurses in only very limited numbers. This resulted in much of the care of the sick in their own homes falling on friends and neighbours or casual untrained helpers.

In many cases sick persons were left without any nursing support at all. While criticising the Poor Law Guardians for not developing nursing services the Commission realised that they had great difficulty in recruiting suitable staff and that "owing to prejudice and ignorance, the poor often resent the intrusion of a trained nurse whose ideas of cleanliness and order are not in accord with their habits". Many who gave evidence to the Commission felt that "the outdoor nursing question" was "the most important question with which the rural Guardians had to deal" while some District Medical Officers put forward the view that many cases "die simply from want of proper nursing" (RCPL 1909: 359).

Dr McVail and others believed that one way to improve the service was to build up a supply of persons willing and able to carry out the domestic and less skilled nursing tasks. He argued that:

"there is nursing and nursing. What many paupers need is a little skilled guidance in tending chronic ailments and in others it is housekeepers rather than nursing that is wanted - the washing and cleansing of an aged man or woman, attention to body and bed clothing, the keeping of the house clean and fresh" (McVail 1909: 112).

The staff of the County Nursing Federation were very much against the use of trained nursing staff for domestic or cleaning duties or for the employment of untrained assistant nurses (RCPL 1909: Q 72458 Appendix IX Vol VI VII). How far this attitude towards assistant nurses is due to the trained nurse's fear of an unqualified rival is not clear.

The County Nursing Federation had been formed to co-ordinate and monitor the work of the various small voluntary nursing organisations which had sprung up over the years (RCPL 1909: Q 72408 Appendix IX Vol VI VII). Like many organisations they argued that nurse attendants should be employed to supervise the homes of the sick poor (RCPL 1919: 11 Q 485577).

Dorset Health Society had made positive attempts to provide some form of support whereby trained nurses supervised groups of untrained nurses called 'cottage nurses' who carried out many of the unskilled nursing and domestic tasks in the homes of the poor. Some actually lived for a period in the home of the patient.

It was stated that they were not;

"trained nurses but they worked under the supervision of a trained nurse. They do not do the trained nursing work but they do the general work of getting the patient in a condition to benefit by trained nursing, - that is, they clean the cottage, they will do the cooking, they will keep the windows open, they will take the sack of straw out of the chimney and clear out the accumulation from under the bed, they will wash the people, and see that the beds are properly made and properly sheeted, and that the patients are properly dressed, properly washed and

clean. All these details they are able to do just as a trained nurse would do it, and they relieve the trained nurse from that work" (RCPL 1909: 424 Q 9337).

It was later put very forcibly that this type of appointment saved the trained nurse much "time and energy" (RCPL 1909: 424 Q9338). The East Riding Nursing Association also provided a nursing service to the poor in their own homes but only to those who had paid a subscription. A special feature of this service was that "the nurses in all cases, except in Beverley, sleep in the houses of the patients. The nurses are not so highly trained as those attached to the Queen Victoria Jubilee Institutions" and were "drawn from a different class". These nurses in the Association numbered 55 and during the year 1907 nursed 541 patients half of which were maternity cases (RCPL 1909: 174 Appendix XV).

The accumulation of evidence as to the deficiencies in the community nursing services and arguments for the development of a support system for trained nurses were so forcibly put to the Commission that they recommended that "immediate steps be taken for the organisation of a satisfactory system of nursing, or attendance, for the outdoor sick poor; the nursing arrangements should, from time to time, be inspected by both the Public Assistance Authority and Local Government Board" (RCPL 1909: 369). This recommendation applied to services for sick mothers and young children and it was in the field of Infant and Maternal Mortality that the recommendation had most effect, a development discussed in the next chapter.

1.7 Summary and Conclusions.

In this chapter a number of themes have emerged: some, such as the adherence by the Government to the principles of self help; the pauperizing effect of illness; and the trend from individualism towards collectivism or state responsibility had indirect effects upon the home help or nursing services. Other trends, however, such as the professionalisation of medicine and nursing, the disappearance of the handywomen, lack of skilled nursing personnel and the developing awareness of the needs of the elderly were to have a more direct and immediate effect upon the development of the home help and nursing services.

The society which created the 1834 Poor Law was slowly and painfully learning to accommodate itself to the changes and strains brought about by pressures of economic and population change. The Industrial Revolution and increases in population occurred in a society with limited resources and techniques in the areas of government and official administration (McCord 1976: 87). Society was not able to provide enough educated persons to fill the growing number of posts in fields, such as nursing, for which specialised skills were necessary (Pinker 1976: 64). Society's attitude towards poverty and the response of individuals towards the Poor Law, coupled with the inability of the system to help the sick until they became destitute, acted as a barrier to reform. The creation of an embryo medical service in the Poor Law and Friendly Society movement only catered for skilled men; Friendly Societies only provided income maintenance for the sick, not medical treatment.

Many groups of workers were striving for the status of a profession.

Medical Officers of Health, for instance, were in conflict with Relieving Officers in a system which placed much emphasis upon economic status rather than the health of the patient (Flinn 1976, Hodgkinson 1967). Nurses striving for professionalisation came into conflict with not only the relieving officer (Nightingale 1876, Rathbone 1890) but also the doctor, (Rathbone 1890) the untrained assistant (Dowding 1894) and the 'handywoman' - developments discussed in following chapters. This drive for professionalisation was a strong force: despite the lack of appropriate personnel, both nurses and doctors sought to abolish the 'handywomen' who had provided a basic personal service to families for many years. This development (discussed in chapter 2) had a profound effect upon the home help and nursing service during the 20th century. Nurses working with the sick poor had a mixed nursing and domestic role which caused much soul searching within the profession which had profound effects upon the way in which the home help service was organised and the tasks which it carried out in this century. The deficiencies and shortcomings of the home nursing system were many, and organisations such as the Metropolitan and National Nursing Association set out to define high standards and raise the status of the district nurse. These attempts to professionalise the work of the nurse eventually led to the raising of standards but they also in part led to the delegation of 'non nursing' or 'basic nursing' tasks to 'assistants' and the eventual emergence of the community nursing auxiliary in the 1960s. The nursing professions' abivalence towards the untrained assistant or auxiliary is still a concern in the 1980s.

The emergence of the community nursing profession and the untrained nurse or 'assistant' working under trained supervision can be understood

in terms of the development of professions within a pluralist society. The wish of nurses to separate domestic tasks from the skilled nursing role and the trend for the medical profession to see the nurse as subordinate to them are indications of the professionalisation of the nursing and medical services. The professionalisation of decision making in an advanced industrial society, such as England in the 19th century, can be seen as part and parcel of the trend towards more complex forms of social organisation. Increasingly, skilled personnel, such as nurses, doctors, and midwives, were necessary to develop knowledge and skills in highly specialised fields or to make decisions which had most fundamental implications for individuals and families (Dunleavy 1981) developments which are traced in more detail in chapter two. The Royal Commission on the Poor Laws showed how little co-operation and co-ordination there was between the various nursing organisations and the Board of Guardians, resulting in inadequate and, sometimes, non-existent care of the housebound sick.

By the end of the 19th Century, the elderly poor had become a widely recognised social problem. The increasingly competitive nature of the economy and the need to maximise worker efficiency, led to a gradual easing out of the less productive members of the workforce, e.g. the old, introducing the concept of retirement and pensions. This section of the community was not to have effect upon the development of the home help service until the 1940s.

CHAPTER TWO.

The Development of the Maternity and Child Welfare Services up to 1940.

2.1 Introduction and Summary.

In this chapter the emergence of the professionalisation of nursing is examined and the struggle with the medical profession for control over nursing training and work is analysed. The medical profession's wish to control Midwifery is discussed as are the events leading up to the Midwives Act of 1902. One result was that both groups began to campaign for the demise of the 'handywoman' who for centuries had supported families in times of stress. The eventual outlawing of this group of women is discussed and related both to the emergence of nursing as a profession and to the development of the home help service.

The government's reconstruction policies after World War One are examined. The effects of the setting up of the Ministry of Health in 1920 upon the development of Maternity and Child Welfare services, and indirectly the home help service, are analysed. Attempts by government to lower the rate of infant mortality are discussed and the small part

played by the new home help service is highlighted.

The war brought many changes to the country; it tested social institutions and forced re-organisation in many areas. Priorities were reassessed, old inadequacies highlighted and the trend towards collectivist economic and administrative policies continued. The war highlighted the critical need for labour in the armed services, the factories and on the farms. This shortage of manpower strengthened the market position of the working classes (Marwick 1974: ch1). The First World War caused much distress to the civilian population and also distorted the traditional work pattern for women. After the war, women were reluctant to return to their traditional roles. Domestic service suffered and the effect of this upon families is discussed, as are the government's attempts to alleviate the problems caused to middle-class families. The difficulties in developing services between the wars are examined against the background of economic decline and the unavailability of suitable or trained domestic personnel.

Finally the attempts to introduce 'assistants' to provide support to trained nurses are discussed and their attempts to control the development of this group of workers are analysed.

2.2 Maternity and Child Welfare.

From the 1870s onwards, the birth rate in Britain was falling,

"and at the same time Britain's imperial supremacy was threatened by the growing industrial imperialist nations of Germany and the United States. The question of guaranteeing the supply of labour power, in terms of both the quality and quantity of present and future workers, could no longer be left only to 'natural replacement' and immigration" (Rathbone 1986: 21).

A rapidly falling birth rate meant that there was no guarantee that the supply would match the demand for new workers. Writers such as Fleming have identified a shift in state thinking and planning in that infant and child health became matters for public concern:

"as the State had a new interest in their survival, the health and welfare of adult workers carried a new weight because health and strength could not be damaged beyond repair by poverty if labour power was in short supply; the welfare of mothers, without whom there would be no future citizens and workers, had ultimately to be considered. In other words, the falling birth rate was a major factor in the development of the Welfare State in Britain" (Fleming 1986: 22).

In cities, families in communities helped each other in times of stress.

Rathbone, writing of Liverpool, observed:

"In so close a community there are many varied sources of help. One unfailing source is that of neighbours and friends. They know the circumstances of the family as no outsider can hope to know them and time after time come to the rescue, helping with food and shelter, clothing, attendance as the case may require" (Rathbone 1913: 10).

In many rural areas self-help was also the first line of defence in times of stress for many families. Even in confinements women would try to manage without professional help. Clothing and groceries were provided for many of the 'respectable' poor by village lying-in charities who loaned parcels of linen and other items (Horn 1976: 186).

Despite concern expressed in the late 19th century by the medical profession, the incidence of maternal mortality was dropping. The rate per 1000 live births was six in 1847 and in 1903 had fallen to 4.03 (Chamberlain 1981: 108). Mortality rates were considerably lower in cases where the handywoman had been involved when compared with hospitals and lying-in wards. Chamberlain suggests that this was due to the fact that in many cases where the 'handywoman' was used the family itself provided dressings and cloths, no instruments were used so reducing the possibility of cross infection (Chamberlain 1981: 111). As

I shall discuss later, much of this fall was due to the increased activities of medical officers in the field of sanitation and maternity and child welfare.

The majority of poor women at childbirth were attended by the local unqualified midwife or 'handywoman' but neighbours could also be counted upon to help out (Hine 1980: 32-43). The 'handywoman' was usually a local elderly untrained woman who delivered babies and attended the mothers before and after birth. When neighbours died, she laid them out. "She took care of her local community in birth and death, and for much of the period in between" (Chamberlain 1981:1). The most obvious reason for the use of the 'handywoman' according to Chamberlain was economic but it should be remembered that very few qualified nurses or trained midwives were available, even if families could pay for their services (McCleary 1933: 143). Pankhurst (1930: 102) argues that 'handywoman' carried out tasks for little or no remuneration but others point out that she provided nursing and domestic services at an economic rate (Chamberlain 1981: 111-123). Hodgkinson argues that women employed by the Boards of Guardians were not very competent and that many people complained of their ignorance (Hodgkinson 1967: 137). It could be that the women employed by the Guardians might have been less acceptable than the 'private' handywomen and therefore had to go to the Poor Law to get work. In the absence of adequate state support for many, much help in times of illness therefore came from family or neighbours. Chamberlain tells us that

"this form of care was a valuable support and one which doctors and registered midwives would not undertake. Indeed even those who might have been able to afford a trained midwife (a midwife's fee was often the equivalent to a week's wages) often preferred an untrained one because of the extra tasks she provided" (Chamberlain 1981: 112).

This statement of Chamberlain's would seem to add an extra dimension to her economic argument.

The medical profession viewed the care of mothers and infants by handywomen as a service "in the hands of untrained ignorant women" (McCleary 1935: 122). Apart from the women they delivered, and some of the local medical practitioners, no professional group favoured the handywomen who were regarded as vestiges of an outdated system of community support. The trend was towards professionalisation;

"experience and familiarity could not be regarded as appropriate qualifications for the new providers of pregnancy and delivery care, despite the fact that sufficient experience was exactly what many of the new providers lacked, and that by the 1930s many critics of the maternity services had begun to bemoan the new alienation of the childbearing woman from her professional attendants" (Oakley 1984: 113).

When discussing this subject it must be remembered that male medical ideas and values have been the main yardstick against which historians have evaluated materials from the past. Versluysen argues that

"traditionally, the medical men have dismissed any personnel or ideas falling outside their own domain of control as of little significance or consequence. Historians have generally accepted this dismissal with great alacrity and little criticism" (Versluysen 1980: 178).

The medical profession and historical convention have suggested that the 'handywoman' and many nurses were simply a mass of illiterate old wives who caused more illness than they ever prevented or cured. The movement to stop the work of the handywoman, according to Chamberlain, must be seen as part of a movement that sought to outlaw traditional healers, and the devaluing of experience and of domestic and basic nursing skills. Much of the legislation was a result of extensive lobbying by the physicians (Chamberlain 1981: 67-138) and the efforts of doctors to control the work of the midwife. There had been many conflicts between midwives and doctors in the early days of antenatal care. The Ministry

of Health commenting on the relationship between the midwife and the medical profession wrote:

"The first object must be to remove any suspicion from the mind of the midwife to the effect that the medical officer of health and his staff exist for the purpose of finding fault with her and harassing the midwife in her work" (MOH 1929: 49).

There is evidence of this conflict up to the 1950s (Brockington 1954: 163).

Until midwives came within state registration at the turn of the century, working-class childbirth remained beyond the pale of the male medical establishment. Midwifery, particularly with the working class or poor, was not a lucrative practice and doctors were loath to take it on (Oakley 1976: 48). There was a strong tendency on the part of the medical profession to regard midwifery as an inferior and poor relation of 'proper' medicine (Oakley 1976: 33) Chamberlain argues that

"all attempts at professionalising midwifery in the nineteenth century was bitterly opposed by the medical establishment, for they perceived that educated and organised midwives might well abandon working-class women and encroach on their lucrative middle-class preserve" (Chamberlain 1981: 107).

Oakley, on the other hand, argues that the main reason why the male takeover in medicine was not immediately followed by a complete takeover of the midwife's role was part of a larger process in society related to the ideology of domesticity prevalent at this period.

"The Victorian era saw a general narrowing down of the options available to women in the occupational field. An ideology of domesticity became pre-eminent, and activities incompatible with this consequently suffered. Medicine for women was one casualty, and others included a general contraction of women's industrial labour" (Oakley 1976: 37).

This is an interesting argument but until more research is carried out on this aspect of the Victorian period can the validity of this view be established or tested. Others argue that the relationship between

doctors and nurses reflected the moral condition of male dominance. Doctors had a monopoly of knowledge relating to disease and its treatment; nurses' work was regarded as being in service to this knowledge (Williams 1978: 40). Florence Nightingale concerned herself with how nursing should be organised, not with changing its subordination to the medical profession. According to Garmarnikov, Nightingale argued that "to be a good nurse one must be a good woman"; she proposed the equation: good nurse = good woman. Garmarnikov has argued that this equation is also a recurrent theme in writings on nursing in the late 19th century (Garmarnikov 1978). Doctors were later able to establish a strong position as a result of their special relationship to the emergent middle class. The medical profession during this period established itself as a "free profession, selling their services to the well-to-do" (Walker 1982: 59). Hodgkinson also argues from the economic standpoint pointing out that doctors later wished to control the midwifery profession and ensure their fee (Hodgkinson 1967: 137). As Freidson points out, the motive for professionalisation and professional dominance as an explanation of change in medical care should never be underrated (Freidson 1970). The medical profession's social position was beginning to be so powerful as to be able to ward off attacks on its ideology and practice (Harrison 1981: 34).

The position of the midwife had been legally defined in 1902 by the Midwives Act, which set up the Central Midwives Board to keep a roll of certified midwives. The two-tier system of midwife and handywoman, according to Oakley, later developed into another hierarchy:

"doctor (de facto, predominantly male) and midwife (by law, always female). Soon after the Central Midwives Board was set up, there were signs that midwives were fighting to maintain control. Among doctors a feeling predominated that the certification of midwives was an untoward

development, since it presented them with competition in an already underpaid area of work" (Oakley 1976: 50).

A bitter struggle with the doctors ensued before a place for them in the maternity services was assured by the Act (Abel-Smith 1960, Donnison 1977, Chamberlain 1981). This conflict was identifiable well into this century. A 1949 working party report on midwifery protested:

"that the doctor must accept the midwife as his fellow practitioner and not attempt either to relegate her to the station of his handmaiden or to displace her unnecessarily from the position of authority in the patient's eyes (Brockington 1954: 163).

The Midwives Act of 1902 was the first attempt by Parliament to regulate the profession of midwifery to protect the public. Members of the House of Commons feared that the regulating of the profession would cause problems for many poor people, especially those living in rural districts, by removing the services of the untrained handywoman, particularly at a period when there was a shortage of trained midwives (McCleary 1933: 143). Some GPs refused to use the services of the midwife preferring instead the untrained 'handywomen' who watched the patient and called the doctor at the moment they considered appropriate (Lewis 1980: 150). The main provisions of the Act were such that no woman could lawfully use the title midwife unless certified by the Central Midwives Board; no woman could attend at childbirth for gain except under the direction of a doctor (Midwives Act 1902 Ch.17 Section 1).

The number of trained and certified midwives varied from area to area, especially in rural districts; long after the 1902 Act many unqualified women were still practising midwifery (Lewis 1980: 150). In 1915 handywomen were still to be found in London nursing and washing the babies as well as carrying out domestic chores and providing a much

wider service than the home help of the period (Daniel 1925: 13). It was not until 1926 (Midwives and Maternity Homes Act 1926) that the law was strengthened. It was no longer necessary, in order to secure a conviction, to prove that an uncertified woman had attended women in childbirth "habitually and for gain". Personal supervision as well as the 'direction' of a qualified medical practitioner was made a condition of avoiding liability (Bedfordshire County Council 1928:65). However, as late as 1929 a Government Committee on the employment of Midwives reported:

"It is difficult to escape the conclusion from the large volume of evidence submitted in regard to the practice of uncertified women as midwives, that the attempts which have been made by law to put an end to the abuse have largely failed in their object and there would seem no advantage to be gained by further legislation in this respect. We believe the remedy can only be found in the application of a state scheme of Maternity" (McCleary 1935: 160).

The conflict between midwives and the medical profession continued. A GP writing in the Practitioner, in 1929, felt that the Ministry of Health was biased against doctors and had an 'obsession' with midwives, "when in fact their practice only deprived the patient of proper medical care on a par with the best surgical work of the day" (Cressy 1929: 126-9). On the other hand, midwives feared that the Ministry of Health had not made their role clear enough which allowed the doctors control over their work (Nursing Notes 1930: 137, Nursing Notes 1930a: 153, Nursing Notes 1931: 18).

As many as two-thirds of all nurses, at the beginning of the 20th century, finishing their training went into private nursing, but unemployment among private home nurses was not uncommon during this period (Tooley 1906: 277). The conditions in the private nursing field showed how action was needed to protect

public from untrained and unscrupulous women, and to protect the fully trained nurse from bad working conditions and competition from the unqualified. Nurses themselves sought to improve conditions by forming co-operatives, the first being the London Nurses Association which admitted only trained nurses (Tooley 1906: 271-277, Morley 1914: 185-186); the untrained worked under their supervision (Carter 1939: 69-70). What were the motives for the nurses' actions? Abel-Smith argues that the fact that nursing consisted largely of manual work and had previously been associated with domestic service

"made it particularly important that it should be distinguished from it. The fact that many women of the domestic servant's class were still entering nursing made the ladies who entered nursing insecure. The fact that most of the duties performed by the nurses looked to the casual observer so close to those performed by the housewife in her daily round may have led to exaggerated attempts to differentiate the work" (Abel-Smith 1960: 242).

All professions are reluctant to accept the help of aides and auxiliaries for fear that their own position may be compromised (Wilding 1982:56). After the registration of nurses in 1919 (Nurses Registration Act 1919) and later legislation which strengthened their position, local authorities began to employ qualified staff; this brought to the attention of the authorities the acute shortage of trained staff which became the subject of widespread comment. After this Act, the nursing profession was able to set educational standards for entry which were too high to yield enough trained nurses to meet demand (Abel Smith 1960: 242). As Wilding states, the "nurses concern was with status and the long-term future of the profession. On that altar present patients were sacrificed" (Wilding 1982:55). More and more nurses were needed to work in the homes of the sick but because of the economic situation the Ministry of Health did not see it as their role to advise or pressurise

local authorities to employ trained staff (M O H 1926:21). The 1919 Act failed to correct the supply situation; one of the reasons may have been that trained and untrained received the same pay. Agencies in the 1930s were still employing both types of staff (Abel-Smith 1960: 127).

2.3 Infant Mortality.

During the late 19th century, interest in Child and Maternal Welfare had begun with the recognition that infant mortality was a national problem.

The Webbs point out that public health workers had realised that

"ordinary measures of environmental hygiene, which had so successfully been applied in other fields of preventative endeavour, were inadequate to afford effective safeguards for infant life" (Webb S and B 1929: 578).

Medical Officers of Health had begun to record the numbers of infant deaths and to investigate their causes (Lewis 1980: 15). The evidence of the Interdepartmental Commission on Physical Deterioration in 1904, the first major national survey ever made into the health of the people, helped lead to attempts to improve the nation's health. The Commission's report devoted much attention to the welfare of infants (Report of the Interdepartmental Committee 1904: 50-55). The Commission recognised "that it was in the national interest to safeguard the next generation and thereby improve the quality of the race" (Lewis 1980: 15). In 1904 the Registrar General also included an extensive analysis of infant mortality in his annual report (Lewis 1980: 27).

The first International Conference on Child Health held in Paris in 1905 engendered so much interest among certain medical officers in England that they organised the first National Conference at Caxton Hall in

London the following year (McCleary 1935: 105). As a result, many Medical Officers and Local Authorities began to implement infant welfare schemes on a larger scale. John Burns M.P., President of the Local Government Board, made an "impassioned speech at the 1906 National Conference" which "showed how active government concern was" (Lewis 1980: 33). At this period the majority of infant welfare work was carried out by voluntary organisations; the Royal Commission on the Poor Laws had identified many of these organisations and took evidence from some.

The first decade of the 20th century saw a series of measures introduced to improve the health of the working mother and her children. The problem of infant mortality was thought to be "largely one of bad personal, domestic and environmental conditions" (MOH 1937: 12), a situation the Ministry believed to be "inseparably interlocked and that measures adopted with the view to reducing the maternal mortality rate are also those likely to effect a reduction in the death rate of infants in the early weeks of life" (MOH 1937: 12). Medical and nursing services were to be directed to the care of the mother and the preservation of maternal health (MOH 1937: 12). One of the auxiliary services thought important was the home help:

"The services of suitable women, provided by the Local Authority, to carry out domestic duties in the homes of the women during illness or pregnancy, at a time of confinement and throughout the puerperium may be of great benefit if satisfactory private arrangements cannot be made. When the mother has been removed to hospital the services of a help may relieve her of domestic worry and enable her treatment to be continued for as long a period as may be considered desirable on medical grounds" (MOH 1937: 233).

The scope of services offered was in fact limited and by no means met the demands of groups campaigning for improvements in child and maternal

welfare. Anxiety by many was focused on the implication that the large number of infant deaths had for society.

"The birth rate then was a matter of national importance: population was power. Children it was said belonged 'not merely to the parents but to the community as a whole'; they were a 'national asset', 'the capital of a country'; on them depended 'the future of the country and the Empire'; they were the 'the citizens of tomorrow'" (Davin 1978: 9-65).

Concern for Infant and Child mortality led the Local Government Board's Medical Officer, Dr. Newsholme, in a supplementary report to the 39th Annual Report of the Board, to comment on this problem (LGB 1910). The object of this report was:

"to determine, on the basis of our national statistics, whether reduction in infant mortality implies an untoward influence on the health of survivors to later years; to indicate the communities which are characterised by a continuing high rate of infant mortality; and to assess, so far as is possible, the relative value of the different factors of excessive infant mortality" (LGB 1910: 1).

He reviewed the factors influencing infant mortality, some of which were: the quality of help given at birth; the age of the wife at marriage, poverty and social conditions; the extra domestic employment of married women; and the urban and rural conditions of life. He discussed these details and drew certain conclusions about the problems caused by lack of domestic help:

"all the counties having the relative social position indicated by the fact that more than 10 per cent of the females over 10 years of age in the county were engaged in domestic service, had a medium or low infant mortality, while all the counties in which there were fewer domestic servants than 10 per 100 of the females over 10 years of age in the county had a high infant mortality" (LGB 1910: 55).

This, he felt, pointed to the fact that domestic help was a factor in preventing infant mortality. Those counties with the highest ratio of domestic servants were, however, also likely to be the most affluent. Social class also played a part in infant mortality, a fact unrecognised by Newsholme. The report also pointed out that "frequently insufficient

nursing both of mother and infant" during confinement "was a determining factor in infant mortality" (LGB 1910: 56). He also argued from the statistics available at that time that high infant mortality was associated with poor environmental conditions. Ashby pointed out that it was towns in industrial centres which were likely to have a high mortality rate and that the more people to the acre the higher the death rate (Ashby 1915:23).

2.4 Support for Mothers and Young Children.

The development of home help services must be seen as just one small sector of support for mothers with young children within the wider maternal and child health welfare service. Many working-class women preferred to be at home for births after the first because of the difficulty of caring for other children. Women's groups realised this and pointed out the need for home help support in any maternity scheme (Lewis 1980: 130). The work of Booth and others highlighted a portrait of poverty in the cities, with its ill effect on the health of young children. However, poverty was not confined to the towns. When questioning Booth over his evidence to the Inter-Departmental Commission on Physical Deterioration in 1904, the Chairman referred to a letter in that day's 'Times' from a woman describing conditions in rural areas:

"Man, wife and large family of young children. No water fit to drink anywhere. Woman boils and skims pond water. While drinking it children constantly require medicine, have no appetite, skin becomes yellow and suffer in other ways. Whenever possible the water is kept in wooden tubs and when children drink this they (with the exception of the eldest boy who is never well) recover their normal health. House built many years after the passing of the Public Health (Water) Act 1878" (Report on the Inter-Departmental Commission on Physical Deterioration 1904: 50-55).

It was the evidence of this Commission, which, as mentioned earlier, was the first major national survey into the state of the health of the people of Great Britain, which was to lead to real efforts to improve the health of the nation's children.

An article written by General John Frederick Maurice, in 1902, provoked a frightened and angry popular discussion "that linked in men's minds, so they could not again be separated, the questions of public health and the national welfare" (Gilbert 1966: 85). The underlying cause of the inability of many men to meet the army's physical requirements was identified by Maurice as maternal ignorance and inadequate devotion to duty (Maurice 1903: 45).

Alarmed at the ease with which untrained civilians had defeated their armies in many battles in the Boer War, the War Office had also placed the blame for their lack of success on the poor quality of their recruits. The Commission was appointed to see if there had been any physical deterioration of certain sections of the population, and, if so, what measures could be taken to remedy the situation (Lewis 1980: 15). The report voiced a principle that was to become more and more dominant as the century progressed: the need for a centralised service. "Local independence militates against security, the principle of local self-government must be subordinated to the more important interests" (Report on the Inter-Departmental Commission on Physical Deterioration 1904: 24). The medical care of pregnant women was not referred to in the report (as conducive to improved health) but there was, however, a great deal of emphasis in it on the welfare of the infant and young child. These proposals were translated into action: Relief (School Children) Order 1905, the Education (Provision of Meals) Act 1906 and the

Education (Administrative Provisions) Act 1907. The state was beginning to advance into an area of family care previously regarded as one of private responsibility. Improvement could not however come in child health until reforms in other related areas were made; for instance, Booth had put forward the view that overcrowding affected children's health (Report of the Inter-Departmental Commission 1904: 17). Others argued that the employment of the mother late in pregnancy and her return to work too soon after childbirth had a bad effect on the health of young children. The existing law, which required that employers should not knowingly allow a woman to be employed within four weeks after she had given birth, was often disregarded. Many believed that women should not go out to work (Lewis 1980: 78). In spite of the difficulties in enforcing the legislation, medical advisers believed that the period during which women would not be permitted to return to work after their confinement should be extended, even though these advisers were aware that regular employment was a necessity for many (Report of The Inter-Departmental Committee 1904: 47). For infants it was alleged that their mother's ignorance often contributed to premature death. Why did mothers need educating? In the first place, they were reported to have little understanding of how to feed or care for their children hygienically and were often deemed irresponsible in not consulting doctors often enough for advice on infant care (Newman 1906: 173). In the House of Commons, July 19th, 1910, Dr. Addison asked leave to introduce a Bill to require that in Public Elementary Schools, instruction should be given in hygiene and, to girls, in the care and feeding of infants. 120,000 infants died, he stated, in this country under the age of one year. In his own constituency 300 out of every

1,000 born died before reaching their fifth birthday (Anon. 1910: 74).

After the outbreak of the First World War, the Government actively encouraged local authorities to organise child welfare programmes (PRO MH 10/78). The importance of home helps in such schemes was stressed by the Women's Co-operative Guild "In the opinion of working women themselves one of their most pressing wants is for reliable help in the home" (Womens Co-operative Guild 1917: 4, PRO MH 55/518). This need was also highlighted by committees of the Ministry of Health and BMA:

"To specialists, the trained home help with carefully defined duties was primarily a means of professionalising this aspect of maternity work and of superseding the undignified 'crude arrangements' mothers made with 'gossiping neighbours' to help during the after childbirth" (Lewis 1980: 130).

Government advice largely embodied many of the recommendations of the Women's Co-operative Guild on Child Welfare. The Guild argued for a national midwifery and nursing service supported by home helps and in order to prevent the home helps from doing midwifery work they suggested that the helps should be supervised by the public health authority (Davis 1915: 2, 211). The Government hoped that "a grant of assistance from the Exchequer would stimulate those Local Authorities who were slow off the mark in operating a service" (PRO MH 10/78). Central Government, encouraged by the efforts of some local authorities, urged others not only to support the child in his first year but to offer a more comprehensive service dealing with the mother and child up to five years of age. An extension was advised on two fronts:

"for securing improved antenatal and natal conditions, and for continuing the work in relation to childhood beyond the first year of life" (PRO MH 10/78).

The memorandum accompanying a 1914 circular offered an outline of a Maternity and Child Welfare scheme which included arrangements for

"such assistance as may be needed to ensure the mother having skilled and prompt attendance during confinement at home".

The home help service was to play a small part in this overall plan for the welfare of children and mothers. In July 1914, the Local Government Board issued a circular indicating that Parliament was being asked to agree to public expenditure in the field of Maternity and Child Welfare in respect of clinics, dispensaries, salaries of health visitors and other officers (Local Government Board 1914). The circular specifically drew attention to the limited character of much infant welfare work, which concentrated on the first year after birth, stating: "it is clearly desirable that there should be continuity in dealing with the whole period from before birth until the time when the child is entered upon a school register" (Local Government Board 1914: 9).

During November 1914, the Government Committee on the Prevention and Relief of Distress had issued through the Local Government Board advice to authorities on how to alleviate the distress caused by the war to expectant and nursing mothers. The advice covered such matters as nourishment, extensions to the antenatal programme and suggestions that Local Representative Committees should consider whether in the circumstances of their district there would be any advantage in organising a scheme for the employment and training of women willing to carry out domestic duties in the home "during the temporary indisposition of the housewife" (PRO MH 10/79). The circular referred to an existing scheme of 'sick room helps' which had been in existence for over 20 years.

One society in particular needs mention as it is often quoted as the organisation which was responsible for starting the modern home help

service. The Ladies Conjoint Visiting Committee of the East End Jewish Board of Guardians began an experiment in 'sick room helps'. The first report of the committee in the last years of the 19th century reported that the 'sick room helps' were supplied in "cases of illness among the destitute poor" and it was hoped that the assistance given "in cleaning and airing the room, looking after children, and cooking the food whilst the mother is incapacitated" would "materially alleviate the distressing incidents of sickness in poor families" (Jewish Board of Guardians (JBoG) 1896: 58). Later, the Board were reporting the scheme a success and expanded the service (J B o G 1897: 66, J B o G 1899: 19). The object of the scheme at the beginning of this century was to provide "Maternity Nursing and the care of the home among the Jewish poor" (RCPL 1909: 570 Appendix X1(1)).

Plans in many areas for home help schemes did get off the ground and the Central Committee on Women's Employment arranged for the training of a number of women in this field (PRO MH 10/79). I found no other reference to the activities of this Local Representative Committee's attempt to train home helps.

Many voluntary social and political groups had pushed for the introduction of a national home help service. Notable in this field was the Women's Co-operative Guild who recognised that working class women lived in poor areas, married young and had more children and therefore needed much support in the home in times of illness (Ilsley 1967: 105-106).

The Guild argued that more attention should be paid to the welfare of the mother and much of the evidence they collected pointed to the fact that many women had problems during confinement related to the lack of

proper medical, nursing and domestic support. Herbert Samuel commented that their evidence painted "an intimate picture of the difficulties, the troubles, often the miseries, sometimes the agonies" experienced by millions of women during childbirth (Davis 1915: 3). The Guild published a series of letters from their members outlining their experiences during confinement which they felt was all the more poignant because they were the experiences of "the better paid manual worker" (Davis 1915: 3). The Guild referred to the fact that "writers on infant mortality and the decline of the birth rate never tire of justly pointing to the evils which come from the strain of manual labour in factories for expectant mothers", the same evils which were to be found in many homes from "incessant drudgery of domestic labour". They pointed out that "people forget that the unpaid work of the working-woman at the stove, at scrubbing and cleaning, at the wash tub, in lifting and carrying heavy weights, is just as severe manual labour as many industrial operators in factories" (Davis 1915: 6).

There is little doubt about the fact that a large proportion of working-class women before the war really were plagued by ill health, and that this made their lives more difficult, as well as affecting their children. But the aspect seldom explored by those who commented upon this state of affairs was the effect of frequent pregnancies upon women. The Women's Co-operative Guild certainly drew attention to this aspect of the lives of many women; "out of 386 women who have written these letters, 348 have had 1396 live children, 83 still births and 218 miscarriages" (Davis 1915: 9). The women themselves knew that they were worn out by a succession of births and miscarriages, and weakened not only by poor diet, but by the heavy domestic labour done about the

house, which most of them found more exhausting than factory work.

The Local Guilds proved formidable pressure groups. Many pressed their Local Authorities to adopt their suggestions and also encouraged many working-class women to gain appointments to the Town and County Councils. The Guild did not however call for philanthropic action but called instead for a state scheme under the direction of a Ministry of Health (Davis 1915: 17, 211-212).

Many of those who gave evidence to the Guild spoke of the need for some form of domestic support for mothers during childbirth. In many cases, any help found had to be paid for as had medical or nursing support. For many, the difficult choice was between food or paying for help. The Guild argued at the highest level; Mrs Layton, a Guild member, wrote of her experience in approaching the Local Government Board on this matter:

"The L. G. B. offices were crowded one day by mothers with their babies, an unusual sight for Whitehall! They came to ask Mr Herbert Samuel to recognise that, during the war, the care of maternity was more important than ever. I specially pressed for Home Helps and told of how one of my patients was left alone in the house for two days at her confinement, with a little child of three in her bedroom. The child ran downstairs and poured paraffin on the fire and screamed with fright at the result. The mother ran down the landing in nightdress and no shoes. No mother should be left alone at such times" (Davis 1974: 50).

Some of the influences upon women's health were long term, others were exacerbated by the war. Various groups such as the Women's Labour League, the Railway Women's Guild, the War Emergency Worker's National Committee and the National Association for the Prevention of Infant Mortality approached the Local Government Board on the subject of 'The National Care of Maternity in Time of War' in the belief that "the desolating waste of life inseparable from the operations of war makes it increasingly incumbent upon the nation to assist mothers and to render the conditions of childbirth as favourable as possible" (Co-operative

News 1914). Their demands were for medical advice, extra nourishment for mothers and the provision of midwives (Co-operative News 1914).

The Government continually urged authorities to increase their activities and spending in this field, despite restricting expenditure in other areas (LGB 1916: 20). Advances were encouraged for many reasons which were best summed up by The Right Hon. Herbert Samuel, M.P., President of the Local Government Board, in 1915:

"It is necessary to take action, first for the elementary reason that a nation ought not to tolerate widespread suffering among its members. Action is also necessary because for lack of it the nation is weakened. Numbers are of importance. In the competition and conflict of civilisations it is the mass of the nations that tells. The ideas which Britain stands for only prevail so long as they are backed by sufficient mass of numbers. Under existing conditions we waste, before birth and in infancy, a large part of our possible population. The time is past when a shallow application of the doctrine of evolution led people to acquiesce in a high infant death rate. The theory, too, is passing away that the country is over-full and that the danger to be feared is not a lack of population but its excess.

The conclusion is clear that it is the duty of the community, so far as it can, to relieve motherhood of its burdens, to spread the knowledge of mothercraft that is so often lacking, to make medical aid available when it is needed, to watch over the health of the infant. And since it is the duty of the community, it is also the duty of the state. The infant cannot, indeed, be saved by the State. It can only be saved by the mother. But the mother can be helped and can be taught by the State" (Davis 1915: Preface).

2.5 Reconstruction 1918.

Infant mortality declined during the war because, as stated by the Chief Medical Officer, "The war has had the effect of directing greatly increased attention to the means of improving the health of mothers and their children" (Bell 1918: 475). As previously mentioned, many had other motives for supporting the Infant Welfare Movement. There were those who supported it because they wished to "maximise the future

military potential of the country" (Winter 1977: 487).

The Government did not, however, expect to have to provide reforms as early as 1918. Gilbert observed that the Government did not expect the war to come to an end; indeed, it was felt at the time that the war was only reaching its climax. The collapse of Germany was totally unexpected (Gilbert 1970: 58). The possibility that the war might suddenly end seriously distorted the Government's schedule for social reconstruction. According to Gilbert, the Government was more concerned with making Germany pay for the war than with social reconstruction (Gilbert 1970: 16, 23).

The Government had, however, begun to consider the post-war reconstruction of the economy as early as 1916. The Women's Employment Advisory Committee of the Ministry of Reconstruction devoted much attention to the question of home helps, both as a necessary part of health care provision and as means of employment of women (Ministry of Reconstruction 1919, PRO MH 55/517). This committee of the Cabinet in turn set up nine subcommittees to deal with important aspects of reconstruction (MOH 1920c: 99-100). Many of these subcommittees, one of which was the committee on Subsidiary and Kindred Services, never reported their findings (Webb 1963: 813), thus losing the opportunity to highlight the problems of mothers and children, particularly during and after childbirth. There is a reported reference to the work of this committee (Subsidiary and Kindred Services; one of the nine subcommittees) in the Women's Advisory Committee on The Domestic Service Problem which had been requested to

"consider the general condition in regard to domestic service as affected by the employment of women on war work, and to indicate the general lines on which the available supply of labour for this purpose may be utilised in the best interests of the nation" (Ministry of

Reconstruction 1919: 1 Cmd 67).

The Women's Advisory Committee on the Domestic Service Problem was divided into four groups to study different aspects of domestic service, one of which concerned home helps. What it had to say was important not only because it was the first public report on home helps but also for its insight into the problems of families affected by lack of domestic support. After meeting several times, it came to the conclusion that it was not advisable to proceed further without reference to the Committee dealing with the question of Subsidiary Health and Kindred Services, as the question of home helps intimately affected that committee.

A subcommittee of the Women's Advisory Committee on the Domestic Service Problem passed the following resolution in relation to home helps:

"That with a view to preventing sickness which is caused by the unavoidable neglect of children in the home, the Local Government Board should be asked to remove the restriction which at present confines the provision of Home Helps to maternity cases, and to extend the scope of the Board's grant for the provision of such assistance in any home where, in the opinion of the local authority, it is necessary in the interests of the children that it should be given" (Ministry of Reconstruction 1919: 3 Cmd 67).

The resolution was adopted by the main Committee, and the Home Helps Subcommittee was dissolved. The Home Helps subcommittee concerned itself also with support for those who were not poor but could not obtain domestic help. They declared:

"We are not unconscious of the great need that exists for further preventative measures in connection with health services, more especially as regards children, and we think that the question of Home Helps must first be explored in this connection. We are of the opinion, however, that, as regards help with domestic work, the position of the wives of professional men with small incomes and of the large army of men of moderate means who are engaged in commerce and industry is becoming critical and that some form of municipal service might help solve this most difficult problem" (Ministry of Reconstruction 1919: 3 Cmd 67).

A Memorandum to the report called for a free home help service. The

"home help paid or partly paid, by the local authority is a small free ration of help in the mother's illness. Nursery schools provided by the Education Authority will, of course, be free; there is also an opening for private nursery schools. A limited "free ration" of cleaning by the local authority would be economical of labour, life and health, and it is hoped that the Ministry of Health will obtain powers of this kind for Local Authorities" (Ministry of Reconstruction 1919: 34).

The pressure for some extended domestic support for mothers with children under one year led the Government to introduce a home help service in a limited form in the Maternity and Child Welfare Act of 1918. This Act extended the powers of Local Authorities, given under the Notification of Births (Extension) Act of 1915, to arrange for the medical and social care of expectant mothers and children. The 1918 Act stands out as one of the most important landmarks in the maternity and child welfare movement. It enabled local authorities to do anything that might be sanctioned by the Local Government Board for attending to the health of expectant and nursing mothers, and of children who had not attained the age of five years. Advice was issued which outlined the basis of a scheme which would be acceptable to the Ministry. Fifty per cent subsidy was offered from the exchequer. The scheme allowed the Authority to recruit women, as home helps, to take over the domestic duties of mothers during the puerperium (a period of six weeks after birth). Any authority wishing to start a scheme had to appoint a Maternity and Child Welfare Committee to encourage at least two working-class women to sit on these committees (Clarke 1922: 175). By February 1920, as many as 25 Authorities had started maternity and child welfare schemes and another 40 had plans to do so. How many of these involved home helps is not known (MOH 1920d: 119). Local authorities were reluctant to spend money on the home help service and expenditure never exceeded two per cent of the annual maternity and child welfare budgets

between 1919 and 1928 (PRO MH 55/260). It is known, however, that Islington, Cambridge, St. Pancras, Ealing, Eastbourn, Preston, Grimsby, Huddersfield, Darlington, St Marylebone, Heston, Islworth and Wolverhampton all operated home help service before 1920 (Mother and Child 1936: 250)

Dr. Janet Campbell, the Senior Medical Officer appointed to the new Ministry of Health in charge of Maternity and Child Welfare, spoke of the difficulties authorities experienced in recruiting suitable home helps. She also pointed out that their duties were purely domestic and as such

"should never encroach upon those of the maternity nurse or midwife - there is a danger that the home help may wish to assist with maternity nursing, and that a new type of "handy-woman" may thus come into existence. It need hardly be said that her duties must be strictly limited and defined, and she should not be employed unless a midwife or nurse is engaged as well" (MOH 1920d: 120).

It was suggested that there should be twice as many home helps per population as General Practitioners (MOH 1920b: 8). Many Authorities, however, had difficulties in finding even limited numbers of "tactful, domesticated women of good character, capable of doing invalid cooking, of looking after the household, and of taking charge of the domestic arrangements of the home" (MOH 1920b: 8). Even when a full-time wage was offered it was still found difficult to recruit "candidates for this relatively unskilled house-work" (MOH 1920c: 129). The size of the wage was, however, a likely factor in poor recruitment. For example, during the war, home helps in Islington had received 12s.6d per week and 6d. a day for meals, where these were not taken with the family. In Birmingham they had received 2s. a day for a ten hour day compared to 24s. per week paid to cotton workers in 1918 and 30s to 40s to munition workers

(Lewis 1980: 131). Thus the Women's Co-operative Guild hoped that if the home help was given the status of a public servant with better wages, recruitment would pick up (Elliott 1951: 129). This point was further taken up by the WVS in 1944 in their attempt to organise a more effective service.

2.6 The Decline of Domestic Service and its Effect upon Families.

The call for domestic help by some of the professional or middle classes was in response to their problems in finding suitable experienced domestic servants in the last quarter of the 19th century and the first quarter of this century. The non-availability of young girls in this field was thought to have an adverse effect upon many mothers' health in times of stress. In the final quarter of the 19th century many changes in society were in part a response to the emergence of a broad, well organised labour movement. Trade unionism began to transcend narrow craft boundaries to embrace the unskilled worker. The first half of the 20th century also brought many social changes, one of which was in the area of women's employment. In 1881, domestic service absorbed more working women than the textile industry, which was the second largest employer of female labour. The number of servants in employment began to decline after 1881 despite women in the 19th century being pressurized by the Church and male trade union groups into becoming domestic workers rather than factory workers, where it was believed that they picked up crude habits and mixed with bad company (Braybon 1981, Campbell 1877: 226-228, Cadbury 1906: 111-112, 115, Hewitt 1958). The experience of leaving home for domestic service was a fairly typical one

for many young girls in the 19th century (McBride 1976: 45). At the end of the 19th century in Britain, around 20 per cent of households employed servants, and around one-sixth of all English women were domestic servants (Davidoff and Hawthorn 1976: 73). Even the families of skilled working men often had a young living-in servant girl to do all the scrubbing, dirty work and baby-minding. Roughly two-thirds of all female servants were 'general' domestics of this kind (McBride 1976: 14). At the beginning of the 20th century domestic servants still comprised one of the largest groups of female workers.

"The structure of domestic service itself had undergone some modification by the end of the century. Particularly evident was an increase in the number of part-time domestics who lived away from their place of work, due to the difficulty in obtaining residential servants" (Ebery and Preston 1976: 12).

The large house never had difficulties in recruiting suitable staff but by the beginning of the 20th century households began to find recruitment a problem; but the situation was not so grave as to attract public or government attention until after the war (Elliott 1951: 126).

During the First World War the drift away from domestic work accelerated. Many women found that their new war occupations offered them definite hours of work, comradeship and free time that corresponded with that of their families and friends. Domestic work, because of its low status, has been grudgingly accepted as the only alternative to poverty and unemployment (Elliott 1951: 126). In an informal investigation outside a labour exchange in February 1919, 65 per cent of women interviewed said they would not take domestic work on any terms (Woman Worker 1919). By the end of the First World War the reluctance of women to enter domestic service was seen by the government as a serious and urgent problem and the Women's Advisory Committee was asked in 1918

to investigate the matter and report (Ministry of Reconstruction 1919). The government had acknowledged and accepted that the employment of women on war work had given them an experience, as a result of which they were reluctant to return to domestic employment. Nonetheless, the committee tried to portray domestic work as a suitable employment for many women. However, the dress or uniform marked its wearers out as different and the paternalistic attitudes of employers made matters worse. The long hours of work were a major drawback and the limited hours allowed for 'off duty' rendered any kind of social life difficult. Employers complained that any staff they could recruit were not of a suitable standard and not able to deliver the service which they had come to expect.

The lack of domestic support began to affect middle-class homes and in many cases this interfered with the careers of middle class women who had to stay at home and do the housework:

"Not only during the war and at the present time but to some extent previously, employers found domestic help unobtainable for considerable periods, with the result that home life has suffered, and women skilled in other occupations have had to curtail their own work to attend to their home" (Ministry of Reconstruction 1919: 23).

The effect of this shortage of domestic help was felt particularly by families with young children, and the consequent injury to the well-being of mothers and children was sometimes serious. "In relation to health and efficiency, decency and reasonable comfort of home life, the question may be regarded as a national one, than a matter affecting only employers and workers." It was believed that the domestic problems experienced by many mothers placed an "excessive strain on their vitality" and was "a cause of burdensome anxiety and weariness both of body and spirit". Members of the committee argued that as families found

it difficult to recruit domestics, local authorities should provide a domestic service on the rates (Ministry of Reconstruction 1919: 23, 35). The 1919 Committee only briefly touched on the problems which might be caused by the new Unemployment Insurance scheme on the supply of girls for the service (Ministry of Reconstruction 1919: 18). The later difficulties and frustrations of the public at what they alleged was the problem caused by the unemployment payments to out of work females was picked up by a national newspaper, the Daily Mail, in 1923. It was alleged that many:

"young women were willing to accept the supposed indignity of the 'dole' rather than strengthen their characters by doing domestic chores. Mistresses who regarded the 'dole' as a subsidy to slackers were to grow intensely angry with the government for not drafting girls into the kitchen" (Turner 1962: 278).

By 1923 employers complained so loudly that the government held a public enquiry into the matter. The Committee appointed by the government found, like the 1919 Committee, that conditions of service and public and employers' attitudes were to blame; others put the shortage of domestic servants down to the increased education given to girls (PRO ED 11/278). In order to raise the status of the domestic servant it was argued that more and better training facilities and a change in recruitment policies was necessary. One of the recommendations was very farsighted; it recommended that a "certain number of domestic science courses, to consist of six months training, with maintenance grant in lieu of unemployment benefit" be set up in certain areas of the country. This was the first time that a government committee had considered paying students to complete a training course (Ministry of Labour 1923: 14). The committee also pointed to the difficulties and problems encountered as a result of the lack of domestic support and once again

recommended that local authorities should extend their home help services (Ministry of Labour 1923: 24).

The reports of 1919 and 1923 no doubt stimulated much discussion about the position of the domestic servant and the problems caused by their decline in numbers. Nevertheless, "behind the request for these reports was an ever-growing movement to raise the status of the domestic worker, and an increasing appreciation of the social value of her work" (Elliott 1956: 128). In 1931, 70,409 males and 1,332,224 females were classified as domestic servants serving nearly half a million private families or 4.8 per cent of all private households. Rather more than 75 per cent of that total had only one servant apiece (Ministry of Labour and National Service 1945: 4). The problems arising from the declining number of domestic servants were not seen as a major cause for concern until the social and economic conditions caused by the Second World War placed severe burdens on families to look after their sick and elderly relatives.

2.7 The Role of the New Ministry of Health and the Maternity and Child Welfare Service.

As Townsend points out, social policy in the 1920s was relatively stagnant and in some cases "regressed, in the sense that measures and resources were not introduced on a scale sufficient to offset new inequalities and deprivations" (Townsend 1975: 18). However, a number of developments in the health field had a profound effect upon care in the community for mothers and young children.

"One manner in which this 'question of maternity' was taken up was in the creation of the Ministry of Health in 1919. Although there had been pressure for such a department before, the pressure had been almost

entirely concerned with environmental reform - with sewers and drains rather than 'scientific' medicine, and doctors as a group had only been really interested when they had needed to strengthen their economic position. The new Ministry of Health immediately initiated a great deal of important work on maternal and child health, and it did not do so purely because this was the climate of the time; rather, it did so because its own creation represented a solution to the administrative problem of which national body should be responsible for this branch of the public health" (Oakley 1984: 69).

The Ministry of Health Act 1920 created a new Ministry which brought together many of the fragmented health services previously managed by various Boards. "Practically the whole world of Public Health had been united in demanding a united Ministry" (Webb S and B 1963: 818). "The necessity of taking further measures to secure the health and welfare of child-bearing women and infants, and reducing the number of Authorities concerned with such measures" influenced public opinion also (MOH 1920c: 8). Both the Majority and Minority Reports of the Royal Commission on the Poor Laws in 1909 had in some form recommended it (Clarke 1922: 144, 148). The old system had proved inadequate;

"(i) partly because of a somewhat restricted apprehension and vision of the meaning, purpose and scope of preventative medicine; (ii) partly because of lack of co-ordination of the several parts of the organisation which had grown up in the course of time, first under the Poor Law Commissioners and subsequently under the Local Government Board and their relation to the newer results of the School Medical Service and the Insurance Commission and the exigencies of war; and (iii) partly because of division, and sometimes even conflict of control and finance" (MOH 1920c: 7).

The public expected the Government to be fully prepared for any health problems which might arise after the war. It had been claimed that the general state of the health of the nation had declined during the war and had led to lowered resistance to infections. As a result many died in flu epidemics in 1918 (Drummond and Wilbaham 1957: 529). The Government were also particularly concerned that serious disease might be brought into the country by returning servicemen from overseas and

that this might seriously affect a tired and neglected population (MOH 1920: 8, Abel-Smith 1964: 280).

It was recognised very early on in the life of the new Ministry that its existence would not of itself solve many of the problems experienced by Local Authorities. The first Medical Officer saw that the new Ministry's role must be to build a solid foundation for the future which would be a first step in a scheme of national unification (MOH 1920c: 10). The Ministry was divided into five divisions: General Health, T B and V D, General Practitioners and Insurance, Sanitary Administration, and Maternity and Child Welfare under Dr Janet Campbell. By 1920, some form of a scheme of Maternity and Child Welfare had been operating in every County in England and Wales (with one exception in Wales) 1754 maternity and infant welfare centres, 221 day nurseries and 89 maternity homes had been set up. This improvement on past performance was, however, felt to be far from adequate - the death rate in childbirth was at the same level as in 1895 (Ministry of Health 1920c: 44). Better care was advocated although the Ministry felt that the standards of nursing and midwifery were adequate (MOH 1920c: 110). This view was in direct contradiction to that of the members of the Women's Co-operative Guild who had shown overwhelmingly that the standards of nursing, midwifery and medicine were very low in many cases (Davis 1915).

To help reduce mortality Dr Campbell advocated organising the services into antenatal, natal and post-natal stages. Many working-class women at this time preferred to have their child at home. Only 54 per cent of births were attended by midwives, many of whom were independently employed, which at this time was encouraged by the Ministry. The strain of childbirth, the resulting poverty for many, and the inability of

mothers for many reasons to find or afford domestic help affected the mothers' health. It was this concern that led Campbell to advocate changes (MOH 1920c: 116).

As the demand for domestic or home help support grew, concern at the service's slow development was voiced in a number of official reports. The First Report of the Ministry of Health (MOH 1920d), the report of the Chief Medical Officer (MOH 1920c), the report of the Welsh Consultative Council on Medical and Allied Services (MOH 1920b) and also the Consultative Council on Medical and Allied Services on the Future Provision of Medical and Allied Services (MOH 1920a:), all called for an increase in the service "with clearly defined functions and working under proper supervision" (MOH 1920a: 21).

The Women's Advisory Committee on the Domestic Service Problem in 1919 reported on the problems of recruiting suitable staff; the committee also examined the problems caused by the lack of domestic help for the sick poor.

"We would wish to draw attention to the very real need for consideration of the large number of women who cannot afford to employ domestic help regularly, but who urgently need assistance in time of incapacity through illness or other causes. The whole machinery of a working woman's home breaks down if she is ill, so that frequently she continues the performance of her household duties when she is totally unfit for them, and much suffering and definite ill-health brought about by the overwork might be avoided if a system of "home helps" were developed which would render such assistance available" (Ministry of Reconstruction 1919: 24).

The report called for an extension of the service, for full time home help appointments and for more authorities to establish such schemes which could later be developed on a commercial basis (Ministry of Labour 1923: 24). The 1918 Maternity and Child Welfare Act was never fully implemented. Sylvia Pankhurst wrote that by 1927 only 57 local

authorities were supplying home helps during confinements and she was critical of public attitudes towards the service, which she felt should be raised to the status of a profession (Pankhurst 1930).

What attitude did Local Authorities adopt towards the continued pressure and advice from Central Government? Midwives and General Practitioners often opposed the introduction of Maternity and Child Welfare schemes (B.M.J 1916: 51). The BMA's own scheme for a national maternity service stressed that the GP "should always be the bedrock on which the medical services of the country, including midwifery, must be built up" (A National Maternity Service 1929: 259). Tensions developed between doctors, midwives and local authorities, who competed for control of existing schemes and for a stake in any new service (Lewis 1980: 141).

Some authorities, such as Bedfordshire, encouraged voluntary and church organisations to organise nursing services for the poor in their own homes and also employed health visitors to visit mothers in the community (Bedfordshire County Council 1928: 19, 51).

Many Authorities were, however, concerned about the cost of introducing new or extended schemes (PRO MH 55/682). Janet Campbell's report on Maternal Mortality (1924) reinforced the view that the service had to be developed. She pointed out that the unofficial "handywomen" were still being used in many areas and she was particularly concerned about their operating unsupervised and carrying out nursing duties. She suggested that Local Authorities should undertake their supervision (Campbell 1924: 83). Thus, in the 1920s, the maternity care field was shared by untrained women, midwives, municipal clinic medical officers, GPs and specialist obstetricians. Lewis points out that it was

"ironic that in prescribing middle-class ideas of responsible motherhood, child and maternal welfare policies often discouraged already existing patterns of mutual aid between women. For example, the health visitor competed with the grandmother and neighbours for the role of advisor, and the local authority approved home help and the trained midwife with the 'handywoman', who was proscribed by law but highly valued by working class women, because she delivered the baby and looked after the family" (Lewis 1980: 20).

After the victory in the First World War, instead of a resurgence in economic growth, came the depression. The inter-war period was characterized by repeated, halting attempts to cope with the unemployed and uninsured together with recurring efforts to impose cuts and economies. A reduction in levels of unemployment benefit with a cut in wages created social and economic conditions which reflected in deteriorating health for large sections of the working-class community. The Committee on National Expenditure chaired by Sir Eric Geddes in 1922 did not recommend a cut in public expenditure in the health services, particularly in the maternal and child welfare services, as it did for many other areas of public spending. However, it did recommend that there should be no increase in expenditure in this field (First Interim Report of the Committee on National Expenditure 1922: 2-148). Later, in 1931, the Labour government set up a committee, the May Committee, to advise on public expenditure since the House of Commons considered that the burden of taxation was restricting industry and employment. The committee recommended that the growth of expenditure in the health field should be stopped. Social services and health had to take their share of reductions, although the committee felt that minor adjustments in this field would have been justified only if it had been possible to make sufficient reductions in other fields of expenditure (Committee on National Expenditure Report 1931: 142, 145). In July 1931 a run on the

pound led to a serious financial crisis. Bankers advised that it was due to lack of confidence in the Government, and called for a balanced budget. Consequently, substantial cuts were made in expenditure, including a reduction in unemployment benefit (Barker 1972:8). These conditions were exacerbated by the limitations of the Health Insurance scheme (Gilbert 1970, Branson and Heinemann 1971, Stevenson 1977). Women and children were worst provided for, since they were excluded even from the limited system created by the 1911 Insurance Act.

All governments struggled to maintain economic orthodoxy in the matter of balanced budgets during peacetime and any policy which threatened to increase financial burdens was feared. Government expenditure on social services had increased from under 4 per cent of the gross national product (GNP) up to World War 1 to at least 8 per cent of the GNP in every year between the wars (Peacock and Wiseman 1961: 91). Certain limited additions were made to the maternity and child welfare services, but the restrictions on local authority spending between the wars were a serious obstacle to any real improvement (Spring Rice 1939).

While the Government publicly urged Local Authorities to do more, in private it recognised their problems caused by the economic restraints placed upon them. The Prime Minister, Ramsay MacDonald, minuted the Minister of Health when replying to a memo from him on the abandonment of the plans for a national maternity service:

"Could we go on laying the foundations (of a national maternity scheme) at a much smaller cost to the Exchequer? I know feeling amongst women of all classes and parties is very strong, it is natural instinct which will be hard to come up against. If we have to face the worst I am willing, but note that what we propose is to add local charges without bearing any (however slight) national obligation" (PRO CAB 23/70 16 (32)7).

However, the Chief Medical Officer had to admit in 1932 that there had

been a reduction in services in some areas (PRO MH 55/273 1932).

Demands from various quarters for the reform of the medical services continued to mount during this period and there was continuous pressure from the Labour Movement for a unified system of medical care covering the whole population as originally outlined in their resolution, 'A National Health Service', at the party conference in 1918 (Eckstein 1958, Navarro 1978 and Murray 1971).

The 1918 legislation did provide a basis for action, however tentative, for local authorities. During the 1920s some local authorities did provide services but they needed encouragement from general government - an encouragement that never came, because the financial crisis of the early 1930s squeezed these developments at local level and stifled them at national level.

2.8 The Role of the Home Help.

One of the aims of many in the maternal and infant welfare lobby was to promote a moral responsibility on the part of the mother. Services were personal and individual, health visitors advised mothers in their own homes, and education on personal health care and nutrition were also given to girls at school and mothers at infant welfare centres and antenatal clinics. There are few surviving accounts; the most informative that I could find were those published in the Mother and Child Journal of that time, on the part played by the home help service during the years 1918 to 1940. Schemes that existed were "relatively infrequently organised and their value did not appear to have been sufficiently appreciated by some local authorities" (MOH 1937: 245). The

lack of domestic help at this time was often one of the reasons why "women refuse to remain in bed when so advised or decline to enter an institution for requisite treatment either during pregnancy or at time of confinement" (MOH 1937: 245).

The Ministry wrote that the lack of domestic helps was a contributing factor to clients not obtaining domestic support; but others pointed out that even when the help was made available it was not taken up (Daley 1952: 991). Even those who argued that a "good service of home helps" was "essential to the efficiency of any maternity and child welfare scheme", could not overcome the difficulties of recruiting staff of a sufficient standard (Mother and Child 1939: 321). It was difficult to obtain recruits to carry out the wide range of duties expected.

Helps were reported to have supported families for up to two or three weeks and in cases of protracted illness for up to three or four months (Mother and Child 1939: 324). One writer, outlining a 1920 scheme, did not experience the same recruiting difficulties as many others did. Daley claims to have had "many applicants and the brightest and most intelligent women were chosen" (Daley 1952: 991). This recruitment policy, however, was the downfall of his first attempt to successfully operate a scheme. "Surprisingly we learned that we had chosen the helps too well" he writes. The result of his policy was that many mothers felt that the home helps were too young and attractive to be left in charge of the household while the wife "was in hospital or confined to her bed" and refused the services offered. Some families, however, did use the service when the father was away from home (Daley 1952: 992). At least one other authority reported that a scheme partially failed because of the "natural reluctance on the part of the woman who has

never had a home help to hand over not only the house but the husband to a stranger's mercies whilst she is confined to bed" (Mother and Child 1931: 258). Daley explained his inability in part to operate the scheme successfully to the high level of training given to the helps. Three months training in baby care caused many problems and was a source of friction between help and midwife. "The helps gave themselves 'airs' and fell out with the midwives" by criticising their methods of caring for infants (Daley 1952: 992). As a result of these experiences the scheme was allowed to lapse and was started again a few years later with different training and recruitment policies. Part-time appointments were made and the scheme was widened and made available to families with an ill member as well as maternity cases.

In 1931 the Home Help Society sent out a questionnaire to all those authorities operating a service (this is the only reference in the literature concerning this society that I have been able to trace) (Mother and Child 1932: 250). The results from 56 Local Authorities and eight Voluntary agencies gave some indication of the service offered in 1931. The duties of the home help between the wars was effectively a domestic one with a few authorities allowing home helps to wash or dress babies. A typical help would attend a home where confinement had taken place for a period of nine to twelve days, Saturdays, Sundays and Bank holidays included. She would spend about 10 hours a day in the home, from 8am to 6pm. Authorities in many areas gave precise instructions as to the tasks to be carried out. In some authorities she was expected to do two weeks' ordinary washing for families with not more than two adults and six children, She was not, however, allowed to do arrears of washing, to cook or to supervise children. It was emphasised that the

help must not interfere in any way with the instructions of the Doctor or nurse or undertake any nursing duties.

Home helps were supervised in many authorities by the Health Visitor or Assistant Medical Officer but in some no such support was available. Only in two schemes were supervisors specially appointed for the task. These were in Liverpool and Birmingham where so many home helps were employed that full-time supervisors were necessary.

The information received by the Home Helps Society in 1931 indicated that there were at least 422 home helps employed, many of whom were casual labour or available only to work in emergencies. Liverpool employed 60 full-time staff with 20 available for casual work. Ten schemes employed only one home help. Those authorities with full time staff, employed them on other duties when no maternity cases needed support. Only eight authorities believed that training was necessary and one authority, Birmingham, provided one month's instruction in cooking, laundry work and housewifery.

The scales of payment differed from area to area and had not improved much since the early 1920s. Full-time staff in London received 20s. per week; in Worcester 5s. per week; in Huddersfield the pay was 45s. a week. Part time payment varied from 8d. per hour to 1s. Four authorities paid a retaining fee of between 3s.5d. and 10s. per week (Mother and Child 1932: 258, Pankhurst 1930: 80). The average wage for women in the late 1930s was 32-3 shillings per week (Cole & Postgate 1961: 644). Compared to the average wage home helps were not so well paid and in at least one authority they campaigned for higher pay (Pankhurst 1930: 83).

The charging system raised many problems for users of the services. In

one county, Cambridgeshire, the user had to provide full board and lodging for the help as well as pay an average of 10s. per week to the authority. In most schemes, however, the scale of payment was based on the family's income and expenditure. In Birmingham and Halifax, if the income of the family after deducting rent fell below 9s. per member of family, the charge was 1s. per day; if the income was over 18s. per member, the cost was 5s. per day.

The main difficulties experienced by authorities in getting mothers to apply for or accept support from the home help service were financial and objections to having strangers in the home. This was particularly a problem in rural areas where the home help was expected to live in. However, in some areas the demand for the service exceeded the supply, especially in respect of authorities that did not charge for the service. Most authorities reported that the service was providing a much needed support to mothers and families (Mother and Child 1932: 258).

During this period maternal mortality rates were still persistently high (Ferguson and Fitzgerald 1954:27) and official committees set up to look into the matter had come up with the disquieting conclusion that many of the deaths could have been prevented by more effective antenatal care and midwifery (Final Report of the Departmental Committee on Maternal Mortality and Morbidity 1932, Report on Investigation into Maternal Mortality 1937 and Report on Maternal Mortality in Wales 1937). Health visiting developed during the inter-war years as had ante and post-natal clinics, infant welfare centres and dental treatment centres for mothers (Twentieth Annual Report of the Ministry of Health 1939: 240). With a 50 per cent reduction in the infant mortality rate since the beginning of the century, the emphasis of campaigns was now clearly on the mother's

health: maternal mortality had even been rising (Fleming 1986: 68). A Women's Health Enquiry Committee, set up in 1933, to investigate the general conditions of health among women (Spring Rice 1939: 21) concluded that improvements in women's health needed to be linked to the provision of a Family Allowance and to improved social services including home helps to relieve mothers not only in times of illness or crisis, but to enable them to take holidays away from home (Spring Rice 1939: 207). Under the Maternity and Child Welfare Act of 1936 the home help service was extended to families with young children up to five years of age; but by 1938 less than half of the 400 welfare authorities in England and Wales had instituted schemes (Ferguson and Fitzgerald 1954: 30). During this period, maternal and child welfare workers, as Lewis points out, shared a common approach to the problem but at the administrative level the self interests of, and tensions between, the groups served to further restrict the services offered.

2.9 Conclusions.

A number of principles and trends have been discussed in this chapter. The restriction on expenditure in the 1930s; the move from community or family self-help to reliance upon 'professionals'; the professionalisation of nursing; the demise of the untrained and unsupervised handywoman; and the development of a group of nursing 'assistants' under professional supervision to undertake the less skilled tasks. Other trends highlighted are attempts by the state to centralise services and undertake some welfare roles previously held to be the responsibility of families and friends; the concern for the

mother and child; the effect of manpower shortages; and the changing role of women.

At the beginning of this century the majority of poor women were attended during childbirth by the local 'handywoman' or were aided by family and neighbours. One characteristic of an industrial society is the emergence of a professional workforce (Goode 1960: 902). This can be understood as part of the trend towards more complex forms of social organisation. Increasingly, skilled personnel are seen as necessary to develop knowledge and skills in specialised fields, to supervise untrained staff or to make decisions which have most fundamental significance for individuals or families (Dunleavy 1981: 205). This trend towards professionalisation of the medical and nursing workforce, resulting in conflict between the two groups, lasted well into the 20th century. Doctors did not wish to take on midwifery cases (particularly in working-class populations) for economic reasons and many also regarded this work as not 'proper medicine'. However, in the early 20th century, as midwives became more organised, doctors made attempts to control their training and define their role, aware that they were in competition in a market where financial reward was not all that great. Even though attempts at the upgrading of midwifery were opposed by the medical profession, the Midwives Act was passed in 1902. This was the first attempt by Parliament to regulate a sector of the nursing profession. The domination of one group by another can be explained by what Wilding calls a 'pluralist conflict model' in which the conflict is seen as between "fundamentally ad hoc groups - seeking to advance their own interests and further their own collective mobility" (Wilding 1982: 15). The defensiveness of some doctors in the face of the threat from

maternity and child welfare schemes was reflected throughout the medical profession in their responses to the idea of a national maternity service and, in particular, to efforts to upgrade the level of skill amongst midwives.

Midwives were threatened on two fronts: the medical threat to their position and the continuing conflict with the 'handywoman', which lasted well into the 20th century. With the gradual demise of the 'handywomen' the gap was filled by the Local Authority 'official handywoman' or home help, organised and supervised in most cases by either the medical or nursing profession. Even so, role friction between midwives and home helps continued well into this century (Daly 1952).

One aspect of the 'professionalisation' issue already mentioned was the nursing profession's attitude to the domestic aspect of their role which, it has been argued, was difficult to differentiate from housework (Abel-Smith 1960: 242). As a result they began to rid themselves of this aspect of their work and delegate the less skillful tasks to 'assistants'. As pointed out in the last chapter, this delegation was not, however, seen as a good thing by all of the profession. In the case of midwives this delegation was to home helps, who they insisted on being responsible for so that the possibility of the emergence of a new 'hany woman' would not materialise. The development of the unqualified nursing assistant could be seen as an attempt by the nursing profession to define a problem (how to rid itself of the domestic tasks) in such a way that the solution came within the accepted bounds of their professional expertise; by doing this they extended the boundary of their assumed professional skill and embraced authority over the lesser skilled worker (Wilding 1982: 34). This development of 'nursing

assistants' was, however, contested by some nurses, fearing that their own position might be compromised. The Nurses Registration Act was passed in 1919 and the professionalisation of nurses was further strengthened by later legislation.

As the intervention of experts became more common in childbirth, so the management of childrearing became regarded as more technical. At the same time, the basic everyday needs of the mother in regard to housework was neglected. The demand for home helps in particular by women's groups showed their awareness of this side of the problem. However, both working and middle-class women found it difficult to obtain domestic help in their homes, a situation made worse by the dearth of young females entering the work. The lack of domestic support was reported as having an adverse effect on women's health in times of illness or stress. This shortage of labour was due to the social changes taking place in women's employment opportunities and role in the early part of the century. Women themselves began to identify their needs (for instance the need for help in the home) and campaign for change. By the end of the First World War, the reluctance of women to enter domestic work was so great that the Government regarded it as a serious problem. This state of affairs continued until World War Two, which ultimately gave a death blow to the system of domestic servants for all but the wealthy.

Little data exists on the role of the home help services between the two wars. The duties of the home help during this period would seem to have been restricted to simple domestic tasks. The late 19th century saw the state begin to assume responsibility for what had previously been the sole domain of the family in such areas as child health and education. A

centralised approach to the provision of social services, a principle which was to become more important as the century progressed, was advocated. The depression of the 1930s demonstrated that poverty and unemployment were not the result of individual failure and that solutions could not be found in the rehabilitation of the individual. According to Moroney this in turn led to an acceptance of the need to develop collective interventions in both economic and structural terms (Moroney 1976: 4).

One important theme which runs through the first part of this thesis is the status of the home help. Because of the services' association with domestic service or domestic work, recruitment was hampered in the 1920s and 1930s. Recruitment was also to be difficult in the 1940s, a development to be discussed in the next chapter.

CHAPTER THREE

Developments in the Home Help Service to 1948.

3.1 Introduction.

Twice in this century world war on a scale hitherto unknown has necessitated a mobilization of our whole society in a way that is new, a situation that has caused much debate amongst historians as to the long-term effect on society. Some, like Titmuss (1956) and Marwick (1973), have attributed important developments in welfare provision to the influence of war; others have sought to demonstrate its unimportance as an accelerator of social change (Milward 1970).

The effects upon the family, in particular mothers and young children and the elderly, of the social problems caused by war are discussed in this chapter. The problems of the sick and aged caused some concern during the early 1940s and many of the social and economic reasons for this are examined. Whether this concern was as a result of shortage of hospital beds, influenza epidemics or the fear that problems caused by lack of services for the elderly would undermine the morale of the civilian population are discussed. Changes in patterns of work are

examined and their effects upon social policy are considered in relation to domiciliary services. The role of voluntary organisations, in particular the WVS, are discussed in connection with the development of the 'home help' service for mothers and young children and the 'domestic help' scheme for the elderly.

Events leading up to the implementation of the National Health Service Act and National Assistance Act are discussed, in particular their effect upon the evolving home help service and family support. The post-war organisation of domestic employment became a concern of the government which led to suggestions as to how families could be helped by an extension of domiciliary services. Attempts to organise these services are discussed in relation to the prevailing policy of 'self help' for families.

The immediate post-war period saw an urgent debate on the social and economic consequences of an ageing population and an increasing research activity into their needs. Some of the arguments surrounding this debate and the development of a policy for the elderly are discussed.

3.2 The Second World War: Its effect upon the Domiciliary Care Services.

Family life at the beginning of the 1940s was very different from that before the First World War. Many changes had taken place: in housing, in education, in the position of women and in the standard of living in society. Two other important changes were the decrease in family size and the changing family structure (see table 3.1).

Large families were better equipped to cope with the needs of the sick,

handicapped and elderly members in times of stress. As the family shrank,

"the possibilities of intra-family help also shrank. As the families with dependent children were small, fewer families had older, reasonably responsible, children who could help with babies and the two to five year olds" (Ferguson and Fitzgerald 1954: 2).

TABLE 3.1.
Family Size. 1900 - 1940 England and Wales.

| Year of Marriage | Average No. of children | Birth Rate per 1000 pop. |
|------------------|-------------------------|--------------------------|
| 1900 | 4.0 | 28.7 |
| 1910 | 3.0 | 24.5 |
| 1920 | 2.4 | 22.8 |
| 1930 | 2.1 | 15.8 |
| 1940 | 2.1 | 15.9 |

(Source: Moroney 1976: 18 Table 2.1)

Ferguson and Fitzgerald also point out that, particularly in times of severe social stress and upheaval such as war, small families had more difficulty in coping. They gave two reasons for this: "in the first place individual families were dispersed and so in bombed cities were whole neighbourhoods. Secondly mobilisation of men and women was so rigorous that it left unoccupied very few people in the community other than the very young, and the very old and incapacitated" (Ferguson and Fitzgerald 1954: 3). For the professional and managerial classes the disadvantage of small families was compensated for by the availability of domestic servants, a source of help which was to be denied many during the war (Ferguson and Fitzgerald 1954: 2). In peace time this change in family structure might not have been crucial as help would have been available from husbands living at home and unmarried children at home or nearby to offer support to the elderly in times of crisis (Sheldon

1948).

The problems of the aged sick and infirm in war time also threatened

"to become unmanageable. Thousands who had formerly been nursed at home were clamouring for admission to hospitals when families were split up, when homes were damaged or destroyed, and when the nightly trek to the shelters became a part of normal life for Londoners. Yet everything except humanitarian considerations - which often take second place in war - spoke against the poorest and most helpless members of the community. To nurse them was not only uninteresting but often unpleasant; the work soon dampened the enthusiasm of newly enrolled V.A. Ds who expected to nurse soldiers and not incontinent and senile old people" (Titmuss 1956: 448).

Bruce points out that the episode of the war that was most dramatic, revealing and had most influence and impact on attitudes and social policy was evacuation. Evacuation

"held up a mirror to society which had assumed, largely without thinking about it at all, that it was doing well enough by all its members. Loud were the cries of distress when homes were spoiled by dirty and incontinent children, shocked were hostesses by the poor and scanty clothing of many evacuees, which earned for their home towns the title of 'Plimsoll City', and worse still was the reaction to many mothers evacuated with young children (Bruce 1968: 302).

Titmuss writing of the development of social services in the Second World War pointed out the disruption during this period to the lives of children and adults (Titmuss 1956: 516). He highlighted the "effect of a war environment on the loneliness and limited capacity of old age to help itself", which led to an excess mortality during the 1939-1941 period of over 2,300 elderly people "from falling down stairs, out of bed, elsewhere in the home, out of doors and in unknown circumstances" (Titmuss 1956: 334).

The 1931 census showed that the elderly accounted for 7.4 per cent of the population, many of whom had a complex web of potential services available to them (Marsh 1965: 22-31). A number of the elderly were not covered by the contributory or non-contributory pension legislation or

failed to obtain a pension sufficient to meet all their needs. It was not until 1940 that a mechanism for 'topping up' pensions was available through the Old Age and Widow's Pension Act. Medical support for the elderly was a complex system. Some were entitled under health insurance schemes to primary health care, others had to seek care from the public assistance committee of the local authority (Marshall 1948: 38-60). There were various forms of institutional provision in different types of hospitals and for those defined as not requiring medical treatment but still in need of institutional support there was the non-hospital parts of Public Assistance Institutions (Board of Trade 1940: 94).

3.3 Mobilisation: Its effect upon the Community.

Owing to mobilisation, many men were not available to help their families in times of stress or illness. Nearly 15 per cent of the male working population were called up in 1940 and over 30 per cent were mobilised by 1944. That was over four and a half million men, over 50 per cent of whom were married (Ferguson and Fitzgerald 1954: 3). As large numbers of women went to work in the services and factories, the Ministry of Labour adopted powers to direct the female labour force to certain industries and workplaces, so that by 1943 single women up to 50 years of age could be detailed to work away from home. In 1943, over two million women were in the forces and industry and a further one million were doing voluntary war work.

This movement of population had an adverse effect upon the ability of the family and local community to support its weaker members. "It is clear that mobilisation on this scale and the transfer of many young

women away from home into the services or industry must have considerably reduced the help which members of families and neighbours were able to give to each other". Matters were made worse by the reduction in the number of domestic servants available by as much as 60 per cent (Ferguson and Fitzgerald 1954: 6). To provide some support to families, the Government made provisions for the postponement of the calling up of domestic servants in the households of the aged, sick and infirm or where they were the sole mobile person (Hansard 1942: Col 840).

The social and economic conditions of the 1940s threw the resulting problems of the elderly into the limelight. Problems caused by the disruption of society as a result of the war forced the Government of the day to increase its social services in spite of the fact that many people and some members of the Government felt that they should even be reduced (Titmuss 1956: 329). The writings of Richey (1951), Burr (1949) and others suggest that the main drive behind this policy was the wish to prevent the elderly sick or frail from entering hospital, a policy explained by the Ministry of Health in 1944 and again in 1946 (DHSS 99063/3/35, Ministry of Health 1947a: 81). However, concern for civilian morale was also a factor in extending services for the elderly, as indicated by the Ministry of Health in 1944 (DHSS 99063/8/1A. (6)).

A number of short-term measures to meet the immediate needs of the elderly and mothers with young children were introduced, many of them organised in co-operation with voluntary bodies such as the The Women's Voluntary Service.

Local Authorities and Voluntary Agencies co-operated in an effort to co-ordinate services. The London Council of Social Services, along with

many other Councils in large cities, organised Old People's Welfare Committees. By 1944, the London Council, concerned at the wasteful overlap of effort, opened discussions with statutory authorities on the possibility of setting up Old People's Welfare Committees in every London Borough (Slack 1960: 15). One obvious way to help the old in the community was to supply them with domestic help. In war time the absence of husbands, difficulties of finding relations to help, the shortage of hospital beds all pointed to the need for community support and, in particular, domestic help in the home. In the summer of 1942 the Government began an inquiry into the extent of domiciliary support in the community. It was found that only about 55 per cent of authorities operated a home help scheme, most of which were very small and many of them only available to mothers and children (Ferguson and Fitzgerald 1954: 10).

The authorities' failure to develop services quickly enough was put down to their inability to recruit appropriate staff (Hansard 1953: Col 576). Others, however, put the problem down to the low priority given to such services:

"In the plans for the war time operation of the Social Services considerations of safety rather than considerations of welfare were predominant. Inevitably, therefore, the maternity service did not loom very large in the plans. For the maternity service had no claim to special usefulness in war" (Ferguson and Fitzgerald 1954: 27).

It was hoped that by moving mothers and young children to safe parts of the country the services would be adequate to meet the need. However, mobilization withdrew social support from the vulnerable on a massive scale.

3.4 Mothers, Children and the Elderly

Why then did the Government change its mind and develop the child welfare services? As early as 1942 the Government was showing concern at the plight of mothers and young children. The unevenness of the service provision and the structure of the service delivery system was causing most concern.

In England and Wales alone there were over 400 Welfare Authorities with permissive powers to provide social and welfare services such as health visiting and maternity clinics. There were also 188 authorities responsible for the supervision of the midwifery services. As a result of this unco-ordinated system, many mothers went without the continuous care which was necessary if services and support were to be effective (Maternity in G.B 1948: 29).

The Royal College of Obstetricians commenting on the services available at that time found that they were "not of the class deserved by the Nation" (Maternity in G.B. 1948: 8). In 1939 the majority of pregnant women refused to be evacuated, deciding instead to stay with family and friends during their confinement. Out of the 140,000 women the Government hoped would accept evacuation, only 12,000 left their homes (M O H 1941: 31) and many of those returned to their homes within a few weeks of leaving them (Public Health 1940: 172). Also, as Bruce highlights, how striking "was the pull of the family to evacuees who returned home in large numbers when danger seemed less imminent" (Bruce 1968: 303). It was obvious to many that evacuation led to failure in family life and neglected children.

By the summer of 1942, the crisis in the maternity and child welfare

services had become acute. Women began to press for, and use, institutions such as nursing homes or maternity homes in which to spend their confinement. This trend had begun before the war but was intensified by wartime conditions, which made it increasingly difficult for mothers to find paid or unpaid help at a time of crisis. Richey points out that during the war "the plight of many households where the mother or housewife was laid aside or absent by acute illness or other family emergency" was a factor in inducing the government to authorise measures of emergency help (Richey 1951: 1). Burr, in 1949, claimed:

"The Minister of Health was distressed at the position of sick and infirm persons who were unable to obtain either hospital accommodation - which was much limited in the number of beds - or help in the homes of which they were particularly in need. Moreover, it was apparent that many of these sick or infirm people, many of whom were aged, were quite unable to pay for the services required" (Burr 1949: 3).

The Advisory Committee on the Welfare of Mothers and Young Children therefore recommended to the Minister that the home help service should be extended. Pressure was also put on the Minister to extend the service to the sick and infirm (Hansard 1942a: Col 364, Hansard 1942b: Col 1307). The Ministry reviewed the maternity and child health home help scheme and issued advice to local authorities to extend the service to mothers in confinement at home as well as during the lying-in and ante-natal period. The availability of the service was to be in no way dependent on the financial circumstances of the client (PRO MH10/149). In 1944, Ernest Bevin and officials from the Ministry of Labour and National Service were pressing the Minister of Health for an extension of the home help services to include the elderly sick and frail (DHSS 99063/8/1A. (1)). The government agreed to widen the criteria for the home help service and the Minister of Health opened discussions with the

Standing Joint Committee of the Metropolitan Boroughs and other local authorities about the possibility of the government taking over more responsibilities in the form of a home help service for the sick and infirm (Hansard 1944b: Col 414).

As a result of these discussions a Green Paper was issued in which the Minister stated:

"All domestic work to which women are now sent by employment exchanges is priority work of a high order. It is essential for it to be performed if the sick and wounded are to recover, if the rising generation is to have the good start we want them to have, if mothers in childbirth are to regain strength, if war workers are to be well fed and cared for, and if the old and invalids are to be properly looked after" (Hansard 1944c: Col 314).

The advice given to Local Authorities in circular 58/44 was much more ambitious than anything the government had recommended before, particularly when seen in the light of advice given to them in circular 179/44 on 'Domestic Help' for sick and infirm cases (PRO MH10/151). The Government had in 1944 passed an Order in Council which added Regulation 68E to the Defence (General) Regulations 1939 allowing local authorities to extend a 'home help' or 'domestic help' scheme to the elderly and the infirm. Those local authorities wishing to operate the scheme were recommended to co-operate and co-ordinate their efforts with appropriate voluntary organisations such as the Women's Voluntary Service (WVS), an organisation which will be discussed later. As a result of this pressure, the Minister agreed that the work was of national importance, encouraged the direction of women into the service and introduced a minimum wage. New rates of pay were set, conditions of service laid down and encouragement given from the Ministry of Labour to women to take up the job. Some argued that the Minister had not gone far enough and set up "really effective administrative machinery" to "enable

anyone who wishes to get a home help or domestic servant" (Hansard 1944b: Col 414). It was not thought necessary to encourage authorities to set up schemes in rural areas, as the Government argued that country people would help each other in times of stress. By 1946, it was clear that this policy had been built on a false premise. The WVS argued that "the neighbourliness of country folk, which made such a service unnecessary, was proved wholly incorrect" (The WVS and Home Help: 15). The changing role of women discussed in the last chapter continued in the 1940s. Many women, as in the early part of the century, continued to press for medical and domiciliary services, services now made even more necessary by the problems caused by mobilisation. How far this pressure was responsible for change is debatable in view of the arguments now put forward about the importance attached to civilian morale. However, what is certain is that a national home help service was extended to encompass the elderly and infirm but authorities found difficulties in developing programmes because of the difficulties of recruitment. The unique wartime situation contributed to the development of domiciliary services as they had during and after the First World War.

3.5 The Women's Voluntary Service and Domiciliary Care.

Concern about the lack of domestic help available for private families surfaced early in the war. A few voluntary agencies attempted to fill the gap left in the local community support system brought about by wartime conditions. The WVS had in 1939 organised a 'Housewives Service' in response to demand in London and other large cities from many women

who, because of home responsibilities, were unable to offer their services for Air Raid Precaution duties. These women volunteered to help ARP Wardens and their neighbours in times of distress. The WVS was formed in 1938 as "a new women's organisation sufficiently flexible to cope with unimagined difficulties likely to arise in Civil Defence" (Beauman 1977: 6). By 1942, over 300,000 had been recruited by the WVS and were supporting their local community with

"courageous help during and after 'incidents', their spirit of good neighbourliness found many opportunities for usefulness, as for instance, shopping and housework for women employed in war factories, getting tea for children who returned from school before their mothers were back from the factory" (The WVS and the Home Help Service: 4).

A widespread influenza epidemic in 1943 led to an appeal from the Ministry of Health to the St. John's Ambulance Brigade, The British Red Cross and the WVS for help. In order to define their respective spheres of responsibility the WVS and the British Red Cross met in October 1943 and agreed that the Red Cross should confine its activities to offering support where there was "sickness and disability" and that the WVS should operate by providing domestic support. "Nursing Aid work will be undertaken by members of the British Red Cross and St. John's Ambulance Brigade" who will work only "on official medical request from the doctor or district nurse. To the WVS will fall the task of cooking or the day to day domestic help" (The WVS and Home Help Service: 8).

The WVS circularised its members to this effect in a communication titled 'Emergency Home Help Service'. This advice made it clear to those wishing to set up a scheme that it was to be quite distinct from the Government's Maternity and Child Welfare 'Home Help' service. This new operation was viewed as an extension of their own 'Housewife Service'. The WVS worked in co-operation with local Medical Officers of Health in

implementing new services which were well received, but by the time it was in full swing the influenza epidemic was abating. The lessons learned however were not lost; many were put into operation later when the WVS expanded the home help service itself as in the Isle of Wight. This scheme aimed "to stimulate and encourage part time women to help in homes where there" was "illness and to form a pool of women that doctors, MOHs and district nurses" could draw upon in times of emergency (WVS 1943: 10).

To help set up new schemes the Ministry hoped that authorities would call upon the WVS for advice and, because of the recruitment difficulties experienced by authorities in setting up or expanding their services, the Minister requested the WVS to do all in its power "by means of propaganda and publicity to indicate the essential character of the work performed by Home Helps together with their serious lack" (WVS 1943: 3).

3.6 The Domestic Help Scheme for the Aged.

As discussed previously in this chapter, war time conditions had made it clear that there were groups other than mothers and young children who needed community support. Many families who experienced difficulties during the war period were reluctant to make use of the pre-war assistance services which, as far as services for the aged were concerned, were based on the old poor law and workhouse tradition. Many who needed assistance would have viewed any "suggestion that they use the existing public institutions with horror" (Ferguson and Fitzgerald 1954: 9).

By 1942, many middle-class families were struggling to cope with sickness among their elderly relatives (Hansard 1942a). Many sick and elderly people were failing to obtain admission to hospitals, which caused strain on those who looked after them at home (Hansard 1942b).

The Ministry of Labour summed up the situation as follows:

"The overriding claims of aircraft and munitions have swept the vast majority of maids, trained and untrained alike, into essential national war work. But total war has brought great sufferings and hardships to countless households; especially to families which include the aged, the sick, and young children. Family life among the middle and upper classes in this country has for generations rested largely on the assumption of domestic help of some kind being available. There is much evidence of strain and consequent ill health" (Ministry of Labour and National Service 1945: 7).

The question facing the the government was whether to place new or extended services in "the voluntary services, the local authorities, or the labour exchanges" (Lancet 1943: 307). The medical profession argued for a domestic help service based on labour exchanges. They saw any new service as purely a domestic one. Voluntary organisations, they argued, were weakest where need was greatest and local authorities were unable to offer a uniform service particularly in rural areas. They settled for the new service to be managed by a "professional welfare officer" based in the local Labour Exchange.

General Practitioners feared that the demand of any new service would place new pressures on them. They considered that:

"If the services centered on Labour Exchanges, a uniform national coverage could be guaranteed; the complete potential pool of home helpers would be ready to hand; and a further humanising link between the Labour Exchange and the general public would be established. As a corollary, it would seem essential that each exchange should have a trained officer in charge of the home help service to assess need, to sift out bogus claims, and to visit homes. In choosing her home helps she would wish to have to remember the fear of the 'other woman' which sometimes keep the sick wife on her feet. We will look to her to assess social and medical need, let us hope the practitioner will be spared another certificate. Once the medical expert has given his orders it does not take a medical expert to see that they are carried out" (Lancet

1943: 307).

The Minister's immediate concern was the supply of female domestic labour to hospitals and allied services. Parliament were aware of "the very strong feelings" in the country of the serious difficulties owing to the shortage of domestic help (Hansard 1944a: Col 321). To try to encourage girls to enter the service and improve their conditions the Minister set up a committee

"to make recommendations as to minimum rates of wages and conditions of employment which should be recognised for the purpose of any special arrangement which may be instituted for meeting the needs of Hospitals, establishments for the care of the children and of the sick, aged or disabled persons, the school meals service or similar organisations for domestic help" (Ministry of Labour and National Service 1943: 2).

To help recruit more part-time workers the committee recommended a minimum payment of 1s.2d per hour, which applied also to the home help service (Ministry of Labour and National Service 1943: 6). Local authorities were willing to support an extension of the home help service provided they were given the legal authority to do so and the cost was reimbursed by central government (DHSS 99063/8/1A (3)).

Circular 179/44 outlined conditions under which Local Authorities had to operate if they wished to submit a scheme for the provision of 'Domestic Help'. They had to:

1. Appoint and maintain a register of home helps available for work at any time and arrange for their payment.
2. Arrange for assessment procedures to determine the urgency of applicants for the service.
3. Assess what part of the cost should be borne by the client and set up payment procedures.

The service was made available to the following categories of client:

1. Where the housewife falls sick or must have an operation.
2. Where the wife is suddenly called away to see her husband in hospital and arrangements have to be made to look after the children.
3. Elderly people who are ill or infirm.
4. Where several members of the family are ill at the same time. e.g.

during an influenza epidemic (Sheffield Health Committee 1945: 4).

Many people were encouraged by the actions of the government but there were those who doubted if local authorities had the political will to set up schemes. Mrs Macdonald, who organised the City of Oxford Project, then hailed as a model for future schemes, remarked, "It is one thing to give local authorities statutory powers it is another to get a plan to work" (Macdonald 1949: 179). Others doubted if the authorities would be able to recruit enough suitable staff (DHSS 99063/8/1A (8)). Adding to these difficulties was the confusion in the minds of the public about the service, which arose because of the use by the Government of the two terms 'Domestic Help' and 'Home Help'. Each service operated under different legislation but the distinction was merely an accountancy one. The 'Home Help' scheme provided under the Maternity and Child Welfare provisions for mothers and children was financed directly from the local rates with a grant from the Exchequer. The 'Domestic Help' scheme provided under the 1944 legislation, for the elderly and sick, was financed directly from the Exchequer. This confusion and a shortage of appropriate labour proved an obstacle to the development of the domiciliary care services. It was, as Ferguson and Fitzgerald point out, inevitable that as the strain on the nation's manpower grew more and more intense, problems of staffing the social services should grow more and more difficult. There developed a shortage of all kinds of workers, particularly in those occupations where recruitment had already been inadequate before the war (Ferguson and Fitzgerald 1954: 284).

"By February 1945 there were only nineteen local authorities who were known to be starting schemes" (Ferguson and Fitzgerald 1954: 11). There were only 11,967 households receiving any kind of domestic support

either from private, 'Domestic' or 'Home Help' schemes (Hansard 1944d: Col 2402). One example of such a scheme was Sheffield City Council's, which had in early 1945, submitted proposals to the Minister which he approved in March of that year. In this scheme the recruitment and supervision of home helps was the responsibility of the health visitor.

Three types of home help were recruited:

1. Whole time, on the basis of a guaranteed week of wages irrespective of their schedule of engagements.
2. Reserve Home Helps who were employed on a daily basis.
3. Part Time Home Helps who were employed on an hourly basis.

The hours of duty of the full-time staff were from 8am to 4.30pm daily and 8am to 2pm on Saturday. No service was offered on Saturday afternoon, Sundays or Bank Holidays (Sheffield Health Committee 1945: 4-5). By the end of 1945, the city had recruited 10 whole-time and 10 part-time home helps who between them had supported 84 maternity cases and 111 general cases (Annual Report, Health of Sheffield 1946: 35).

The need for the provision of a 'home help' service had been well argued by many and was recognised by Government as a need; it passed legislation to allow local authorities to develop services if they wished. Some doubted if they had the political will to do so but a major block to any such development was the shortage of suitable women to staff the service. This problem was recognised and the recruitment for domestic service was seen as a national priority but many authorities still experienced difficulties in recruitment. Two local authorities had set up experimental projects; the City of Oxford and the London Borough of Lewisham, which were later to be used as models for other schemes (PRO MH10/56). The London Borough of Lewisham had commenced a home help

service in 1930 which was expanded in 1944 to meet the new demand from the sick and infirm. The scheme was staffed by one supervisor, an assistant supervisor and eight clerical assistants. Three of the clerks also spent three half days a week assessing clients, with the assistant supervisor reviewing the cases of elderly persons every month. Over 50 per cent of the expenditure on the scheme was on the 'Domestic Help' service provided for old people (Simpson 1948: 208). One scheme in particular aroused much interest nationally and internationally - the City of Oxford service.

3.7 The City of Oxford Home Help Scheme.

Mrs. T. Macdonald, the City WVS Organiser, believed that the original WVS 'Emergency Housewives' scheme was a part solution to the problem of providing support to families. She was convinced that active steps had to be taken to remove the stigma from paid domestic work in the home. She argued that the domestic workers' status could be raised by training and by their being recognised employees of a local authority, with suitable pay and conditions of service. She also had the idea of presenting the home help service as a new career for women imbued with a spirit of service to the community and organised by voluntary organisations (The WVS and Home Help Service: 5). Writing later she stated:

"In recruiting, this emphasis on a public health service was a trump card. The home helps quickly realised that they were employees of the city like nurses, school teachers or policemen, and that they were visiting houses as workers in the health service and not as drudges to be bossed about" (Macdonald 1949: 179).

In Collaboration with the City Treasurer and Medical Officer of Health

she, in November 1944, drafted a home help scheme which was endorsed by WVS Headquarters and accepted by the Maternity and Child Welfare Committee of the City as an experimental scheme for one year. Her ideas were further strengthened by the Government's proposals in Circular 179/44 which were issued two weeks later on December 14th.

To launch the scheme in Oxford the Rt.Hon. Florence Horsbrugh, the Parliamentary Secretary to the Minister of Health, was principal speaker at a public meeting in the city (The WVS and Home Help Service: 6). The scheme produced a booklet entitled 'New Career for Women' which outlined the advantage of working as a home help. This booklet was reprinted three times and at least eight local authorities reproduced it locally. Organisers emphasised that the service was not a supply of charwomen, but an emergency service of trained helpers strictly for households in temporary difficulty:

"Home helps then were to concentrate on health, with maternity cases in families with children under five as top priority. A medical certificate (from a doctor, a district nurse, or a hospital almoner) had to be presented by every applicant for help. It was to be an emergency service; that is, it would take only short term cases. This excluded old people and those with chronic illnesses" (Macdonald 1949: 79).

After some months, however, the service was extended to the elderly and chronic cases. The priority list of the scheme was much the same as recommended by the Government:

- Mothers before and after birth of child.
- Miscarriages.
- Temporary illness in active women.
- Temporary illness in old people,
- Chronic invalids.

(Report on City of Oxford Home Help Service, March 1945: 2).

By March 1945, the service had 45 applications for help which were dealt with in the following manner:

| | |
|--|----|
| 1. Number of applications for all kinds of help. | 45 |
| 2. Number who did not pursue personal application. | 17 |
| 3. Number visited but did not accept help. | 10 |
| 4. Number Visited and helped | 12 |
| 5. Number visited and booked in advance | 6 |

(Report on City of Oxford Home Help Service, March 1945: 2).

The item, 'Number who did not pursue personal application' referred to those clients who, for whatever reason, did not support their application with a doctor's note or certificate. Of the 10 who did not accept help it is interesting to note the reasons given: neighbours helped out; doctor had advised holiday; private domestic arrangement made; the landlady did not allow strangers into the house; or the husband refused to have his home inspected (WVS 1945: 2).

By April 1945, it had become clear that full time clerical and administrative support with adequate office facilities was needed. The City Council agreed to a WVS request for the appointment of one full-time and one part time supervisor. Four caseworkers visited the applicants (it is not clear if these were paid or volunteer appointments), explained the workings of the scheme, assessed need, client ability to pay and collected any fees. The service was managed by an executive committee comprising WVS volunteers and Local Authority representatives.

In October 1945, the number of home helps employed had risen to 35, by November to 40 but by January 1946 the number had fallen to 31. This fall in the number employed was put down to recruitment difficulties caused by

"householders offering accommodation to home helps and their returning demobilised husbands in part return for service, newly returned husbands from the war who were reluctant to allow their wives to work and to marriage and pregnancy" (WVS 1946: 1).

A financial appraisal of the scheme after eight months showed that for

every £1,000 spent £800 were recovered from clients. The City treasurer reported that the freeing of hospital beds was also off-setting some of the costs incurred. The WVS were, however, less confident that the scheme was audited properly. This concern was heightened when the City began to question the cost of the service despite the Treasurer's optimism. Mrs. Macdonald wrote to Lady Reading, the Chairman of the WVS, in October 1945, stating that the city was concerned about the cost. She argued that "no serious attempt to analyse facts or figures" had been made and it was impossible to show where the deficit, if any, was (MacDonald 1945a). Lady Reading replied on the 22nd of October 1945 that she had "seen the appropriate Ministry of Health person" who encouraged her to do everything she could to develop home help services but he could not "take on any financial responsibility centrally" (WVS 1945). In order to help keep costs down the Medical Officer of Health suggested to Mrs. Macdonald that the hospital almoner should assess cases (Macdonald 1945b). By January 1946, the two sides had come to an arrangement. The Town Clerk wrote to the WVS that the City "felt now that various administrative difficulties had been sorted out nothing would be gained by the city taking over any part of the running of the scheme" but he admitted that when financial accounts were available the matter would be looked at again (The WVS and Home Help Service: 9). This scheme attempted to raise the status of the home help service by presenting the home help as a new career for women in the local government service. This move was reasonably successful but even so the scheme did experience some difficulty in recruiting suitable women.

3.8 Post-War Organisation of Domestic Employment.

"With the growing importance which was being accorded to the home help and to the domestic worker in hospitals, it is not surprising that the efforts which had been made over a long period by many organisations and individuals on behalf of the Domestic Workers in private employment should at length come to a head" (Elliott 1951: 132).

In 1945 the Minister of Labour and National Service set up a committee to review various schemes for the post-war organisation of private domestic employment. Mr. Bevin had been under pressure in the House of Commons to clarify the situation regarding domestic employment. Members questioned him on the 15th February 1945 on this matter, particularly on the effects of the lack of help in the home for the old and infirm. The matter was made all the more urgent because of the political pressure brought by many people who were receiving letters from their daughters in the services stating that they "had nothing to do in the services" (Hansard 1945: Col 366).

The Committees report showed the extent to which some officials were committed to maintaining the supply of working class women for domestic work for the middle classes (Ministry of Labour and National Service 1945). The report noted that the war had disrupted the structure of domestic service and as a consequence there was much evidence "of ill health among families and especially families with old members" (Ministry of Labour and National Service 1945: 7). To remedy the lack of domestics the committee argued along the same lines as the WWS, that improvement would only come about by raising the status of the domestic worker. To achieve this the committee recommended the setting up of a Corporation for Domestic Workers to be called The National Institution Of Houseworkers. The aims of the Institution were:

"1. To supply competent domestic workers either trained by the Institute in their own centres or of those whose efficiency they were otherwise satisfied.

11. To adopt regulations for minimum rates of wages and conditions to which employers of the Institute's certified workers would conform".

There was to be no compulsion upon either the employer or employee to make use of the Institute but the report stressed the conviction that if such an organisation were established, the standards set would little by little "influence the whole field of domestic employment and in time be authoritative" (Ministry of Labour and National Service 1945: 11).

The committee also foresaw many difficulties facing women after the war:

"We think that the difficulties of a housewife will be in large measure met by the part-time service; by increased efficiency (a cornerstone of our proposals) and by income tax relief. But some ragged ends remain and in certain respects the post-war world will not spell an easier life for women. A social revolution is at present taking place in the homes of the nation. Life after the war is unlikely to revert to the pre-war pattern.

The Institute must ensure that the housewife gets good value for money. If she has to rely on part-time service it must be of a quality adequate to the tasks in hand" (Ministry of Labour and National Service 1945: 18).

Any service provided after the war was not expected to replace self-help. The committee considered ways in which mothers could support themselves by setting up self-help groups:

"Each mother in turn could secure some hours of freedom if another mother or neighbour arranges occasionally to take her book and sewing to sit in the house" (Ministry of Labour and National Service 1945: 18).

It would seem that officials encouraged authorities to extend and expand services in such a manner that they did not undermine the family or neighbourhood support systems. The principle of family responsibility was upheld; a home help should be offered only after a family had failed to find friends or neighbours to help (PRO MH10/149). The reasons for this are discussed in the next chapter. Ministry of Health officials

examining the effect of war upon the family, acknowledged the impossibility of finding a substitute for the family in times of stress. As Bruce points out, "social policy aimed henceforth at maintaining the family intact, and, where necessary, restoring it and improving the quality of its care. Only in the last resort was a substitute sought, and then it had to bear the closest possible resemblance to the original" (Bruce 1968:303). War-time shortages of manpower and finance had made the government an arbiter on questions of family social policy and brought the Ministry of Health to the fore as an advocate for services for certain groups of the population (Ferguson and Fitzgerald 1954:13).

The committee on Post-War Domestic Service were also very concerned about the problems "of the hard-pressed working-class mother and the aged, sick and infirm persons, whose financial circumstances make the standard rate of the Institute impracticable" (Ministry of Labour and National Service 1945: 9). Matters were made worse for these families because domestic or home help services did not exist in many Local Authorities (Ministry of Labour and National Service 1945: 19).

The Deputy Chief Nursing Officer of the Ministry of Health and staff from the Ministry of Labour and National Service began an investigation into a small number of "domestic help schemes which according to statistics furnished in June 1945 appeared to be functioning successfully, and others which seemed to be less successful" (The WVS and Home Help Service: 11).

Visits were paid to Hertfordshire, Bermondsey, Lewisham, Oxford and Reading Health Departments as well as the Regional Offices of the Ministry of Health in these areas. The resulting report which was

confidential left no doubt

"that the extended powers given to welfare authorities under Regulation 68E had failed to provide the necessary stimulus, and that the supply of home helps would be totally inadequate to meet emergencies during the winter" (The WVS and Home Help Service: 11).

One hundred and eight authorities had requested the Minister to approve their schemes but many never got off the ground because of recruitment difficulties. There was little co-ordination between schemes; many authorities visited had little or no knowledge of the operation of other schemes. The investigators recommended that the services of the London Borough of Lewisham and the City of Oxford should be used as models. This report formed the basis of the Ministry of Health's subsequent policy for the development of the Home Help Service (The WVS and Home Help Service: 12).

As a result of the success of the Oxford scheme, the findings of the officials of the Ministries of Health and Labour, and the recommendations of the committee on the Future of Private Domestic Service, the Minister issued advice to local authorities in the form of a circular in June 1946 (PRO MH/10 156).

He reiterated his House of Commons announcement of February of the Government's intention to set up a National Institute of Houseworkers, which he hoped would allow local authorities access to a new source of recruitment for the service. The circular went on to recommend the home help schemes in Oxford and Lewisham as models. Full-time organisers were strongly recommended and recruitment of the home helps was advised through local representative women's organisations, midwives, health visitors and district nurses as well as the local employment exchanges. The pay and conditions of helps was to be tied to local conditions.

Details of the Oxford scheme had been sent to all WVS regional offices with instructions to initiate similar projects in co-operation with Local Medical Officers of Health. Proposals for any new scheme had to be submitted by the local authority to the Minister for approval. Arrangements were also made for the Minister to circulate from time to time progress of individual authorities' schemes. Brief reports of all the new schemes were requested by September 30th 1946 (PRO MH10/156).

3.9 National Health Service Act, Part 111.

In November 1946, The National Health Service Act reached the statute book. Part 111 of the Act laid a duty upon Local Authorities to provide certain Nursing and Domestic Help services. Under Section 29 of the Act, Authorities were given powers to provide a comprehensive home help service for

"households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age" (PRO MH10/160).

The day the Act came into force all reimbursing arrangements under Defence Regulation 68E ceased. The new service would be grant-aided on the same basis as other local authority services.

Much of the advice and powers given were based on information gained from the experience of the WVS home help schemes. Difficulties had been reported by them in using the unoccupied time of full-time helps; in getting women to work with tubercular and cancer patients; and in dealing with dirty homes and problem families. Difficulties encountered in the social, medical and financial assessment of clients were also reported. Authorities were advised, when assessing clients, that they

were to include the cost of the domestic help as well as insurance, travelling costs, time, salaries of organisers and clerical staff. Home helps were to be used in households where tuberculosis or other infectious diseases were present only on the instructions of the Medical Officer of Health.

Unlike the home helps service, other community services to be provided by local authorities were to be mandatory, not permissive. Section 25 placed a responsibility on authorities to provide a nursing service to persons in their own homes. No such duty had rested on local authorities before. The service was to be free; authorities could employ qualified nurses, and assistant nurses provided they were supervised by qualified staff. The Government realised that because of the shortage of qualified staff, recruitment would prove to be a problem. Therefore, the authorities were allowed to develop their nursing services over a period of years (PRO MH10/156).

The extended powers provided for in the Act in relation to home helps was not obligatory and many felt that some Local Authorities might not take seriously their responsibility to set up a service. For example, the WVS Headquarters Home Help Specialist, from her experience gained travelling around the country, was convinced that progress would be slow unless "both centrally and locally, WVS was active in providing the necessary stimulus" to local authorities (The WVS and Home Help Service: 16).

Many authorities, when submitting their proposals to the Minister, indicated no changes in their services from their pre-1948 system. Sheffield City Council was a case in point. Proposals were submitted under headings provided by the Ministry. Part 1 was a description of

their existing scheme and Part 11 a description of the service to operate on the appointed day (M O H 1947: 23 Appendix F). For example, the only difference in Sheffield's proposals was increase in staff from 25 to 30 full-time and 19 to 30 part-time home helps (City and County Borough of Sheffield Proposals 1948). The London County Council's scheme contemplated only the "continuation of the pre- 1948 arrangements" (Nepean-Gubbins 1962: 1).

To enable authorities to share ideas and learn from the successful schemes, the WVS convened on the 11/12th of November 1947, with the Ministry of Health's support, a National Conference on "Some Aspects of the Home Help Scheme". The WVS had always refused to refer to the 'Domestic Help Scheme', preferring instead to call it the 'Home Help Scheme'. The aim of the conference was

"to provide an opportunity for Home Help Organisers to discuss some of their problems and pool ideas, as well as to enable Authorities who have not yet appointed Organisers to obtain information from those who are already operating a satisfactory service" (The WVS and Home Help Service: 17).

On the second day of the conference Mr. Bevin spoke on the need to develop the service and in particular the need for both statutory and voluntary organisations to plan and work together. More revealing of Government intentions and priorities, however, was a speech by Mr. Wilkinson, a senior Ministry of Health civil servant, who gave an indication of what the government saw as the priorities for the new service. He considered that the National Health Service could not function efficiently unless an adequate domestic help service was provided but he stated the service must set priorities:

"It would be impossible to meet every demand of every kind on an automatic basis. The scheme did not set out to provide domestic help for all and sundry at the public's expense. The scheme was intended to help those who would really suffer unless such help was available. The needs

of the ill, nursing and expectant mothers were obvious, provided they had no one on whom they could call. The aged should not be considered as having an automatic claim, but their circumstances should be investigated. The period of need should also be carefully watched and the amount of help to be given. Public funds must be protected" (City of Sheffield 1948: 6).

The Government at this time obviously saw mothers and young children as a priority for domestic support. The Maternity and Child Welfare movement was, in 1948, still a strong force (reasons for this are dealt with in the next chapter). Was this policy justified? No survey had been carried out into the needs of the elderly since Booth's survey in the 19th century.

The Royal College of Obstetricians and Gynaecologists' national survey into the social and economic problems caused by pregnancy and childbirth tried to find answers to such questions as:

"what services are available to women bearing children, how far are they being used and what are the factors affecting their use? Do they help women to regard childbirth as a normal process? How do they prevent premature birth and infant death and promote the health of mothers and infants?" (Maternity in Great Britain 1948: VI).

The report argued that gainful employment during the last few months of pregnancy was associated with relatively high prematurity and still-birth rates (Maternity in G. B. 1948: 141, 168).

It was also thought possible that similar risks could be incurred by women with heavy domestic duties, who continue to do all the housework or who, because of the lack of domestic help, would not enter hospital for their confinement. Domestic help was considered essential during the last weeks of pregnancy, during the lying-in period and for some weeks after the birth (Maternity in G. B. 1948: 177). In 1946 almost 90 per cent of the help in the home came from husbands, relatives or friends but even so existing needs were not met. Mothers whose needs were

greatest received the least help (Maternity in G.B. 1948: 179, 183). Families were the most important source of help and support to mothers. Eighty three per cent of help was given by them with the home help service only providing 1.6 per cent. Sixty per cent of mothers interviewed would have liked the support of the home help service. "The service in existence in 1946, based on the permissive powers of the 1918 Maternity and Child Welfare Act, was totally inadequate to meet the demand expressed" (Maternity in G. B. 1948: 187).

The demand for the service varied very little with social class.

Some who had experienced the support given by the service were dissatisfied but the main criticism was the very restrictive nature of the service provided. Even in exceptionally well served authorities, such as Lewisham, home helps were provided for only 30 per cent of confinements in 1946. A few maternity cases only were helped, and those for the lying-in period alone (Maternity in G.B. 1948: 189). The 1948 report concluded:

"Domestic help is essential to give mothers a chance of resting in the last weeks of pregnancy and after confinement, but many women were not receiving assistance in 1946. Even the well-to-do mothers were not always helped, but lack of help was much more frequent in the poorer groups, especially among "women with large families" confined at home. Where help was given it came chiefly from relatives, though husbands occasionally assisted, and among the better off a paid help was quite often employed. The assisted mothers were by no means always helped for an adequate length of time" (Maternity in G. B. 1948: 90-191).

This report highlighted the inadequate home help service provided prior to 1948 before the introduction of the National Health Service. The priority of the service was to support mothers and young children. The Maternity and Child Welfare report showed all too clearly the need for an expansion in this area. Were the Minister's priorities justified? Was

the position of the elderly before 1948 any better than that of mothers with young children?

3.10 Services for the Elderly.

The immediate post-war period saw an urgent need for a debate on the social and economic consequences of an ageing population and an increase in research activity on topics concerning old age. Studies by Sheldon (1948) and Rowntree (1947) began a debate on a range of issues concerning the elderly. Indeed, some went so far as to argue that too much concentration on the needs of the elderly might hinder economic growth (Political and Economic Planning 1948:84). Beveridge himself had warned "it is dangerous to be in any way lavish in old age" until "adequate provision has been assured for all other vital needs, such as prevention of disease, and the adequate nutrition of the young" (Beveridge 1942:42).

Emphasis was laid by most authorities on the care of mothers and young children despite the mounting evidence which pointed to the needs of the elderly (Hamer 1962: 15). There were those, however, who saw that the potential of the service would not be fully utilised until it became available on a much wider basis to the aged and sick.

An editorial in *Mother and Child* ran:

"so far as the aged are concerned institutionalisation becomes essential when domestic help is not available. Those who know the aged realised how they will fight to the last ditch to be allowed to remain in their own surroundings, in their own room with their own independence, no matter how squalid the environment may be, rather than accept the antiseptic if kindly atmosphere of the institution. There are many small homes for the aged doing very good work and excellently run, but even these old persons prefer to remain in their own homes. This can often be achieved by the provision of a little daily domestic help. The needs of the aged are few and they are content with little, but they

always retain a spark of independence and when deprived of this happiness goes with it". The writer went on to call for authorities to "Plan boldly and realise that in section 29 of the new Act we have an opportunity for initiative and wise planning" (Mother and Child 1948: 205).

Rowntree (1947) provided some of the answers concerning the needs of the elderly which were later supported by Sheldon (1948). He surveyed several local authority areas, looking at the needs of the elderly and in one particular area a detailed survey of the welfare services provided for the elderly by the statutory services was carried out. Many of the elderly needed help with housework, especially old men who "were living alone, old women in the higher age groups and those who" had "physical disabilities or" had "elderly people living with them needing care" (Rowntree 1947: 49).

The shortcomings of the existing home help service were commented upon but Rowntree was perhaps also the first to comment on the relationship between housing policy and the provision of home help which he argued had:

"a direct relation to housing policy. The old should not be isolated from the rest of a housing estate- if houses for the old were built in small groups rather than being scattered indiscriminately among other houses, it" would "be easier and cheaper to provide certain communal services including domestic assistance" (Rowntree 1947: 50).

The provision of an adequate home help service was felt to be all important as the community nursing support to the elderly was sparse and inadequate. Rowntree states that the

"ideal provision would be a daily visit in their own homes by a nurse, preferably one who had special training in the care of the aged; but at present the shortage of nurses is so serious that it is often impossible to arrange for old people to be nursed, or even looked after in such matters as being fed and washed in their own homes" (Rowntree 1947: 57).

Sheldon's inquiry, published in 1948, was a more detailed study of the needs of the elderly but only in one Local Authority, Wolverhampton.

However, the results do support Rowntree's findings. Half of the elderly people surveyed had had an illness requiring bed rest since reaching the age of 60 years. In these cases wives did most of the nursing for the men; but when women were ill they were nursed by the daughter of the family. No less than 64 per cent of the women in the survey had nursed an illness in the home since reaching the age of 60. In many of these cases domestic help would have been preferred rather than nursing support (Source Sheldon 1948: 68 Table xxxix). In nearly 60 per cent of all cases the old person would have welcomed extra domestic or nursing help in the home (Sheldon 1948: 167-170).

When examining the nursing of spouses in fatal illness, Sheldon found that although all those responsible for the care of the ill person were over 60 years of age they were "obviously prepared to work themselves to the bone in looking after their loved ones". Many never recovered from the strain. Nursing help in these cases was considered to be only of partial value "but domestic help would have been an immense boon to all" (Sheldon 1948: 173). From his sample of 456 subjects, 40 per cent stated they could cope without help in times of illness in the home, over half stated that extra help would be essential. A second group was absolutely dependent upon services and a third group were those who could manage if the illness was of short duration (Sheldon 1948: 176). Sheldon stressed the importance of some form of domestic help for the elderly:

"It is clear from what has been stated that the provision of domestic help to old people in illness is a matter of considerable importance. Many of them are carrying on their normal domestic work with no reserve of physical strength to deal with the extra burden of illness; others are exhausting their strength doing both; often by the management of prolonged illness of spouse. In other cases the daughter is forced to lose work-time to stay at home and run the house. The need is already well recognised and provision has been made for the supply by local

authorities where possible but the details already given emphasize the importance" (Sheldon 1948: 178).

In view of Rowntree's evidence and the government's priorities Sheldon was, I think, being optimistic in the view that there was adequate provision of services to meet the needs of the elderly.

3.11 Conclusions.

During the two World Wars, the social and economic conditions brought about by war provided the main thrust for the development and extension of the home help service. Many changes had also taken place between the two World Wars; the decrease in family size, the changing family structure; and the changing role of women. Domestic service as a commodity for the middle-class family was drying up. The changing role of women, accelerated by their involvement in the war effort, coupled with the effects of mobilisation and evacuation left many of the more vulnerable members of society without the traditional family or community support. During the early years of the war the plight of the sick and infirm caused some concern but it was, as during the early years of the century, the plight of mothers and young children which caused most concern. During the First World War the issue of fertility and national efficiency was the impetus for change; during the Second World War much of the pressure for change (in domiciliary services) came from the concern for the mother and child, the sick and infirm brought about by the lack of domestic support due to the redirection of manpower to the war effort. The problem of mothers obtaining home help or paid domestic help was made more difficult than usual by mobilisation

which contributed to the decision of the government to extend the service to mothers in confinement.

Difficulties in recruitment had always been put forward as a reason for the slow development of the service. During the war, essential war work also swallowed up the vast majority of women, many of whom had worked in domestic service. Women were reluctant to enter the work (home help) because of its connotation of domestic service and low status - a problem which had not been adequately addressed during the inter-war years. The domestic support of mothers (and the elderly) in the home became of such importance that it was deemed to be a national priority. Women were directed into the service and a national minimum wage agreed. To remedy the problem of recruitment the home help service was presented as a new career for women in the public services, an attempt to improve the image of the service which was not a success as highlighted by the City of Oxford scheme.

The disruption caused by the war also raised the need to develop services for the elderly. A negative attitude towards the Poor Law meant that many did not take advantage of the limited domiciliary or institutional services available. However, it was considered a priority to extend the home help service to the elderly during the war years but, by 1947, the mother and young child had again become a priority for the service. Although not a government priority, the immediate post-war period saw an increase in research activity into the needs of the elderly. It was argued that the home help service would not achieve its full potential unless it was made available on a wider basis to the aged. The development of the service as mainly a support for the elderly is discussed in chapter four.

With the development of domiciliary services, attempts were made not to undermine the system of family and neighbourhood support. The welfare state had developed on the assumption that it was the role of the family to care for its own members, which assumes that the family is a private domain to be protected from state interference (Walker 1982: 26). It was argued that domiciliary service would only be provided if no other source of help was forthcoming (City of Sheffield 1948: 6). The home help service of the post-war period was designed not to undermine family responsibility; the aim was to maintain the family intact, and, where necessary, restore it. It was assumed that much care would be provided within the nuclear family. As Sheldon and Rowntree had shown, most of this care came from female members of the family. The role of women here is critical since it is female relatives who by and large were, and still are, the key figures in the elderly person's support system. The social organisation of 'tending' or care was to become an issue in social policy which is discussed in the next chapter. This situation of female care within the family was to be legitimised by the state through the ideological assumption that it is 'natural' for this care to be provided in this manner.

CHAPTER FOUR

Home Help: A Service for the Elderly.

4.1 Introduction.

In this chapter, I discuss how the relatively new 'home help' service has developed since its inception as a statutory service in 1948. Much discussion in those early days focussed around the problem of what was an appropriate role for the service and many of the origins of today's confusion and inconsistencies surrounding the role of the home help can be traced to events which occurred in those early days.

The developments in the 1950s and 60s are examined in the context of the official view, held during that period, of the role of the family in caring for its members. As the needs of the elderly became more pressing in the early 1950s, calls were made for the development of community support services for this group. Voluntary organisations responded, and many local authorities also developed new domiciliary care schemes; but as a result of manpower shortages and financial restraints, many began to question the nature of the home help and community nursing role.

Parallel with this debate ran local authority dissatisfaction with the

performance of the voluntary sector in this field, which led to pressure for legislation to allow them to co-ordinate and provide a more effective service.

By the 1960s, the home nursing and home help services were the most widely known domiciliary services. To encourage the complementary development of both the health and local authority services, the Minister introduced a ten-year forward planning structure, which is discussed in relation to domiciliary services. Information gained from this planning exercise made it clear, however, that the home help service was very underdeveloped and that the standard varied from authority to authority. As a result of a subsequent review of a sample of authorities, advice was issued encouraging them to provide a more effective service.

The relationship between the functions of the home help and home nursing services were not clear; this confusion was aggravated by inter- and intra-professional rivalry compounded by the large number of agencies providing services. Pressures for change led to the setting up of a committee to examine the Personal Services. The Seebohm Committee, which was set up to investigate the organisation of the personal services, produced recommendations which are examined against the background of the developing professionalisation of social work and the ambivalent attitude of the home help service to its allegiance to the nursing and medical profession. The eventual incorporation of the home help service into the new social services department is discussed and its effect upon the home help service analysed.

4.2 The Post War Family.

No useful discussion on domiciliary services in the 1950s and 60s is possible without putting the development in the context of the family and the official view of the role of family in caring for its dependants. The true nature of 'family' care for the sick and elderly was exposed by Sheldon. The results of his survey underlined the fundamental importance of 'caring' from female members of the family during times of crisis (Sheldon 1948:164). However, Sheldon expressed the dilemma as follows: "We must do everything possible to assist the family in the care of its aged dependants without at the same time relieving it of the necessity for still taking an interest in the matter" (Sheldon 1948:319). Commentators since then, and in particular in the 1950s, have claimed that the 'welfare state' undermined 'family' responsibility towards its members including the elderly (Thompson 1949, Bligh 1951, Hospital and Social Service Journal 1959: 35). Thompson warned that:

"The power of the group-maintaining instincts will suffer if the provision of a home, the training of children, and the care of its disabled members are no longer the ambition of a family but the duty of a local or central authority" (Thompson 1949:30).

Local authority staff also expressed such sentiments. In 1959, the Chief Welfare Officer for Manchester was lamenting the families' "changed attitude towards aged dependants" (Hospital and Social Services Journal 1959: 35). Two questions were posed during this period: did the family accept its 'responsibilities' towards the sick, frail and elderly? And did domiciliary care support or undermine the family in this respect? It is impossible to understand these attitudes without a consideration

of assumptions held by the state concerning the 'natural' obligations of the family. A heavy emphasis on the rebuilding of family life after the Second World War implied a return to traditional roles for women (Wilson 1977: 60). The main emphasis of this period was on the role of woman in motherhood. Literature on 'dual career' families even stressed that child care was of prime importance (Myrdal and Klein 1956:118). Much of the discussion of women's role "in literature has focussed upon her functions in relation to the present and future workforce, and has made little reference with regard to the retired workforce" (Bond 1982:12). Evidence from empirical studies of the period (Rowntree 1947, Sheldon 1948, Townsend 1957) showed that families did 'care' for the elderly and that the bulk of this caring was carried out by wives, daughters and daughters-in-law. Some believed that the "belief in the decline in filial care of the elderly" was an "unfounded and as yet unproven myth" (Lowther and Williamson 1966:1460). However, some doctors still believed that there was a danger that support services might undermine the responsibility of the family:

"The feeling that the state ought to solve every inconvenient domestic situation is merely another factor in producing a snowball expansion on demands in the National Health (and Welfare) Service. Close observation on domestic strains makes one thing very clear. This is that where an old person has a family who have a sound feeling of moral responsibility serious problems do not arise, however much difficulty may be met" (Rudd 1958: 348-349).

The primary care of the elderly lay with the family. Townsend's work in the 1950s began to highlight the relationship between the elderly and other generations in the family. Townsend was able to show that the elderly not only received but also provided family services and he argued for the development of services to support these networks of care (Townsend 1957). Other studies of this period indicated that disability

amongst elderly people was widespread in those living in their own homes. Rather than being restricted from a fear of undermining the family, domiciliary care needed to be developed to support families and help the isolated (Townsend and Wedderburn 1965, Shanas et.al. 1968).

4.3 A New Domiciliary Service.

In the last chapter I discussed how the 'chronic sick and elderly' became an issue during the Second World War. MacIntyre (1977: 41-63) argues that official reports of the period reflected not only humanitarian interest in the elderly and how best to meet their needs, but a concern about them as an organisational problem. Services for mothers and young children could be seen as beneficial in terms of individual health and as a medium for assisting the productive or fighting capacity of the next generation. Provision for the elderly does not have these benefits for the nation; "not only may it be viewed as having no positive investment functions, it may also be seen as producing negative returns on investment by keeping persons alive and consuming resources even longer than they would have done without that care" (MacIntyre 1977:45). Various reports from central government and the BMA assumed that it was possible to distinguish between the frail elderly in need of general care and support and the sick in need of medical and nursing support (Morgan 1944, DHSS 94001/8/7, DHSS 94018/1/24, Ministry of Health 1947b, Anderson Report 1947, Ministry of Health 1948a). After 1948, the National Health Service was to concern itself with the sick and the National Assistance Act with local authority residential care for those in need of general care. However,

in the 1948 National Health Service Act there was little statutory provision for the elderly; what there was, was largely concerned with the provision of residential accommodation. Brown (1972), Townsend (1964) and Parker (1965) stress the inadequacy of the 1948 Act in terms of its obsession with residential care. For example, Parker argues that the concern to foster family life in the child care legislation was lacking in the National Assistance Act which made no attempt to provide any sort of family substitute for old people. Institutional provision was accepted without question (Parker 1965: 106). The assumption of the government was that it was the duty of the individual and his or her family to provide for old age, the exception being those who required residential care (Brown 1972: 28).

Despite domiciliary services being seen as second best (Rowntree 1980: 98), pressure from central Government and the considerable behind-the-scenes activity of the WVS meant that most local authorities had home help schemes well advanced on the appointed day, but the difficult financial climate hampered their attempts. The number of home helps had risen considerably since 1948 when there were only 3,108 full time and 8,230 part time staff (WVS 1950: 3): the following year there were 18,655 home helps in England and Wales, 3,964 whole-time and 14,686 part-time supporting 139,816 cases (Beauman 1977: 96).

Managers of the service in 1948 faced a difficult task. They had to build up a "new service whose dimension and precise functions were unclear, evolving their own methods of working, recruiting and training staff, and at the same time trying to meet heavy demands with inadequate resources and experience" (Donnison 1965: 89). The development of the home help service took place in a department, the health department,

which was itself undergoing a major re-organisation as a result of the National Health Service Act. The home help service "having a comparatively minor part to play, was left to develop along its own lines without interference or precise guidance" (Donnison 1965: 89). Much the same was to happen in 1972 when the service was transferred to the new Social Services Department.

The care of the aged and chronic sick, however "became the subject of increasing public and professional concern and interest. It was accepted that domiciliary services were essential not merely to eke out inadequate institutional care or to deal with crisis, but because many old and sick people preferred to remain in their own homes as long as possible" (Donnison 1965: 91). By 1950, calls had been made in Parliament, at conferences, meetings of associations and in the press, for an increase in resources to support the elderly (Mother and Child 1949: 127, M O H 1950, The Medical Officer 1950: 75). By the early 1950s, a consensus had developed amongst state officials, politicians and the professions that elderly people remain in their own homes for as long as possible (Townsend 1963: 38, Sheldon 1955: 22, Ministry of Health 1954b: 187). Despite financial constraints there was an expansion in services in some areas of the country and in others new schemes were developed. Kent County Council, for example, expanded its home help service so that by 1956 the number of clients helped had risen from 1,100 in 1947 to 4,200 (Elliott 1956). In London the service grew from 3,159,729 home help hours worked in 1950 to nearly five million in 1957 managed by 29 organisers, 41 assistant organisers and 39 clerks. Male home helps were employed and a night, weekend and bank holiday service operated (Nepean-Gubbins 1958: 840-841).

Not all Medical Officers who managed the service were in agreement with this philosophy of the extension of community care for the elderly, arguing against it and central government or state involvement in the provision of such services. Some felt that the pendulum of community care had swung too far in favour of keeping the elderly in the community (Yap 1962: 241-245).

It was not only in cities like London that the elderly, during this period, formed a large part of the home help caseload. In Essex County by far the greatest number of hours were allocated to the elderly and chronic sick. In 1951; the number of cases was 2,839 and hours allocated 658,161 and by 1953 a total of 1,036,996 hours were allocated to 5,385 cases. Although the number of cases rose, the actual hours allocated to each case dropped, in 1951, 231.82 hours per year were allocated on average to each client but by 1953 this had fallen to 197.82 hours (Grant 1955: 235).

These figures indicate a drop in the number of hours given to each client per year in Essex from an average of 214 per year in 1951 for chronic sick and elderly to 193 hours in 1953. The average hours allocated to maternity, acute sick and T B clients fell from 95 hours in 1950 to 84 in 1953.

By 1950, some local Medical Officers thought that the service had become "bureaucratic" and suffered from an "official attitude" (Symonds 1950: 158). Others, however, realised that services were fragmented and provided by too many small organisations which caused much duplication. These unco-ordinated services, it was argued, also allowed both the helped and the helper to 'cheat' the system. What form this cheating took was never defined but the view was held, particularly by the

medical press (The Medical Officer 1950: 157).

Parliament, the press and professional bodies called for better co-operation, calls endorsed by the government, particularly between agencies providing services to the elderly (M O H 1950). The Government also called for the extension and expansion of services to allow old people to remain in their own homes. However, the lack of information on the needs of the elderly and the relationship between service and demand hampered development (Chalk and Benjamin 1951).

The increased demand for the service was linked to the increasing number of aged and chronic sick patients who, if beds had been available, would have been looked after in hospital (MacGregor and Benjamin 1950: 227). Parliamentary debates were full of rhetoric about the need to keep elderly people in their own homes (Hansard 1953d, Hansard 1958). The Conservative Policy Centre justified the policy thus:

"There they are surrounded by the things and people they know and love. There they are required to help themselves in a hundred ways, all calculated to stimulate their physical and mental processes and so maintain their interest in life. At home, insignificant and unimportant possessions and habits, in which the old increasingly find solace, assume positions of great prominence" (Vaughan-Morgan, Maude and Thompson 1952: 19).

By the early 1950s, the care of the aged and chronic sick had become one of the most pressing problems for health departments of local authorities. Benjamin and Chalk put this down to the

"rapid progress made against infections, the advances made in the treatment of morbidity from the more acute diseases of younger ages, the ageing of the population arising from the protracted decline in the birth rate, and the inability of the hospital service in the face of acute nursing shortage to provide beds for the chronic sick" (Chalk and Benjamin 1951: 65).

Donnison argued that charging policies had also influenced demand for the service by the aged:

"Meanwhile the system of charges (although it was exceedingly complex

and raised only a small fraction of the total cost of the service) demanded relatively high payments from households with a full time wage earner needing several hours of help each day and negligible payments from households with no wage earner needing only a few hours help each week. Thus the aged and infirm may have been more willing to seek help than were mothers with young children. Moreover the provision of occasional help for elderly people many of whom lived alone, must have entailed a more easily sustained pattern of personal relationships (for helper and helped alike) than the provision of more intensive help in a family of young children" (Donnison 1965: 98).

Some authorities did not separate the aged from the infirm and sick categories for statistical purposes until the middle of the 1950s. By 1953, the aged accounted for 86 per cent of all cases supported by the service in London. Mothers and young children were still a priority even though the "growing number of mothers having their babies in hospital provided an alternative means of meeting their needs" (Donnison 1965: 98).

4.4 Concern at the Level of Service Provision.

Concerned at the low level of services available to the elderly, the National Council for Social Services carried out a survey of 100 over 70-year-olds in 1953 and found a high percentage of the elderly who received services were over 75 years with many over 80. The report noted that regular visits to the elderly were few and that over half of the elderly surveyed had no visits at all and many received no help with their household duties. Where help was provided it was the home help service which provided the largest percentage of it; help from friends, neighbours and the district nursing service was rare (Over Seventy 1954: 45). The results are difficult to reconcile with those of Rowntree some years earlier. Owing to this apparent lack of support for the elderly,

the 'Over Seventy' report recommended that the home help service should be extended and made available to the elderly before they became dependent and bedridden (Over Seventy 1954: 36).

Many Medical Officers of Health, concerned at inadequate home support services for the elderly, began to look at new ways to provide services. However, as in the past, the recruitment of sufficient women was a problem which some authorities made attempts to compensate for. For example, the Medical Officer of Cardiff City arranged with the WVS to recruit 'special' home helps or 'home aids' who were offered a higher wage than other local authority home helps. This 'home aid' not only carried out domestic duties but also cooked meals and attended to the personal needs of the bedridden (WVS 1954a: 1). Other authorities made special arrangements to recruit residential home helps who were paid 60s. per week and were expected to live in the homes of the client for the duration of the support (WVS 1950:13).

By the mid 1950s, the high cost of providing domiciliary services for the elderly was causing concern to local and central government alike. To examine the financial and economic pressures, the Guillebaud Committee was set up with particular reference to examine the cost of the National Health Service. The committee's main concern was the problems caused by the increasing number of elderly and the effect upon their pension and income schemes; but they also looked at the problem of providing adequate hospital and domiciliary services. The committee found that although local authorities had powers to provide such services as home nursing, meals on wheels, residential care and sheltered residential accommodation for the elderly, many had not done so because of the lack of suitable staff, a particular problem in the

home help service. The Minister's refusal to approve some of the developments and proposals put forward, and the unwillingness of local authorities to increase the burden on local rates, were also factors in the slow development of services.

The strongest limiting factor was, however, lack of finance (M O H 1956: 200-201). Interestingly, the committee found a shortfall in the domiciliary services offered to mothers with children indicating perhaps a trend in prioritising the service towards the elderly (M O H 1956: 47), a point also taken up by a later committee looking at the Maternity Services (M O H 1959 : 47). The Phillips (1954), Guillebaud (MOH 1956) and Boucher (1957) reports all stressed the value of the domiciliary services in reducing pressure on institutional care, an argument accepted by the Ministry of Health (Ministry of Health 1957). By the end of the 1950s, a gradual movement towards 'community care' had appeared in government policy. Brown (1972) put this shift in policy to the increasing realisation that the issues posed by old people went beyond the tiny minority who needed residential care. As a consequence there was encouragement for a variety of domiciliary services and a growing realisation of the importance of co-operation and co-ordination of services both statutory and voluntary.

4.5 Cost - Co-ordination of Services.

The Guillebaud committee considered the possibilities of financing 'community care', which it felt might be cheaper in the long term than residential care (M O H 1956: 72). Many of the health care needs of most old people had always been met in the community, frequently without

recourse to any form of health service. The Guillebaud Committee advocated the care and treatment of people in their own homes, a concept (Community Care) which, it was argued, provided politicians with a means of reconciling their need to deal with the organisational problem of the old and their desire to adopt a humanitarian approach (MacIntyre 1977). The Guillebaud committee was quick to recognise the inefficiency caused by the number of different agencies providing services and called for co-ordination to eliminate waste.

It recommended that the allocation of administrative and financial responsibility for the domiciliary services should be subject to the most careful "consideration both in the interests of the old people themselves and to prevent waste". An attempt to cut the number of visitors to the homes of the elderly and more co-ordination between the different branches of the medical profession was called for (M O H 1956: 72, 280).

An earlier committee, the Porritt Committee, had commented on the problem of co-ordination or lack of it in the health service but had come to the conclusion that perfect co-ordination was impossible and unreasonable to expect (M O H 1952). However, this argument may have had something to do with the medical profession's reluctance to accept central control rather than the complexity of the service. The Guillebaud committee recommended a combined Health and Welfare Committee to manage services in local authorities so as to improve efficiency and cut costs (M O H 1956: 280) - a move seen by some as an attempt by the medical profession to gain control of such services as social work, and residential and day care for the elderly (Wright and Roberts 1958, M O H 1956, Brockington and Lambert 1960).

The division between hospital and local authority services was of equal concern to many as was the lack of central Government finance. This ongoing lack of finance was felt to be an obstacle to the smooth development of services which distorted the pattern of service delivery. Local authorities argued that many of these problems could have been solved if there was one body responsible for the management of all the services (M O H 1956: 200).

Despite this lack of services and the unco-ordinated approach, some still argued for the status quo. It was difficult, Sheldon argued, "to avoid the conclusion that the community is already saturated with the domestic care of the old people" (Sheldon 1950).

Advice by the Minister in 1957 crystallized for some the concepts of a well developed domiciliary home help service which they saw as being operated by a number of authorities for some years (Nepean-Gubbins 1958: 1). This latest advice concerned the expansion of the role of the home help service and a recognition of the increasing amount of time spent by the home help supporting the elderly (M O H 1957). The Circular ran:

"As Authorities will know, there has been in the past few years a great increase in the proportion of time devoted by the Home Help service to the care of the aged, as the value of the contribution which the service can make to help them to continue to live in their own homes has been increasingly recognised. As the experience of progressive Authorities has shown the value of this service can still be further enhanced if it is imaginatively planned, with due regard, for example, to the times at which the old person needs assistance (may be evening attendance) and to the type of help required, which may extend beyond purely domestic help with cleaning and the preparation of meals to such things as friendly guidance in personal matters and in some cases to help with toilet and hygiene" (M O H 1957: 3).

The home help service began to be a service to the frail, sick and aged, a fact acknowledged by the Ministry of Health (Boucher 1958:8). Wright and Roberts (1958 :235-236) also claimed that the service had drifted

into being a monopoly of the 'aged and infirm'. As a result of this shift many authorities had developed imaginative schemes to meet this new need. Kent County Council had, along with fifty other authorities, a Family Help and Night Sitting service (M O H 1954b: 194). The managers of the Kent scheme were unable to evaluate the effectiveness of this particular service in keeping old people out of hospital because of the shortage of hospital beds (Elliott 1956: 42). By 1960, the home nursing and home help services were reported as the most widely known domiciliary services (Brockington and Lambert 1960: 51). Home nurses in 1960 paid some 23 million visits to clients, over half of whom were elderly people over 65 years of age. The number of nurses employed by local authorities had also risen from 7,000 in 1948 to over 10,000 by 1960 (Hansard 1961a). Nursing agencies varied in the intensity and duration of their services and tended to visit their patients daily for short periods and terminated the support as soon as the patient no longer needed the service. By 1966, over half of the case load of the district nurse was elderly (M O H 1968a).

The 1960s still saw a universal shortage of home helps. However, the number of households visited had risen from 139,000 in 1949 to 490,000 by 1961 (Hansard 1961b). This statistic hid a drop in the average number of visits per year to clients from 12 to 6, which pointed to the fact that the service was not keeping up with new demands. This drop in visiting could also have occurred because of the low quality of management of the service. Home helps discontinued the service to clients on their death, admission to residential care or hospital and not upon any change in client need or priority (Brockington and Lambert 1960: 51).

A report of a survey of the over 80s in 1960 called for the home help service to be provided at an earlier stage of the elderly person's illness or need. Any service offered, it was argued, should allow and encourage the elderly to participate in activities in the community. However, services were found to be so inadequate that "prevention in the sense of having as its primary objective to avoid undue deterioration and ultimate breakdown could hardly be said to exist" (Brockington and Lambert 1960: 80).

Townsend and Wedderburn (1965:44-49) claimed that many old people in need were not receiving a home help service and that many of those who were, needed a more intensive service - views which were supported by others who claimed that the development of the home help service was in reality "patchy, unplanned and characterised by regional variation and confusion as to scope and standards" (National Labour Women's Advisory Committee 1965:10).

Although the stated policy of the Government was to encourage and help old people to stay in their own homes (Hansard 1961c, Hansard 1961d) critics argued that neither the Labour or Tory administration had ever done much to help authorities implement this policy (Townsend 1963: 16-18). The Government could have been open to criticism if it had been more forceful than it was. Klein argues that the government's reluctance to take a more forceful role "would have run counter to the values both of localism and of professionalism". It would have undermined the autonomy "of authorities and challenged the right of professionals to decide the content of their work" (Klein 1983: 51). Information on which to base plans was not available during the early 1960s and because of this lack, local authorities did not have a clear picture of the

needs of users of the service. The Government's request for authorities to submit plans was a welcome beginning to gather the necessary information upon which to begin to plan and develop services.

4.6 Ten- Year Plans.

In 1961, Enoch Powell, the then Minister of Health, asked Health Boards to formulate long-term plans for the hospital service which were later published in 1962 (M O H 1962). This was the first attempt since the creation of the health service to take a comprehensive view of the hospital service. The creation of the plan was the outcome of two trends. First, changes in the political environment and second a gradual creation of a consensus among professionals and others about the need to create a new hospital system (Klein 1983: 73). The plan was made available to local authorities as it was thought that

"complementary to the expected development of the service for prevention and care in the community and a continued expansion of these services had been taken into account in the assessment of the hospital provision to be aimed at. It follows that the local authorities services need to plan for the same period as the hospital services" (M O H 1962).

The hospital plan laid emphasis on the principle of community care (M O H 1962). The average length of stay for the over 65s in hospital had fallen from 34 days for men and 45 days for women in 1962 to 28 days for men and 42 days for women by 1967 (Klein and Ashley 1972: 14).

The aim of the Local Authority 10-year plans, which were to be examined in the light of statements of intent by the hospital service, was to provide a "nationwide picture of the developments as they were then envisaged", with an attempt "to set them within the context of national purposes and common standards" (M O H 1963).

The 1963 plans revised in 1964 and again in 1966 were criticised by academics and local authority staff alike (Hanson 1965: 666). No guidance had been given to local authorities in the interpretation of figures or definition of level of client need (Sumner and Smith 1969: 208-209).

The information contained in the published plans was stated to be only "intentions of authorities" and was not based on any objective research into community needs (M O H 1965b: para 2-5). Despite the obvious needs and gaps in service shown by these exercises, local authorities still saw health and social services for the elderly as separate and not dependent upon each other (Sumner and Smith 1969: 210).

There were, however, some research findings available on which tentative plans or projections of service need could have been based. Townsend's survey of the elderly in 1957 had shown the need for domiciliary services for that particular client group. Only 4.5 per cent of elderly persons received home help, 0.79 per cent the services of the district nurse, 1.3 per cent meals on wheels and 7.30 per cent a chiropody service. Only 11.8 per cent of the elderly received one or more of the domiciliary services and a large percentage of these were in the 80-84 age group (Townsend 1957: 24,30). He argued, as others had done in the 1940s, that the domiciliary services should complement the services of the family and not replace them.

One of the important results of this survey was the attempt to produce guidelines for services based on observed and expressed needs of the clients. Most of the elderly surveyed only received home help on one or two occasions a week, a minimum service which did not meet demand. Estimates agreed that an extra 600,000 elderly needed home help support

(Townsend 1957: 69).

The local authority 10-year plans did not show any shortfall in services nor expressed any demand for an increase. They did however show all too clearly the large variations in level and provision of services between authorities. For example, Rotherham provided 1.18 home helps per 1000 of the elderly population over 65 (0.30 nurses) whereas Plymouth provided 0.08 home helps and 0.20 nurses per 1000 thousand of the elderly population (M O H 1963). These figures could not be relied upon to give a true picture of community support because services such as health authority domiciliary auxiliary nursing services were not included (M O H 1965b), nor did the plans give the figures for the amount of home help hours provided. The plans did, however, envisage an increase to 37,083 whole-time equivalent home help staff or 0.73 per thousand population by 1972 (Ministry of Health 1963a: 18). How far this target was met will be discussed later in this chapter.

4.7 Calls for Change.

It is clear that the role and function of the nursing and home help services were not understood by those who should have understood them. Inter-professional rivalry and jealousies were rampant, services were unco-ordinated and clients confused by the number of visits from the 'welfare' (Donnison 1954, M O H 1956a, M O H 1960, Royal Commission on Local Government in Greater London 1960, Report of the Committee on Social Workers in the Local Authority Health and Welfare Services 1959, Labour Party 1964, Scottish Education Department and the Scottish Home and Health Department 1966, Scammells 1971, Hall 1976). Cooper indicates

that the new practices of the children's department after 1963 were sometimes seen by health departments as trespassing on their territory (Cooper 1983: 57). The services were in a disorganised state and this unnecessary deployment of professional staff was bound to have had, in the long run, economic and professional consequences. This state of affairs was compounded by having 204 Health Authorities and the same number of Welfare Departments, all providing domiciliary services for the community. This situation led to calls for change in the interests of both the client and the economy.

As the use of social and health services were diffused throughout the population on a far wider scale than ever before and to a wider social mix, more and more people were ready to express judgement on the quality and quantity of service. A more knowledgeable and educated community meant a higher expectation of standards of care and a less unthinking acceptance of the traditional methods of service delivery. Community care or care in the community meant more and more people were affected by the services. The rapid expansion and growth in welfare services in the 1960s and a more articulate clientele all contributed to the calls for change and a more efficient service.

The switch in emphasis from institutional to care in the community of the elderly and mentally ill in the 1960s meant that local authorities had to rethink very seriously the quality and type of care that was most appropriate. This emphasis on 'community care' only served to highlight the difficulty of getting disparate professions to co-operate in a team effort. The confused situation and inter-service rivalries caused delays in the development and co-ordination of services (M O H 1960). The lack of co-operation was partly due to administrative differences but it also

reflected professional attitudes. This distrust and lack of co-operation was particularly evident in the provision of services for the elderly. No person or agency had responsibility for leadership of the community care team (Gillie Report 1963, Titmuss 1968).

One survey in 1971 examined the internal organisation of the local authority health services. Over one quarter of cases investigated showed some failure in the provision of services. The report also highlighted many examples of lack of co-operation and co-ordination by the various agencies involved in service delivery. The home help service was found to have filled many of the gaps not covered because of this lack of co-ordination (Scammells 1971: 90-104).

Social workers had always worked in specialist areas such as mental health, child care or welfare of the elderly. This method of working had been condemned by the Jameson report in 1956 because it caused overlapping and complicated the visiting of families (M O H 1956a). The first call for a family social services came from the Labour Party in 1964 which stated that the "structure of the social services is ripe for review so that it may grow and develop coherently to meet the need of an increasingly complex society" (Labour Party 1964). This report was the basis for the subsequent white paper on the need to move from an emphasis on punishment to an emphasis on treatment of children (Home Office 1965)

The Government set up a committee to investigate the organisation of the 'Personal Social Services' which reported in 1968 (M O H 1968a). Evidence to this committee is well summarised by Hall (Hall 1976: 42-58). The evidence underlined the extent of conflict between medical and social work interests. The medical lobby argued for the health and

welfare services to remain under medical control and some felt that this control should be extended to the children's service. The main recommendation was a call to set up a new department in the local authority to manage services for children, the mentally disordered, the elderly and families. The reactions to this report of various professional groups is documented in Hall's book 'Reforming the Welfare' (1976). I, therefore, will confine myself to commenting on the reactions of those bodies concerned with health and home help services.

4.8 Change

The British Medical Association in their evidence to the Seebohm Committee argued for a combined health and welfare department under the control of the Medical Officer of Health. Some local authorities during this period did in fact reorganise their services in this manner and were criticised both in and outside Parliament for doing so (The Medical Officer 1968: 90, Cameron 1968). Medical officers argued that the pressure from social workers for the quick implementation of the report's recommendations were not in the client's or new service's best interests. This organised pressure "puzzled" the doctors and they regretted the "belligerent pressure for immediate implementation of the Seebohm proposals" (The Medical Officer 1969: 207-208).

Those who were responsible for the day to day management of the home help service did not wish to be incorporated in any new department. In 1966, The Institute of Home Help Organisers, the only national body representing organisers, wrote to the British Medical Association, The Society of Medical Officers of Health and the Queens Institute of

District Nursing expressing its deep concern at any attempt to place organisers under the control of social workers or to remove them from their present position "of ancillary to the Medical Officer of Health and Domiciliary Nursing Service" (Institute of Home Help Organisers 1966). Organisers argued that the service existed to further the work of the doctor, nurse and health visitor. One senior home help organiser put the argument thus; "the welfare officers and social workers are our very good friends to whom we often turn for help and advice. The doctors, health visitors and district nurses are our partners. Herein lies the difference" (The Municipal And Public Services Journal 1969: 1845).

Organisers felt so strongly about this matter that they requested an opportunity to give evidence orally to the committee to reinforce their written evidence. The Queens Institute of District Nursing, Royal College of Nursing, Royal College of Midwives, the Health Visitors' Association and the Society of Medical Officers of Health all offered moral support to the organisers and indicated that their evidence to the committee in no way conflicted with their wish to remain in the health service (Institute of Home Help Organisers 1966). Later, in 1971, The Royal College of Nursing suggested that the health service should recruit its own home helps (Parker and Fish 1971: 1981-1983).

The Institute hoped to persuade the committee that their service was medically orientated. In their written evidence they held that the assessment of need should be based on medical criteria only and that the level of demand should be controlled by medical recommendation. They supported this statement by pointing out that home helps were practical people who found it difficult to work with social workers. Organisers saw the nursing and medical professions offering more concrete and

practical services than social workers. They argued, "If we are realistic we would concede that the most valued and also the most highly qualified social workers in the field today are the general practitioners, the health visitors and the district nurse. Their social work is all the more acceptable to their patients because it is accompanied by practical help" (The Municipal and Public Services Journal 1969: 1845). For these reasons organisers saw their future with the medical and nursing profession (Institute of Home Help Organisers 1966, M O H 1968a: Paras 376-377). The committee's enquiries did not show, however, that the work of the home help service had a distinct medical or nursing content. As most of the clients of the new department would be eligible for the home help service the committee recommended that it should form an integral part of any new department (M O H 1968a: para 377).

If their wishes were not met, the Organisers contemplated some form of action. The Institute balloted its members but this threat of action never materialised (Institute of Home Help Organisers 1968). After the publication of the report the Organisers reassessed their position and wrote to the Minister agreeing that the service would function just as well in the new department as it had in the old (Institute of Home Help Organisers Archives Letter 19 Nov. 1968). Not all organisers agreed however. Some expressed mixed feelings and questioned the ability or political experience of the new Chief Officer to command the resources necessary to develop the services (Carter 1971: 7-9). Donnison thought that the report was a "great state paper" (Donnison 1968:3); Townsend felt that the report was "lacking in analysis, drive and vision" (Townsend 1970:7). However, the report did reflect the growing belief that it was possible to distinguish between services that were social

and those that were medical. The 1970 Local Authority Social Services Bill received all party support (Hansard 1970, Hansard 1970a)

4.9 Government Initiatives.

The Government was convinced of the need to increase home help support to the elderly as a priority as and when the economic situation allowed (DHSS 1971a). The Minister recognised that with the present system of local control over resources, needs would vary and the provision of services would be "coloured both by revealed need and the available resources of manpower and money" (DHSS 1971b: 1). Section 13 of the new Health and Public Health Services Act 1968 gave powers to broaden the provision of support services to families and individuals living in the community. Authorities were encouraged to provide services for families with severely handicapped members, sick children or persons with long-term illness, problem families and the elderly. Help was to be offered to the whole household and not, as previously, to an individual in the home. This policy of seeing the client as separate from the rest of the family members had restricted the development of the service and placed hardship on many elderly people.

Support services for the elderly became a priority and authorities were encouraged to provide services in a more imaginative way as part of a much wider support system available to the elderly (DHSS 1971a).

Services for the elderly were to be planned only after the needs of the community had been researched and estimated, "bearing in mind that the concept of 'need' was constantly" changing and was "complicated because it" involved "a mixture of environment, emotional and health aspects"

(DHSS 1971a: 3).

Under the 1968 Act authorities were empowered:

"to provide meals and recreation in the home and elsewhere;
to inform the elderly of services available to them and to identify elderly people in need of the services;
to provide facilities or assistance in travelling to and from the home for the purpose of participating in services provided by the authority of similar services; to assist in finding suitable households for boarding elderly persons; to provide visiting and advisory services and social work support;
to provide practical assistance in the home, including assistance in the carrying out of works of adaption or the provision of any additional facilities designed to secure greater safety, comfort or convenience;
to contribute to the cost of employing a warden on welfare functions in warden assisted housing schemes;
to provide warden services for occupiers of private housing" (DHSS 1971a: 2).

The operative date for the Act was delayed until 1972 because of the economic situation and because health and welfare services were low on the political agenda (Hansard 1967). The decision to implement those sections (S.13, Home Helps and S.45 Welfare of the Elderly) which gave extended powers was reached by the Minister "in the light of the coming into force of the Local Authority Social Services Act and the Chronically Sick and Disabled Persons Act 1972" (DHSS 1971a: 1).

The Social Services Act provided for the setting up of a new Social Service Department offering many of the services of the health department and services to children and families. The Minister felt that the new departments should be in a position to provide an expanded new service so as to be able to offer comprehensive service to the community. It was also hoped that the new departments would rethink "their pattern of welfare services as a whole, and to develop them on the basis of a thorough review of their inter-relationship and of the most effective use of existing and potential voluntary effort". Although no absolute priorities were set it was hoped that authorities would

develop the home help service as a priority (DHSS 1971a: 5,6).

It was with these new and extended powers that social service departments became operational in 1972.

The 10 year plans of local authorities had envisaged an increase to 37,083 whole-time equivalent home helps by 1972 (Ministry of Health 1963: 18) but by 1970 was only 29,600 whole time equivalents (DHSS 1971:203).

TABLE 4.1
Home Help Service England 1971 - 1979.

| Year | 1971 | 1972 | 1979 | % Increase 1972-79 |
|------------|---------|---------|---------|--------------------|
| Organisers | 1,058 | 1,197 | 1,377 | 15 |
| Home Helps | 31,492 | 35,185 | 57,902 | 64 |
| No Cases | 443,208 | 473,883 | 506,000 | 6.7 |
| Cases 65+ | 373,321 | 404,010 | 430,987 | 6.6 |

(Source: DHSS 1973: Appendix 1+2, The Home Help Service in G.B. 1979: Section 2.3.1).

In order to meet the real needs of the community, Hunt had argued for an increase of between two and three times the service in 1968, which was then 26,982 whole-time equivalent (DHSS 1972:203, Hunt 1970:25). Demand throughout the 1960s had been greater than the ability or willingness of local authorities to supply. But since the reorganisation of the personal social services, in 1972, the home help service has grown despite severe economic restraints on local government spending (see table 4.1).

The ratio of clients to home helps was 14:1 in 1972 which fell to 8:1 by 1979. In some areas there was also a drop in the number of home helps and organisers employed. For example, in London the number of organisers dropped from 204 in 1971 to 180 by 1979.

As the DHSS had found in 1972, the largest group of users of the service were and still are the elderly. In 1974, 84.3 per cent of cases in

Greater London were over 65 years of age and the figure for England as a whole was 87.9 per cent (see table 4.2).

TABLE 4.2
Number of Households in England receiving Home Help Service during the twelve months beginning 1st April 1976.

| Home Help to Households for: | % Total | Number |
|------------------------------------|-------------|----------------|
| <u>Clients 65+</u> | | |
| Chronic Sick and Severely Disabled | 6.5 | 43,058 |
| Mentally ill and Handicapped | 0.7 | 4,560 |
| Maternity | 0.7 | 4,597 |
| Others | 4.2 | 28,129 |
| <u>Total under 65 years of age</u> | <u>12.1</u> | <u>80,344</u> |
| <u>Clients aged 65-74</u> | <u>30.7</u> | <u>206,404</u> |
| <u>Clients aged 75+</u> | <u>57.2</u> | <u>378,243</u> |
| <u>Total aged 65 plus</u> | <u>87.9</u> | <u>584,827</u> |

(Source: DHSS 1979a: 36).

In England and Wales the number of cases visited by the home help service rose from 249,000 in 1961 to 396,000 in 1970 to 704,00 in 1980. There was a corresponding drop in the percentage of elderly on the caseload of the home nursing service from 53 per cent in 1966 to 42 per cent in 1979 (CSO 1981: 138). It would seem that the home help service may have been filling the gap left by the decrease in support by the home nursing service. This trend may have been heightened because many Directors of Social Services were keen to develop the caring function of the home help (DHSS 1973: 4).

4.10 New Policies.

Widespread dissatisfaction with the tripartite structure of the National Health Service led to calls for change. The election of a Conservative Government in 1970, committed to improving the efficiency of both

central and local government, meant more and more central government involvement in the affairs of local government. The need for co-operation at national and local level was made even more important by the reorganisation of the health service and local government in 1974.

The health services were reorganised to reduce the inefficiencies associated with the tripartite structure established in 1948. Local authority health services had been seen as a "rag-bag of functions" (Brown 1979: 6). The idea behind the ending of the tripartite system was described by Richard Crossman, the first Secretary of State in the DHSS:

"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 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. Otherwise they will get an unsatisfactory service or even no service at all" (Royal Commission on the National Health Service Report 1979).

The health service reorganisation removed the responsibility for medical and nursing personnel from local authorities and placed them in the new reorganised health authorities. The need for consultation and co-operation was recognised, the National Health Service Reorganisation Act 1973 required the setting up of Joint Consultative Committees at local level to help co-ordinate health and social services planning. The composition and responsibilities of these committees was set out by the Ministry (DHSS 1977a).

This attempt at planning and co-ordination did nothing however to overcome the problem of variations in standards and quality of service between different authorities. By 1976, it was recognised by many that central government should set national standards or guidelines and this was emphasised in the Consultative Document 'Priorities for the Health

and Social Services in England' published in 1976. This practice of setting guidelines was later abandoned by the Conservative Government in 1981, which allowed local Social Service Departments more responsibilities to set their own priorities albeit within tight specific cost limits (DHSS 1981b: 19).

The publication of the 1976 document 'Priorities for the Health and Personal Social Services' was a new departure in government policy. It was for the first time an attempt to establish rational and systematic priorities for the personal social services, a need which had become all the more urgent because of the economic restraints placed on local government by the cuts in public expenditure. Any growth in services had to be financed by corresponding savings in other areas (DHSS 1976: 1, 12). To encourage health and local authorities to plan and provide services for priority groups, monies were made available to Joint Consultative Committees to finance priority areas such as services for the elderly and the younger physically handicapped (DHSS 1977a, DHSS 1976: 3).

By setting priorities it was hoped that the importance of the role of primary care in the community in relieving pressure on hospital services would be realised. This policy had already brought about a drop in the length of time people spent in geriatric hospital from an average of 106 days in 1972 to 84 days in 1977. This drop, however, may have been due to higher death rates in hospitals. The average length of stay of the over 65s in all hospital beds had been falling since 1962. Between that date and 1969 the length of stay had fallen from 34.4 to 28.3 days for men and from 45.4 to 42.4 for women, falls of 18 and 7 per cent respectively (Klein and Ashley 1972: 14).

4.11 National Guidelines.

As mentioned earlier, attempts were made in 1976 to set national guidelines. A standard of 12 home helps per 1,000 of the elderly population was set and one home nurse per 4,000 of the elderly population (DHSS 1976: 39).

These attempts to set norms only served to highlight the very large differences in the levels and diversity of services provided (see table 4.3).

TABLE 4.3
Shortfall in Services for the Elderly.

| Service per 1,000 elderly | 1974 Level | Nat. Guidelines | Shortfall as % of requirement |
|--------------------------------|------------|-----------------|----------------------------------|
| *Home Help | 6.0 | 12 | 50 |
| M.O.W (Weekly) | 600,000 | 1,300,000 | 54 |
| *Day Centre Places | 2 | 3-4 | 33-50 |
| *Geriatric Beds | 8.57 | 10 | 14 |
| Home Nurses per 250 elderly | 1 | 1 | 0 |

(* Per 1,000 pop., Source: DHSS 1976: 39).

Assuming that the number of elderly persons in the community remained constant (and not rise as at present), it was estimated that it would take many years to achieve these targets because of the restriction of a two per cent growth rate (DHSS 1976: 4), and take 35 years at an increase of two per cent per annum to reach the home help target (see table 4.4).

There was a wide variation in expenditure on the elderly by local authorities (see table 4.5). Despite domiciliary services being a priority many social service departments rather than expand had, in

fact, made cuts. For example, Somerset County Council reduced their home help and meals on wheels service as did Surrey, Dorset and many other authorities (British Association of Social Workers 1975, British Association of Social Workers 1976).

TABLE 4.4
Estimated time to reach targets set in Consultative Document.

| Service | Growth Rate per annum | Current Shortfall % of requirements | Years to achieve target |
|-----------------|--------------------------|--|----------------------------|
| Home help | 2 | 50 | 35 |
| Meals on Wheels | 2 | 54 | 39 |

(Source: Radical Statistics Health Group 1976: table 4).

The criticisms and doubts expressed about the time scales set in the 1976 consultative document led to the issue of a further paper in 1977 titled 'The Way Forward' which re-defined the concept of 'community care' by extending it from 'care in the home' to the 'care in the community'. The term covered

"a whole range of provision, including community hospitals, hostels, day hospitals, residential homes, day centres and domiciliary support. The term "community care" embraces primary health care and all the above services, whether provided by health authorities, local authorities, independent contractors, voluntary bodies, community self help or family or friends" (DHSS 1977b: 9).

This 'new' bizarre concept of community care was a strange development.

It is debatable if clients can be said to be in the 'community' if they are placed in homes, hostels or hospitals many miles from their locality. Had these services been available to all in their local communities then the term 'community care' might have been appropriate.

These policy statements have only confirmed the ambiguity of the community care policy. Most of the reports and subsequent experience has shown the lack of strategic planning and political determination to

translate policy into practice. Brown put forward that the general impression given by the Ministry of Health was that they "operated primarily as a restraining factor rather than a promoter of new ideas and moreover one of which confined authorities in their endeavours as well as limiting them in their expenditure" (Brown 1972:272). There had been no sustained attempt to define and measure the need for community care or set policy goals related to the scale of need and the allocation of resources. The DHSS's policy targets, Klein argued,

"dissolved under the acid of reservations. 'Local priorities will naturally be affected by a range of factors - demographic, social and practical - peculiar to individual areas; and it is accepted that local plans will often not correspond to the order of national priorities proposed here' the DHSS's 1976 Priorities Document admitted. And its 1977 successor made it clear that the expenditure objectives - envisaging a shift of resources to favour the elderly and other deprived groups, and from hospital to the community services - were 'not specific targets to be reached by declared dates in any locality'. In practice the language of norms and objectives turned out to be merely a vocabulary of exhortation" (Klein 1983: 128).

TABLE 4.5

Variation in level of expenditure by Local Authorities on services for the elderly 1975.

| Expenditure | Highest | Lowest |
|---|---------|--------|
| Total on social services per 1,000 pop. | 14,932 | 8,568 |
| Elderly per 1,000 of 65 plus | 28,809 | 14,006 |
| Day care Elderly per 1,000 of 65 plus | 2,323 | 0,0 |
| Meals on Wheels per 1,000 of 65 plus | 9,549 | 1,619 |

(DHSS 1978b: 11, 12, 13, County Councils Gazette 1975: 163).

As Walker points out, the absence of clear policy and planning was demonstrated in the 'extension' of community care to include some residential institutions and hospitals rather than remaining as an alternative to institutional forms of care. Co-ordination between different services, rather than an imaginative expansion of domiciliary services became the primary goal of policy, which is a poor substitute

for a shortage of resources (Walker 1982:16, 17). This lack of clarity is crucial in explaining the form that community care policies have taken, because it suggests different conceptions of need at different times and in relation to different groups (Walker 1982:19, Tyne 1982:150). Coupled with this lack of clarity, public expenditure restrictions in the mid-1970s significantly reduced the flexibility of social services to develop community care programmes or improve the standard of services (Webb and Wistow 1982).

The 1977 publication re-emphasised the urgent priority to be given to domiciliary services and showed just how far local authorities had to go to meet the minimum national standards (DHSS 1977b: 24) (see table 4.6).

TABLE 4.6
Average level of provision per elderly person aged 65 plus 1975/76.

| Service | Level of provision per 1,000 pop 65+ | | Shortfall per 1,000 pop 65+ |
|---------------------------|--------------------------------------|----------|-----------------------------|
| | Guidelines | Out-turn | |
| Residential Places Avail. | 25.0 | 18.1 | 6.9 places |
| Day Care Places Available | 3-4 | 2.6 | 1.4 places |
| Home Helps (WTE) | 12 | 6.5 | 5.5 |
| Meals per week | 200 | 119 | 8.1 |

(Source: DHSS 1977b; Fig. 5).

The Labour Government intended to publish a White Paper on services for the elderly in 1979 setting out a general strategy to the end of the century (DHSS 1978a: 6). In preparation of this plan a discussion document on services for the elderly was published in 1978 titled 'A Happier Old Age' a document which was an attempt to draw together the views of all the interested parties, as well as the views of the elderly themselves, which had been published in the report 'The Elderly at Home'

earlier that year (DHSS 1978a: 5).

The White Paper was finally published by the Conservative Government in 1981, a document which had the same flaw as all its predecessors, the implication that the services could only grow when economic resources would permit. It placed much emphasis on the part to be played in the provision of services by voluntary effort and the concept of community care was changed from 'care in the community' to 'care by the community':

"the primary sources of support and care for elderly people are informal and voluntary. These spring from the personal ties of kinship, friendship and neighbourhood. They are irreplaceable. It is the role of public authorities to sustain and, where necessary, develop - but never to displace - support and care. Care in the community must increasingly mean care by the community. Providing adequate support and care for elderly people in all their varying personal circumstances is a matter which concerns - and should involve - the whole community; not just politicians and officials, or charitable bodies. It is a responsibility which must be shared by everyone. Public Authorities simply will not command the resources to deal with it alone; nor, even if they did, would it be right or possible for official help to meet all individual needs" (DHSS 1981a: 3).

This White Paper, in my view, lacked a policy to cope with the increasing number of elderly and their changing needs. Services were listed and praised despite their inadequacy and shortfalls and no firm proposals or policies were put forward (DHSS 1981a: 43). Underlying the precariousness of this policy was the absence of any clear and consistent definition of community care. The term has encompassed care in the community through domiciliary services and now care by the community. The term owes much of its attractiveness to its ability to mean all things to all policy makers. Apart from the recommendation to set up experimental nursing homes by health authorities, this paper has had very little effect, if any, upon the development of social services to date.

4.12 Review of the Home Help Service.

In 1972, the Social Work Service Group of the Department of Health and Social Services reviewed the home help service in 141 English local authorities. The objective of the review was to examine the effect of the transfer from the health department of the service to the new social service department. In some cases detailed discussions and research had been carried out in an attempt to identify where in the new department the service would be best placed. In many departments, however, no such discussions had taken place and in a number of cases the transfer was delayed until suitable premises were found or to allow for discussions on conditions of service (DHSS 1973: 2).

A variety of patterns of organisation emerged as a result of the transfer but three main patterns were usually observed:

- "1. A centralised service with the responsibility for the management, assessment of need and allocation of work resting with a senior organiser at headquarters.
2. The management of the service resting with home help organisers in local area teams. Each organiser being responsible to both the area manager and a senior home help organiser at headquarters who was responsible for the co-ordination of and standards of service.
3. A service fully integrated into the local social service area team with the manager of the team having full responsibility for the delivery of the service" (DHSS 1973: 6).

At this early stage in the integration of the service into the social services department referrals were still predominantly from the health service. Medical and nursing personnel reported delays in the delivery of services and as a result of these criticisms organisers began to develop new referral systems and worked closer with health service colleagues. Referrals from social workers were increasing gradually but some organisers saw those referrals as inappropriate or unsuitable. In

some authorities social workers were beginning to involve themselves in the assessment of clients for the service, a trend which caused the writers of the review to recommend that the respective functions and roles of the social worker and home help organiser should be clarified (DHSS 1973: 9).

Despite the responsibilities placed on authorities by the Chronically Sick and Disabled Persons Act no attempts to assess the need for domiciliary care in the community were being made. Distinct from the assessment of community needs or demands, some authorities began to examine the problem of developing criteria of assessment for individual client need (DHSS 1973: 10). Once initially assessed, clients were hardly ever reassessed or their needs reviewed. Very few organisers had time to make review visits despite this function being reported as part of the the organisers' role (DHSS 1973: 10).

The workload of the home helps was predominantly domestic although a shift towards caring function was noted but no evidence was put forward in the review to support this assertion. The service supported predominantly the elderly (85%) with the chronic sick also receiving some support but mentally disordered and maternity cases received relatively little help. The decline in maternity cases to only 2.3 percent was attributed to the cost of the service to clients, to the increase in hospital confinements, the improvement in domestic equipment and the tendency for husbands to help in the home (DHSS 1973: 12).

The review raised many questions about the role of the home help service. Should emphasis be on a caring rather than a domestic role? Was the service a preventative or rehabilitative one or should it only respond to crises or emergencies? The review also urged as a matter of

priority that the criteria for eligibility for the service should be examined and made clear to clients and agencies (DHSS 1973: 39).

4.13 Conclusions.

Few academics spoke in favour of the National Assistance Act 1948. Brown (1972: 11-28), Townsend (1964: 10) and Parker (1965: 106) highlighted the inadequacy of the act in terms of its emphasis on residential care which made no attempt to provide any sort of substitute family care for old people. Institutional care for old people was accepted without question (Parker 1965: 106). The elderly were a low priority in terms of social policy provision and were treated differently from other groups in terms of residential and domiciliary care. An important theme during this period was the consistent emphasis of the centrality of the 'family' in the care of the elderly. This broad consensus was endorsed by Townsend (1963: 38), Sheldon (1955: 15-26) and the Ministry of Health (MOH 1954b: 187). Such views were echoed by all main political parties during the 1950s and 1960s (Hansard 1953d, Hansard 1958, Vaughan-Morgan, Maude and Thompson 1952: 19, National Labour Women's Advisory Committee 1965: 3). It is possible to perceive these years as a period of incremental progress for the home help and community nursing services for old people (Brown 1965: 92). Increasingly, a preventive service evolved using domiciliary service to support a range of elderly people in their own homes, a service not restricted to those without 'family' support (DHSS 1971b). However, as in the past, recruitment problems hampered the development of the service. Despite this widening of support it was still assumed in the late 1960s that the 'family'

ought to care, which led to warnings that domiciliary services were to support the family not to replace it (Municipal Review Supplement 1968: 131, National Corporation for the Care of Old People 1969: 39). Moroney pointed out that the changes described in this chapter had little influence upon attitudes of family responsibility (Moroney 1976: 56-58). However, the financial consequences of an ageing population began to be recognised (Rossiter and Wick 1982: 20), which could only be off set to some extent by care in the community.

During the last thirty years the home help and community nursing services have expanded to meet demand, particularly from the elderly. In the 1950s it was recognised that co-ordination of services was a necessity; some were suspicious of the medical professions motives for arguing so, fearing that they wished to gain control of the social services; fears which were well grounded as evidence to the later Seebohm Committee was to show. However, during the 1950s and 1960s the expressed demand for the services had been greater than the ability or willingness of local authorities to supply them. The home help provided a mainly domestic service but whether this was a service ancillary to medical and nursing services or to social work was a point settled by the Seebohm Report (MOH: 1968a). Despite the recommendation of the Seebohm Report, the role and function of the home help was not understood by other professionals; but the service filled many of the gaps in client care caused by lack or co-ordination of nursing and social work (Scammells 1971). Later reports highlighted the lack of clarification of the role of the social worker and home help organiser and the need for research to clarify the role of the service (DHSS

1973). It was suggested that the service was changing its emphasis from domestic support to a more personal service.

CHAPTER FIVE.

Development of the Home Help Role.

5.1 Introduction.

In this chapter I shall discuss how the home help role has developed over the last 40 years and examine attempts to shift the emphasis from a domestic to a more personal care role. Several factors must be taken into account when discussing the present home help service. The philosophy of care changes over time; emphasis is placed on different aspects of social care over the years: residential and day care, higher standards of care and living conditions and a better quality of life. The structure of the family is changing and also the characteristics of the elderly population, all factors which interlink and influence the role of domiciliary services.

The National Health Service Act 1946 and the National Assistance Act 1948 created confusion over the distinction between those elderly people who are sick and others who are in need of 'care and attention'. Some argued for the development of geriatric units as the main solution to the problem of the chronically sick elderly, a problem which had been exposed by hospital surveys (Nuffield Provincial Hospitals Trust 1946, Howell 1946: 399). Many elderly people admitted to this form of care

could have been looked after in local authority welfare accommodation if it had been available (British Medical Association 1948, Boucher Report 1957: 1, 51). The years after the Second World War were characterised as an age of austerity in which there were restrictions on many areas of public expenditure (Sissons and French 1963). However, in the twelve years after 1948, 1184 old peoples homes were opened of which only 207 were newly built (Townsend 1964: 22, 24). Some have claimed that loan sanction was a method used by the Ministry of Health to regulate local authority spending (Hepworth 1976: 137); others argued that it (loan sanctions) also discouraged the setting of long-term objectives needed for effective planning (Eosanquet 1978: 109). By the end of the 1950s, the economic state of the country allowed a relaxation of capital restrictions on health and welfare projects, the effect of which was outlined by Sumner and Smith: "Loan sanctions for welfare homes in England and Wales totalled 5.5 million pounds in 1959-60, 8.3 million in 1960-61, and 9.0 million in 1961-2" which compared with an average of 4.2 million pounds for health and welfare projects in the five years preceding 1960-1 (Sumner and Smith 1969: 41). However, inflation must be taken into account when discussing these figures.

Who these homes should have been accomadating was a matter of much debate (Hill 1961: 15, Shenfield 1957: 164). Townsend's evidence in 'The Last Refuge' showed that many residents were frail and that others lacked any major physical or mental disability (Townsend 1964: 66). 'The Last Refuge' is a presentation of evidence which argued that all existing forms of residential care failed to offer a reasonable living environment which met the needs of many elderly persons. Townsend argued that these homes should have been abandoned as an instrument of social

policy (Townsend 1964: 190). He called for a more adequate income and sheltered housing policy for the elderly and a family help service including such services as home help, meals, laundry and night attendance. The overall principle, he stated, should be that,

"when the individual can no longer do some necessary personal or household task for himself, and his family cannot do it for him, then it should be the duty of the home and welfare services to help, and go on offering (and giving) help so long as he is able to live there" (Townsend 1964: 207).

The years between 1964 and 1970 saw a whole series of attacks on residential care (Barton 1959, Goffman 1961, Robb 1967). The periodic economic crisis led to restrictions on public expenditure and cutbacks on capital projects but the residential care sector continued to expand (Ministry of Health 1967, Ministry of Health 1968b, DHSS 1969, DHSS 1969a, DHSS 1975).

The years from the middle 1960s to 1970 saw no great expansion of domiciliary care services; they continued to develop slowly, despite rhetoric about the need to keep elderly people in their own homes and the growing awareness of the problems associated with residential care. Residential homes had come to "loom larger and larger as things that are good in themselves rather than as practical solutions to a passing difficulty" (Bosanquet 1978: 109). However, there was a broad consensus of thought in the 1950s and 1960s, that elderly people should remain in their own homes as long as possible (Townsend 1957: 38, Sheldon 1955, Ministry of Health 1954, Vaughan-Morgan et.al. 1952, National Labour Women's Advisory Committee 1965). These attitudes, coupled with assumptions about the role of the family in caring, discussed in the last chapter, had begun to lead to a recognition of the value of domiciliary services.

Since the early 1970s successive Governments have attempted to tackle the problems caused by the increase in the elderly population. Much of my discussion on the home help service concerns the elderly as they form by far the largest group of users. Other client groups such as the mentally disordered, maternity, chronic sick and families utilise only a small percentage of the service today.

The observations of the government on the needs of the elderly, culminating in 1981 in the document 'Growing Older', was the first attempt centrally to review the role of the elderly in society and the services needed to support them. This attempt to influence policy had a number of themes running through it. Previous documents highlighted the preference for care in the community but later reports placed emphasis on the place of relatives and volunteers in providing community services. Few believed that community care may not after all be cheaper than residential care (DHSS 1981b: 21). The publication 'Care in Action', in 1981, finally brought home to authorities the problem caused by expenditure cuts. The paper pointed out:

"As the growth of financial resources are severely limited and the priority groups are large, further progress cannot be rapid and will depend mainly on the skillful use of innovative approaches including the greater use of what the voluntary and private sector can contribute" (DHSS 1981b: 20).

The Government's priority was and still remains that of getting "the economy right" (DHSS 1981b: Introduction). The paper 'Growing Older' (1981) placed importance on the need for authorities to support groups and individuals who provided direct care to elderly persons:

"The Government sees the primary role of the public services as an enabling one, helping people to care for themselves and their families by providing a framework of support" (DHSS 1981a: 38).

Walker reminds us that community care policy towards the elderly is

being fashioned at a time of "great change in the welfare state, when key determinants of policy are the desire for less state intervention in welfare and less public expenditure on social policies" (Walker 1982: 98). As a result of these policies domiciliary services and, in particular, the home help services are today the subject of much pressure to be effective and efficient.

5.2 The Conversion of the Role of the Home Help.

Much discussion at meetings and conferences in the 1950s continued the debate of the 1940s on the early role of the home help service and the nursing profession. The nursing profession and some home help organisers still saw the ghost of the 'handy woman' behind the home help, particularly in relation to the maternity and child welfare service. . Many believed this fear "ought to be broken down" (WVS 1950: 11) though not all organisers agreed. Burr, a nurse and a supervisor of home helps in London, wrote against any attempts at home helps carrying out basic nursing tasks (Burr 1949: 30). Burr was a qualified Midwife and Health Visitor who held the position of full time organiser but her background and training may have influenced her perception of the role of the home help in relation to the role of the qualified nurse.

Health visitors were also less accepting of the new home help service and were unable to understand why they could not combine their own role with that of manager of the service. This attitude applied particularly to health visitors who worked in rural areas (City of Sheffield 1948: 19, 34). The conflict between nurses and organisers was to continue into the 1970s. Even today, some organisers are still unsure of the

role of the service. Is it a 'caring' or 'charring' service? (Philpot 1982: 22-24, Dexter and Harbert 1983). The medical profession had always seen the service as "essentially that of domestic servants". Many doctors expressed the view that:

" The essential difference between a home help and a domestic servant is that the former attends on account of a definite medical social need without reference to cost; the latter is available to anyone at a price, where the price can be paid" (The Medical Officer 1950: 157).

Many Medical Officers, who were directly responsible for the management of the service, had a narrow definition of the role of the home help service; but some like Dr. Brooke began to question this, arguing that the home help

" must be many sided and have her full share of the humanities and of patience, for it has been said that people get tired of the aged and chronic sick. It is of great value in her training that she should take a certificate in Home Nursing of the St. John and Red Cross and gain instruction in the prevention of accidents in the home. The problem of old people was indivisible, and was important to realise that so many tend to oscillate in the 'no mans land' between health and frailty and so require more of the simpler nursing skills. Simple nursing was done in all the homes of Britain, etc. and was within the competence of a Home Help under the skilled supervision of the District Nurse. The Home Help service was concerned largely with people for whom there was no room in hospital, ie. mostly elderly" (Home Help and the Nation 1953: 6-7).

The Medical Officer of Nottingham, at the same meeting as Dr Brooke, argued opposing views, putting forward that the home help should stop "dabbling" in midwifery and "nursing skills" and keep to her allotted role of houseworker (Home Help and the Nation 1953: 17). Others supported Dr. Brooke's view of the function of the home help. Dr Grant writing in 1955 expressed concern because many considered that the home help "should be denied knowledge acquired by training lest she should encroach on the Health Visitors domain" (Grant 1955: 238).

5.3 The Home Help Role in the late 1960s and 1970s.

Hunt's national survey of the service in 1967 and Harris's study of the needs of the elderly throws some light on the home help service during the late 1960s (Hunt 1970, Harris 1968). Harris in her study attempted to establish criteria of need for services for the elderly. Eight local authorities in England and Wales were chosen by dividing authorities into two types, County Councils and County Boroughs, and within each strata they were ranked in descending order according to a scale which took into account factors such as ratio of home helps to elderly people, proportion of elderly in population etc. (see Harris 1968: 6 for a full list of factors).

Harris was the first to attempt to examine what tasks home helps actually did for their clients, She found little difference between the authorities studied in the types of tasks a home help was permitted to do. However, her research was limited as she had identified only thirteen tasks (Harris 1968: Table 13). Normal housework, sweeping, cleaning, dusting, bedmaking, washing up and cooking meals were all considered as part of the role of the home help as was making fires, carrying coal, shopping and collecting pensions. Only 4.8 percent of home helps in the survey helped to wash or bath clients (Harris 1968: Table 13).

She did not comment on variation between authorities. There were however some variations. Only six per cent of home helps collected pensions in Preston compared to 34 per cent in Coatbridge, eight per cent did laundry in Preston, 54 per cent in Coatbridge. One per cent washed or bathed clients in Worthing whereas 10 per cent carried out this task in

Oakham. There was however little variation in such tasks as dusting, sweeping, polishing etc., shopping cleaning or making beds. Variations were possibly the result of policy decisions of the authorities as to the duties of the home help.

The purpose of Hunt's study was to investigate the way in which the service operated and to attempt to form some estimate of need. In January 1967, all authorities in England and Wales responsible for home help services were asked for details of home help hours allocated to different types of client categories and the numbers of home helps working during a certain week. Authorities were stratified into County Councils, County Boroughs and London Boroughs and a sample of 50 authorities selected with probability proportionate to the number of home help hours. Recipients in each area were selected at random (from two groups, 65+ and another which included maternity, short term illness cases etc.). Home helps were also selected at random from a list of those who had worked during a specific week. 1502 recipients of the service were interviewed, 1192 elderly, 117 chronic sick and 193 other cases. 1,000 home helps were selected of which 996 were interviewed.

To achieve her objectives she organised an examination of certain tasks carried out by home helps. She posed the question to home helps "Can you tell me what jobs you spend most of your time doing (each type of case attended)?" and when this was answered, "Would you tell me whether you did any of these last week?" (Hunt 1970: 56). She identified twenty two tasks which home helps had carried out for clients, such as dusting, sweeping, making beds, washing up, collecting pension, preparing meals, helping client to dress, mending, darning etc (see Hunt 1970: 105-107 for full list).

The results of the survey clearly point to the service being a domestic one; nearly all home helps carried out the domestic tasks. However, some home helps did help to dress, wash and bath clients and carry out personal commissions for them. Clearly some home helps, although agreeing that the service was a domestic one, also carried out personal and basic nursing tasks for clients (Hunt 1970: 57, 105-107).

Over half of the home helps thought that their role was a domestic one (Hunt 1970: 59) but many had at some time also offered advice on such matters as housing, cooking and shopping. Hunt found that older home helps were more likely to be asked for advice and nearly half of those interviewed thought that giving advice was part of their job.

TABLE 5.1
Matters on which advice was sought by clients (percentage).

| Subject | |
|---|------|
| Family problems | 16.3 |
| Financial, insurance, pension | 10.5 |
| Problems connected with forms | 8.8 |
| Client's health | 8.0 |
| Housing | 1.9 |
| Getting into O P H | 1.0 |
| Arrangements with funerals/ wills etc. | 1.0 |
| Other things | 5.4 |
| Personal matters discussed | |
| Advice not asked | 29.3 |
| Others | 17.8 |

(Source: Hunt 1970: 63, NB, Total exceeds response because of multiple response).

Studies since 1972 have attempted to analyse the home help role in terms of practical tasks undertaken. Others have focused on the time it takes for a home help to carry out a given task (Marks 1975: 51-72, Hillingdon L.B. 1977: table 10, May 1977: 17, Gwynne and Fean 1978: 18, Cheshire C.C. 1980: 7). As none of the surveys provide an accurate description of what constitutes a particular home help task, it must be

assumed that some of the categories used overlap; for instance, 'making tea/coffee' is probably included under the heading 'cooking' in all but the Gwynne and Fean survey. The wide variation in results between each survey is not easily explained in terms of general changes in levels of provision and they must owe much to both the research methods used and local disparities in provision. For instance, some authorities may have a well resourced meals-on-wheels service, thus less home helps may have to cook meals (Hutchinson 1975: 35). Similarly, authorities may employ bath attendants, and so home helps would be less likely to wash, dress or bath clients. Areas with a central laundry service may not require home helps to carry out this time-consuming task, though some may still launder personal clothing items for clients.

Other studies point out similar discrepancies between districts within the same authority. (Gwynne and Fean 1978: 18, May 1977: 18). All the surveys indicate that cleaning, polishing, dusting were performed by most home helps; evidence would seem to be at variance with the views of White and others who suggest that the prime role of the home help service is a personal caring one providing "social and emotional care and support to clients" (White 1983: 18).

Certain tasks such as lighting fires show a marked contrast between the pre-1970 studies and the post-1970 surveys and may be explained either in terms of the decline in the use of coal fires or, more likely, in terms of local differences in policy and the relationship of local neighbourhoods to the coal industry. Cooking, washing in the home, mending and darning and emptying commodes were performed by less than half of home helps in some areas and by as few as 7-12 per cent in others. Personal tasks such as help with washing and dressing was

performed by 44 per cent of home helps in Hunt's study but by only as few as 2-7 per cent in later studies. In the two studies that looked at work with children it was reported that few staff carried out tasks in connection with that client group, an indication of how the service had changed over the years.

Hunt's study was the only one to examine or consider the relationship between the home help and the client, particularly in terms of the degree to which clients relied on the home help for advice. Given the close relationship that can develop between the home help and client, it is perhaps inevitable that some clients will seek advice on a number of matters including personal problems. Hunt reported that about half of her sample were asked for their advice on such matters as cooking, shopping and housework. Furthermore, she found that over 67 per cent of all home helps discussed or assisted clients with personal problems (personal problems were not defined) and that nearly half thought that giving such advice was part of their job (Hunt 1970: 63).

Home helps today are expected to support a large variety of client groups - a range which covers the aged, acute and chronically sick, the mentally disordered, expectant mothers, those with young children, problem families and many others. The service and, therefore, the individual home help could be expected to support a wide spectrum of client groups at any one time, a fact recognised by the Local Government Training Board by the late 1970s. The activities expected of an average home help, based on a sample of local authority job descriptions, were listed as follows:

1. To clean and tidy the client's home. The home help (HH) should concentrate on those tasks unable to be carried out by the client, using the appropriate domestic appliances and equipment as available - sweeping, dusting, washing dishes, vacuuming,

- polishing, cleaning floors, bathrooms, kitchens etc.,
2. To bring in coal, light fires and boilers,
 3. To launder clothes- using Client's machine
 - taking clothes to launderette
 - washing personal items/soiled linen by hand
 - preparing clothes/incontinent laundry for collection
 4. To iron clothes
 5. To mend, darn clothes
 6. To make beds, change bed linen
 7. To assist another Home Help or 'Blitz' cleaning squad with the cleaning of an exceptionally dirty or infested home
 8. To shop for food, household commodities
 9. To collect pensions, prescriptions, pay bills for clients
 10. To prepare and cook meals, including main meals, breakfast, supper, snacks and drinks
 11. To use telephone for clients to contact doctor, emergency services or make appointments
 12. To deal with callers to client's home
 13. When other forms of assistance are not available to accompany client to hospital/doctor and if authorised by the Home Help Organiser (HHO) to use own car or authority's car
 14. To care for children in the family ensuring they are fed and clean
 15. To assist in the home care of nursing or expectant mothers and babies
 16. To deliver children to school
 17. To show an understanding of the client's needs and the home circumstances
 18. To report to the Home Help Organiser on the condition of the client and to be alive to any significant change in the client's behaviour, needs or circumstances
 19. To co-operate and liaise with Social Workers, Community Workers and Area Health staff to achieve the proper care of the client
 20. To establish a relationship with the client to ensure that the service and the helpers are acceptable, by communicating with the client, giving support to those clients under stress, and providing a degree of companionship and link with the community
 21. To carry out those personal and caring tasks that are not those of a nurse but those which could normally be expected to be undertaken by a member of the client's family
- e.g. Assisting clients in and out of bed
 Assisting clients to get dressed/undressed
 Assisting clients to wash face, hands, hair, brush hair
 Assisting clients to commode/toilet
 Emptying commodes, disposing of incontinent pads, cleaning clients after soiling or wetting
22. If agreed by HHO, GP and nurse to administer medicines
 23. To encourage clients to use aids provided and if agreed with the nurse and HHO to assist clients with use of aids/artificial limbs
 24. To write or read letters, complete form for blind clients
 25. To complete all administrative documents accurately
 26. To travel between jobs" (LGTB 1978: 27-28).

The amount of time allocated to personal caring tasks is, however, still minimal. Howell et.al. in 1979 found that only four minutes (2%) of home help time was allocated to personal care and only 27 per cent of clients received this type of support (Howell et.al. 1979: 64). Only 15 per cent of clients in Marks' study received help with personal tasks. As with other task headings in similar studies there is a difficulty in comparing the type or kind of tasks carried out for clients under the heading of personal care. Marks' study included many of the same tasks under this heading as the Howell study had but excluded for instance cutting toenails.

Results of studies, cannot be compared because the interpretation in each as to what constitutes a personal task is too varied. Personal tasks in the Howell and Marks studies included: emptying commodes, dressing, getting in/out of bed, washing hair, hands, feet, getting to toilet, undressing, bathing, (Marks only) washing and cutting toe nails (Marks only). In both studies about 27 per cent of clients received this kind of support (Marks 1975: 70, Howell et.al. 1979: 59). In the 1979 study over half of the clients could not bath themselves but only one client received this service from the home help whereas in the Marks study about 30 per cent of clients were given this support (Marks 1975: 70).

Marks commented that the

"main tasks with which clients needed help but did not receive it were bathing or washing all over, followed by washing hair. A few of those who were considered to need help with bathing had been offered the services of a district nurse but had refused them" (Marks 1975: 71).

Another study has reported home helps as having cleaned teeth, cut toenails, bathed and bandaged clients' ulcerated legs (Marrow 1983:

18-19). Home helps have also reported dressing clients' shingles (Harbrige 1979: 21).

It is clear from these studies that some staff in the home help service perform, to differing degrees, basic nursing or personal caring tasks. The published studies to date point to the home help service as being mainly a domestic service although some home helps perceive it as having a caring and nursing element.

In the Gwynedd study (1977) home helps ranked their most pressing training priority as nursing skills. This, it was thought, reflected their confused perception of their role as to whether they were domestic workers or nurses. It might also have mirrored their desire to carry out personal or basic nursing tasks for their elderly dependent and housebound clients (Gwynedd C.C. 1977: Table 7).

This need for some form of nurse training was ranked number one despite the fact the same sample ranked cleaning as their number one task. Time spent on personal care came bottom in their priorities (Gwynedd C.C. 1977: Table 7).

In both the Gwynedd and Hutchinson studies home helps felt that heavy domestic work was not within their sphere of responsibility but both studies concluded that despite the shortcomings of the present service it was and could be flexible (Hutchinson 1975: 35).

Dobinson (1982) attempted to identify in one authority the balance between traditional and personal tasks and the extent to which a change, if any, had occurred in the home help role by focusing on:

1. "The ten clients from each social work office who received most hours of help during one week in November (The working assumption was that the clients receiving most hours would be most dependent and so likely to be receiving personal care).
2. A 'sample' from three districts, one per division, of a cross section of 15 cases each chosen by the home help organiser to reflect a typical

group of clients" (Dobinson 1982: 1).

Eight personal caring tasks were listed; table 5.2 shows clearly the extent to which those tasks were carried out. Eighty three percent of the 'most hours' and 49 percent of the 'cross section' clients received some personal care. However, it was not possible from the study to apportion the amount of time spent on each task for each client.

TABLE 5.2
Personal Care Tasks Undertaken (Percentage of clients receiving support).

| Task | 'Most Hours' | 'Cross Section' |
|------------------------------------|--------------|-----------------|
| Washing/dressing | 50 | 11 |
| Moving about | 47 | 30 |
| Emptying commode | 41 | 11 |
| Reading/writing/letters/forms | 39 | 34 |
| Using the toilet | 30 | 15 |
| Cutting nails | 24 | 17 |
| Washing hair | 18 | 13 |
| Bathing | 11 | 6 |
| <u>Number of Tasks Undertaken.</u> | | |
| No tasks | 17 | 49 |
| Up to 4 tasks | 67 | 45 |
| 5 or more tasks | 16 | 6 |

(Source: Dobinson 1982: 9).

Table 5.2 gives an indication that the home help may carry out more personal caring tasks for the more dependent client but as table 5.3 shows, the cleaning and traditional tasks carried out remain an important aspect of the service. It is interesting to note that both groups of clients had help with cleaning, washing floors, cleaning cupboards etc. to the same extent. Table 5.3 does show how important the traditional domestic support services are to the elderly irrespective of their dependency level.

TABLE 5.3

Cleaning Tasks Undertaken (Percentage of clients receiving support).

| Tasks | 'Most Hours' | 'Cross Section' |
|---|--------------|-----------------|
| Routine house cleaning | 99 | 98 |
| Bed changing | 88 | 66 |
| Washing up | 92 | 70 |
| Washing floors | 92 | 91 |
| Cleaning out refrigerator, larder or cupboards | 77 | 70 |
| Cleaning oven | 61 | 43 |
| Shampooing carpets | 21 | 17 |
| Washing paintwork | 62 | 77 |
| Top to bottom cleaning of house | 3 | 8 |
| Number of Tasks | | |
| One to five | 21 | 41 |
| Six to ten | 79 | 59 |

(Source: Dobinson 1982: 10).

What support do organisers assess their clients as needing? Home helps are reported as spending a large proportion of their time carrying out domestic tasks. The trend towards a more personal caring service is not borne out by the evidence to date. From the limited data available it can still be argued that the service is concerned with offering a practical help to elderly clients (Hammersmith L.B. 1974: 26, Avon C.C. 1976: 19, Gwynedd C.C. 1977: 8, Gwynn and Fean 1978: 16, Howell et.al. 1979: 59, Cheshire C.C. 1980: 6).

There is however some evidence to suggest tentatively that the traditional domestic role of the home help is beginning to widen to encompass more personal and caring tasks. The Coventry project emphasised this and also the emotional support which can be offered by the home help (Latto 1982: 21). Despite the importance of the traditional domestic and cleaning role of the home help, many authorities have agreed to or are in the process of discontinuing this role in favour of a more personal service. Wandsworth social services

department in 1977 recommended to "discontinue household cleaning as being of lower priority" to free resources for more "important home help work" such as personal caring tasks (Wandsworth L.B. 1977: 28). Bradford City recommended in 1979 "that this fundamental principle be accepted; that in deciding priorities for the home help service, personal care should take priority over cleaning" (Hurley and Wolstenholme 1979: 56). This raises questions about the kind of service offered to those clients who do not need such an intensive service. Would they be offered any home help service or would they be expected to obtain the support from the private sector or relatives? These important questions were not dealt with in this study. However, in chapter six the expanding role of the home help and auxiliary nurse is discussed.

5.4 Summary and Conclusions.

There is some evidence to indicate that the role of the home help is changing in response to changes in the philosophy of client care. Home helps in general do mostly domestic work but there have been some attempts to shift the service towards 'personal care' or 'basic nursing'. Writers in the 1950s and 1960s showed that existing forms of residential care failed to offer a reasonable living environment that met the needs of many elderly people, and called for alternative forms of care such as home help, meals-on-wheels, laundry services and adequate domiciliary nursing support. The economic crises of the late 1960s led to restrictions in public spending. Domiciliary services developed slowly in spite of a belief, held by many, that old people should remain in their own homes as long as possible.

Debates on the role of the home help and community nursing services have gone on since the late 1940s. The nursing profession still saw the ghost of the old 'handywoman' behind the home help, particularly in maternity and child welfare cases. The medical profession had always seen the service as that of domestic help only but in the 1950s some doctors began to recognise the potential of the service for personal care. However, the greater part of the home help's time was spent on domestic tasks but in special cases she could perform simple nursing duties.

It was not until the late 1960s that the role of the home help became the subject of research. Harris and Hunt found little differences between authorities in the types of tasks a home help was allowed to do. Despite the size and status of these studies, relatively little information as to the range of tasks carried out by home helps was forthcoming. Hunt's study hinted at a change in the traditional role of the home help. 'Personal commissions' were carried out and advice offered by the home help - trends which have continued. Most studies since 1972 have attempted to analyse the home help tasks in terms of practical tasks undertaken. The wide variation in results between surveys are probably due to the research methods used and local disparities in provision. However, all the surveys showed that tasks like cleaning, polishing, dusting, etc., were performed by most home helps and are considered as having a high priority. Thus, although White and others regard the prime role of the service as a personal one, it is a stance not borne out by the evidence to date. However, today, home helps are expected to support a large variety of people: the aged; the acute and chronically sick; the mentally disordered; expectant mothers and those with young children; problem families. The amount of

time allocated to personal caring tasks is minimal, and it varies from authority to authority. Some authorities however have recommended that personal care take priority over the domestic role.

The low status usually afforded to domestic work has "tarnished the image of the home help service and placed it in a subordinate position among the helping professions. This has led some organisers to believe that improvement in pay, conditions of service, and recognition will only come about by shifting the balance away from domestic work and towards a more personal caring role" (Dexter and Harbert 1983: 200), a trend also commented upon by others (Scottish Home & Health Department 1980). How far this trend has gone and its effect upon other services particularly the community nursing service is discussed in the next chapter.

CHAPTER SIX

The Convergence of the Role of the Home Help and Auxiliary Nurse.

6.1 Introduction

In chapter five I discussed the development of the home help role, examining the trend towards the 'caring' aspect of the job. In this chapter I shall discuss the development of the auxiliary nurse role and the convergence of that role with the home help. Recent organisational changes in Social Services are also discussed, to indicate their effect upon the role of the home help and to some extent the community nursing services.

The home help service has since 1948 developed in response mainly to the domestic needs of an increasingly dependent elderly population. The community auxiliary nursing service in contrast has emerged in response to the need to utilise more effectively the qualified community nurse. However, both have provided services to the elderly in their own homes. Since 1971, shortages of trained manpower has led to a large increase in the numbers of auxiliary nurses employed (Williams 1978). The home help services in contrast has diversified its services in response to financial constraints and the number of 'old' elderly dependent persons living in their own homes. It has been argued that this development has

seen the home help service in some instances assuming responsibility for tasks which have been up till now a nursing role although little evidence is offered to support this assertion. Have developments in the community nursing service affected the home help role? Have pressures on the home help and nursing services led to changes in the home help role? Since the early 1970s, the numbers of auxiliary nurses have increased and new health and local authority care schemes have emerged. Some of these schemes are discussed and compared with the traditional role of the home help service and their effect upon the community nursing service is analysed. In later chapters questions are asked: is the traditional home help service flexible enough to take on an extended role? Does the traditional home help see an extended role for herself? Running throughout organisational reforms in the National Health Service over the past two decades has been the notion that nurses must be relieved of 'non nursing' responsibilities (Royal College Of Nursing 1958, A Reform of Nursing Education 1964, Report of the Committee on Senior Nursing Staff Structure 1966, Report of the Working Party on Management Structures in the Local Authority Nursing Services 1969, Halsbury 1974). Cang commented upon the use of the terms 'Nursing' and 'nursing' which is intended to reflect the "increasing tendency of the nursing profession to disown what might be called Basic Nursing (nursing) in favour of the specialised and more technical work (Nursing)" (Cang 1978: 216). He believes that the basic work of caring for the sick has in the past few years acquired the "status of less important, menial work, unfit for true professionals and something of an embarrassment, therefore, to an aspiring profession" (Cang 1978: 216). As the medical profession delegated 'routine' tasks to nurses (blood

pressure, drips etc.), trained nurses in turn have handed down what has hitherto been considered exclusively nursing tasks to lesser trained or untrained staff (Carpenter 1977). The evidence offered in this thesis would suggest that ever since the middle of the 1850s this phenomenon of professionalisation has been occurring.

6.2 Emergence of the 'Assistant' in the Community Nursing Service.

The social changes and legislation which took place during the Second World War "made it essential for an appraisal of all service - including nurses" (Bendall and Raybould 1969: 163). In 1948, the Ministry of Health established a committee to examine the recruitment and training of nurses which led to a recommendation that a system of nursing aids or assistants be established (Bendall and Raybould 1969: 163). Eventually, a new grade of 'nursing auxiliary' defined as a person who was "engaged wholly or mainly on nursing duties" was introduced, a move which caused much debate within the profession (Abel-Smith 1970: 236). The number of unqualified 'nurses' increased rapidly (Abel-Smith 1970: 234) and by 1954 it was recognised that the assistant nurse had a large part to play in the nursing of the sick in their own homes. A Standing Nursing Advisory Committee recognised there was a place for an

"assistant nurse in home nursing, working under the supervision of a registered nurse. Wider use of her services in this field, for example with chronic sick patients requiring chiefly basic nursing care, would free the more highly qualified nurse for the more acute work" (MOH 1954a: 5).

The position of auxiliary nurse had become accepted by the profession by the middle of the 1950s (Abel-Smith 1970: 238). By the 1960s the community nursing profession could have said to have attained one of the

seven steps necessary for professionalisation put forward by Wilensky as that of "redefinition of the core task, so as to give the 'dirty work' over to subordinates" (Wilensky 1964: 142-146), a process which I have argued in previous chapters began over a hundred years ago. Some of the profession's knowledge had become so routine that it could be mastered and applied by a secondary worker with much less training. Goode also suggests that less qualified personnel are given "the 'dirty work', the tedious, less interesting, preparatory, or cleaning up tasks". Often such helping jobs are even defined legally as subordinate, in that the holders are not permitted to practice except under professional supervision (Goode 1969: 284).

The percentage of staff carrying out such tasks differ from authority to authority. The possibility of delegating certain duties to different grades of staff had been examined, but it was recognised that such an allocation of tasks was not possible. As local conditions varied between authorities it was found difficult to recommend exactly what duties each grade of staff should carry out (CHS Council 1965: 7). However, about half of the duties of the qualified nurse such as bathing, washing clients, foot hygiene, dressing or undressing clients were thought to be suitable for delegation to auxiliaries (CHS Council 1965: 8-10). To utilise effectively the qualified nurse, local authorities were encouraged to examine their working methods (MOH 1965: 1) but by 1967 only about 40 percent were employing auxiliaries, a fact which disturbed the Ministry of Health (MOH 1968).

Qualified nurses who were willing to delegate many tasks were unable to do so; only five percent of the community nurse workforce were of the auxiliary grade (Hockey 1966: 97). Research of this period argued for

the employment of auxiliaries to carry out the basic nursing and domestic tasks (Hockey 1966: 120). Later studies supported this concern (Carstairs 1966, Allen, King and Abbott 1970, Hockey 1972).

Some studies began to highlight the tasks not usually carried out by either the auxiliary nurse or home help (Warren, Cooper and Warren 1967: 141-9, Cartwright, Hockey and Anderson 1973). Cartwright et. al. argued that when a community nursing service is "composed entirely of fully qualified and experienced nurses, demands for less skilled care may well be curtailed" and claims made for an expansion of the ancillary services to supplement the work of the qualified nurse (Cartwright, Hockey and Anderson 1973: 125).

The auxiliary nurse has emerged according to Williams because

"the nature of the environment in which nursing is carried has changed. The increasing cost of skilled nursing labour is leading to its replacement by less skilled workers in the form of auxiliaries which reflects labour costs and the lack of emphasis on individual privacy and entitlement to personal service in the National Health Service. The drive for professionalisation has led to an increasing distance between the qualified nurse and tasks involving actual patient contact, which is being abandoned to unskilled or semi-skilled assistants" (Williams 1978: 34-36).

Available data shows that between 1966 and 1975 the number of nursing auxiliaries in the community nursing service in England and Wales had risen from 212 to 2,391 (see table 6.1).

TABLE 6.1
Ancillary Nursing Growth 1965-1975

| Year | Number |
|------|--------|
| 1965 | 212 |
| 1971 | 1,184 |
| 1972 | 1,485 |
| 1973 | 1,656 |
| 1974 | 2,391 |
| 1975 | 2,391 |

(Source: Hardie and Hockey 1978: 78)

Titles given to this ancillary grade of staff varied from nursing auxiliary, nurse assistant, bath attendant, nursing aides and nurse's aides (Hockey 1972: 164). It was not until 1977, however, that the grade 'nursing auxiliary' was officially introduced into the community nursing service (DHSS 1977) but in England and Wales the precise duties of this grade of staff has never been spelt out. In Scotland the duties expected of the auxiliary community nurse include the following:

"Assistance with dressing and undressing.

Assist in the preparation of the home which may include preparing room; reception of patients discharged from hospital; and helping with undressing.

Weigh patients.

Make beds of ambulant patients and make empty beds and cots.

Help patients to prepare for meals and assist in the service of meals. Serve refreshments and simple diets where appropriate.

Help with feeding patients in all age groups including normal babies and handicapped persons.

Assist with bathing in bed and in the bathroom, with the lifting, turning and moving of patients, including the use of mechanised aids and bed appliances.

Help patients with personal hygiene including care of hair, teeth and nails.

Participate in the rehabilitation of patients in the home, health centres, clinics or hospitals, or dressing, undressing, taking to the toilet and using sani-chairs and commodes.

Participate in giving/or removing toilet utensils.

Care of sanitary utensils including disinfection of baths, bins and buckets after use.

Answer telephone, take, record and transmit messages.

Assist with keeping the routine records, eg weight charts and fluid balance charts.

Participate in social activities for patients.

Escort duties.

Help patient with the care of their personal belongings.

Where appropriate assist with distribution of welfare food" (Scottish Home and Health Department 1977).

These tasks correspond more or less with those expected of a nursing auxiliary in England and Wales (see appendix 1).

Poulton in 1977 noted that nursing auxiliaries spent nearly 45 percent of their time carrying out mainly basic nursing tasks such as bathing,

clothing, taking to toilet and care of pressure areas (Poulton 1977: 22). District nursing, like the home help service, had become by the mid-1970s a support service mainly for the elderly (Poulton 1977: 30). Others reported nursing auxiliaries as carrying out basic nursing and domestic tasks, indicating the potential for overlap or duplication with other services (Berkshire DHA 1980: 1).

A Berkshire study (limited to one District Health Authority) highlighted tasks carried out by two groups of staff (home help and auxiliary nurse) which each felt should have been carried out by some worker other than themselves. Jobs listed by the home help service, which were carried out by them but were not included in their official job description were: getting people up, dealing with incontinence, changing, washing, emptying commodes, giving medication, bathing and heavy lifting. Auxiliary nurses carried out tasks which again were not technically part of their duties: collecting prescriptions, preparing meals for diabetic patients, preparing meals in emergencies, lighting fires, shopping, putting patients to bed, collecting hearing aids and laundry (Berkshire DHA 1980: 2). The report highlighted the fact that as much as 90 per cent of the nursing auxiliary caseload overlapped with that of the home help. This very brief working paper is the only study published to date to identify possible overlap.

Since 1972 and the implementation of the Local Authority Social Services Act, which removed the home help service from health management, and the reorganisation of the Health Service in 1974 (which placed the community nursing service in the health service) there has been a drop in the amount of time that the nursing services spend supporting the elderly. There is some evidence to suggest that this swing away from support for

the elderly has been taken up by the home help service (Latto 1982, Simons and Warburton 1980) although Dexter and Harbert comment upon the fact that the home nursing service may be absorbing functions (not identified) that are traditionally part of the home help service (Dexter and Harbert 1983: 82). The average number of visits to the elderly by home helps, however, has stayed remarkably static since 1976 (C S O 1982: table 13.18) although since 1980 there has been a drop in the number of home helps employed from 64,900 to 54,700 (CIPSA 1983: 31).

6.3 OPCS Study: The Role of The Auxiliary Nurse in the 1980s.

Dunnell and Dobbs, on behalf of the OPCS, carried out a study of the work of the community nursing services, published in 1982. They found that the district nurse spends 62 per cent of her time in direct contact with patients (Dunnell and Dobbs 1982: 33); this percentage was higher than that found by Poulton in 1977 which was 44.7 per cent. Poulton's study was, however, carried out in only one health district. Most of the clients supported in 1980 were elderly, just over half were women over 65 and 30 per cent were men in the same age group (Dunnell and Dobbs 1982: 48). The majority of the tasks carried out by the nursing auxiliaries were in the basic nursing category which were included in the report under the heading 'Other Nursing Care' and were as follows:

"Routine nursing care, bathing, prevention of incontinence/pressure sores.

Other personal care;

Help with lavatory, commode, bed pan,

Help with washing, dressing, nappy changing,

Care of hair, nails, feet,

Feed or give medicine.

Home type care.

Prepare food, drink

Housework, washing clothes, dishes etc.
 Shopping, collecting pension, benefits, prescriptions.
 Supervision of patient care.
 Assessment visits for home condition/social/needs for equipment.
 Delivery and instructing in use of aids/equipment.
 Other clinical."
 (Dunnell and Dobbs 1982: 54).

TABLE 6.2
 Proportion of time spent on each activity: Nurse Auxiliary.

| Activity | Percentage |
|--|------------|
| Technical Tests/assessment/screening and surveillance | 3 |
| Technical procedures* | 4 |
| Other nursing care | |
| routine nursing care | 49 |
| other personal care | 24 |
| home help type care | 2 |
| supervision of patient | 8 |
| assessment visits | 1 |
| Advice/counselling reassurance, education | 7 |
| Unspecified | 2 |

(Source: Dunnell and Dobbs 1982: 56).

*injection, vaccination, immunisation, eye/ear treatment. Inserting removing stitches, dressings, enema.

The tasks listed under 'Other Nursing Care' are not explained in any more detail in the study (see table 6.2).

Nursing auxiliaries provide a much needed support service to the elderly and the appointment of such staff was discussed by the Government in 1978 in the document 'A Happier Old Age', when authorities were requested to examine the possibility of "adjusting the roles of community nurses and for expanding the help provided by auxiliary staff" (DHSS 1978d: 33).

Since then there has been much discussion on the role and place of the nursing auxiliary in the community nursing team. Indeed, some nurse managers refuse to recognise that such a grade of nurse exists. One senior nursing manager in a communication with the author insisted that

"under the 1957 Nurse Act, it is illegal to use the title of auxiliary nurse as the title 'nurse' however prefixed is protected" (Letter East Berkshire H.A. 1983). Yet, as discussed in this chapter, a neighbouring health authority, West Berkshire, employed staff with the title 'nursing auxiliary'.

Calls have been made to transfer the nursing auxiliary from the Nurses and Midwives Whitley Council to the Ancillary Staffs Whitley Council thus in effect classifying them as manual workers (Nursing Mirror 1982: 7). The United Kingdom Central Council for Nursing, Midwifery and Health Visitors in 1982 considered this matter and recommended that the word 'nursing' be removed from the title 'nursing auxiliary' and suggested the term 'care assistant'. The justification for this move was that there is "an essential difference between the preparation needed for the professional Registered Nurse and those who will support her in her work" (UKCC 1982: 6). Discussions are still continuing in the nursing profession on this matter.

6.4 The Extension of the Home Help Role.

I wish to discuss a number of recent schemes which have sought to extend the traditional role of the home help into spheres which might be termed the responsibility of the community nursing service. This trend has resulted in some cases in the withdrawal of nursing services from clients being looked after by these local authority 'home care' schemes. Some of the schemes discussed have attempted to combine the roles of domestic, personal and basic nursing care in an effort to provide a more efficient and flexible service. The Coventry Project, discussed later, is

a case in point. Other authorities have introduced new schemes but have not examined the effect of their introduction on other agencies. The London Borough of Westminster introduced 'home care workers'; West Sussex County Council 'care attendants'; and West Glamorgan County Council 'community care assistants'. All schemes were envisaged as being more flexible, intensive and comprehensive than the traditional home help service. The Glamorgan project provided such a support programme for the elderly by the introduction of community care assistants working a 37-hour week and providing cover between the hours of 8am and 8pm over a seven day period (Foley 1983: 24). The Westminster team of home care workers was managed by a home help organiser who also had responsibility for a team of home helps (Smith 1983: 81), unlike the West Sussex scheme whose organiser was only responsible for the project team (Lockey 1983: 7).

TABLE 6.3
 Frequency with which Personal and Non-Personal tasks were undertaken by
 Care Attendants: January - June 1982: West Sussex.

| | Frequency |
|--|-----------|
| Non-personal tasks | |
| Meals | 21 |
| Shopping | 15 |
| Tidy up client's room | 8 |
| Transport to day care | 1 |
| Personal Tasks | |
| Sitting and responding | 98 |
| Helping in - out of bed- wheelchair | 75 |
| Personal Hygiene | 48 |
| Dressing- undressing | 37 |
| Incontinence | 22 |
| Child care | 14 |
| Pressure areas | 11 |
| Feeding | 8 |
| Overnight stay | 5 |
| Bathing | 1 |
| Bed - linen change | 1 |

(Source: Lockey 1983: 12).

The Westminster project did not analyse the actual tasks carried out but when staff were asked how the work compared with their expectations, most expressed interest in the "social care aspects" of their work rather than the domestic; interestingly, they also felt that the job could not be split or divided into personal or domestic spheres as "practical tasks were often the context for social care. If anything, social care was considered to occupy most of the home care workers' time" (Smith 1983: 87). The home care scheme differed from the normal home help service in a number of ways. It was

"more intensive in the sense that a great deal more time is available for each individual client and this can readily be adapted to the changing needs of the clients. Secondly it is broader and more flexible in the range of tasks that it is able to offer and expected to undertake for its clients. The home helps typically had a larger number of clients, provided a fixed number of hours of service and carried out specifically defined tasks (although not without some variation and a considerable commitment). Their service is primarily concerned with basic maintenance and care and does not possess the flexibility and scope of the home care worker team" (Smith 1983: 93).

The West Sussex service was not restricted to elderly people although most of the referrals were in this age group (Lockey 1983: 14). Most of those referred to in the Westminster and West Sussex schemes were either living alone, ill, frail or living with friends or relatives who could no longer cope (Lockey 1983: 16, Smith 1983: 93).

Tasks carried out for clients in these schemes depended on the nature of the referral, the needs of the client and the existing service that the client was receiving. However, for instance in the Glamorgan scheme (care assistants) there were tasks common to all clients which included:

"companionship, preparation of meals and drinks, washing up, liaison with relatives, neighbours etc. and paper work. Personal care provided for certain clients included assistance with washing, dressing, toileting and getting up or going to bed and a range of other tasks such as cutting hair, shaving, bathing eyes, administering medication, helping with feeding and encouraging the client to eat. Care assistants were responsible for ensuring adequate heating, bedding and clothing as

well as food for each client.

Domestic tasks included making beds, filling coal buckets, lighting fires (though this was often done by the home help) emptying commodes, dealing with laundry, cleaning and sewing. Care assistants also helped with shopping, and performed escort duties for hospital appointments, etc. or sheltered shopping and occasional outings. When necessary, clients were referred to the occupational therapist for assessment for aides, adaptations or rehabilitation or to the relevant departments for meals-on-wheels or home-help provision.

Other duties included collecting pensions or prescriptions, paying rent and various bills on behalf of the client and, when necessary, collecting the the weekly home care stamp. Care assistants were also involved in preparing clients for admission to residential care (short term or long term) or hospital. In rare cases where the client had a young family the care assistant helped care for the children too" (Foley 1983: 34).

6.5 Some aspects of the relationship between the home help and community nursing service.

For only one scheme has there been any information published upon the effect of the extension of the role of the home help on other community services. The Coventry Project set up in 1975 by the City Social Services Department attempted to evaluate the real level of demand for domiciliary services in the community and to decide how this demand should best be met. The home help budget of an identified area of the city was doubled for a period of three years and utilised in a number of ways, one of which was to increase available home help hours to twice the average for the city as a whole. At the beginning of the project there were 25 home helps in the area (523 hours a week); by the autumn of 1978 the level of provision had increased by 98 per cent, whereas in the city as a whole the service had expanded only by three per cent (Latto 1982: 4). One of the aims of the project was to improve and extend, where necessary, services to existing and new clients, and/or to extend the service to include other individuals or groups in the

community who, although they might benefit from home help support, had not usually done so (Latto 1980: 20-21). Staff were recruited who did not hold the traditional views and ideas about the service, who would be prepared to work unsocial hours and with a potential to do more than domestic tasks;

"the organiser looked for an open-minded, non-traditional view of the home help function, a willingness to work flexible and unsocial hours at short notice, and potential to provide a more broadly based rather than strictly domestic service" (Latto 1982: 5).

A strong relationship was established between workers and clients which contributed to the development of working relationships. Clients tended to receive help for longer periods and had a larger percentage of under 65s among them. There was a 50 per cent increase in the number of clients but at no time during the project's duration were its resources used to the full (Latto 1982: 11).

TABLE 6.4
Percentage of Home Help time spent on different tasks.

| Type of Work | Project | | Rest of Coventry |
|------------------|---------|------|------------------|
| | 1975 | 1978 | 1978 |
| Cleaning | 75 | 51 | 64 |
| Shopping-errands | 5 | 12 | 10 |
| Washing-ironing | 6 | 5 | 6 |
| Meals-washing up | 5 | 10 | 5 |
| Client-contact- | | | |
| Personal care | 6 | 19 | 12 |
| Other | 3 | 3 | 4 |

(Source; Latto 1982; 19).

The project did extend the role of the the home help into the "boundary area shared with the community nursing service" (Latto 1982: 17). At the end of the project the home helps were carrying out more personal tasks for their clients than at the beginning, the percentage in personal care support rose from 6 to 19 per cent. However, cleaning was an

important aspect of the home help role (see table 6.4).

The report did not itemise personal caring tasks but a considerable amount of time was spent on such tasks as preparation of food, personal care or emotional support. The home help role overlapped with that of the nursing service (Latto 1982: 21) and one important aspect of the scheme was that the utilisation of community nursing services by client in the scheme was lower than average:

"The use of the district nursing service and of nursing auxiliaries (bath aides) was generally lower among project clients, but the only significant difference occurred at the start of help amongst those clients who had recently been discharged from hospital. However, the level of provision per client was consistently and significantly lower, with the average number of hours provided per client being less than half those provided to home help clients elsewhere in the city" (Latto 1982: 30).

The report points out that the home helps may have been substituting for the community nursing services and that nurses considered the project had allowed them to "reduce the amount of their work with those patients who were also receiving home help" (Latto 1982: 31). There was also a tendency among health visitors to make referrals to the project and then withdraw their own support once the home help support was provided (Latto 1982: 31).

This project highlighted certain aspects of the relationship between the home help and community nursing services. Cambridge County Council attempted to integrate the two roles to provide domestic help and personal and simple nursing care for clients in their own homes whose needs fell into that grey area between health and social service provision. It was felt that many of the roles of the home help and community nurse were interchangeable but both roles were unclear and blurred (Simons and Warburton 1980: 1). The purpose of the Cambridge

research was to describe the tasks performed by the 'domiciliary care assistant' (DCA) and to compare them with the tasks carried out by home helps working with elderly clients; to document the help received by the clients of both groups; and to assess the extent to which both forms of support met the needs of the client (Simons and Warburton 1980: 2). In one of the project areas the 'care assistants' performed mainly domestic tasks and in the other, tasks which resembled those of the auxiliary nurse. They washed and bathed clients, fetched prescriptions, made sure correct dosages were taken, got clients in and out of bed, assisted clients with dressing. The traditional home helps in both project areas reported that their work had elements of both personal and caring tasks but for most clients they cooked a main meal, cleaned the house and made breakfast. Other tasks included shopping for the client, supervising medication, drawing pensions, helping clients to wash and bath and assisting with dressing (each mentioned in six of the ten cases) (Simons and Warburton 1980: 5).

In a number of cases the DCA substituted for the nurses; "nurses dropped out when the DCAs moved in -- although they will call if we are off sick or on holiday". However, nurses were frequent visitors to clients on traditional home help caseloads where they mainly carried out bathing tasks though in some cases the home helps carried out these tasks as the nurses refused (Simons and Warburton 1980: 8).

Most of the clients in the study required domestic, personal and nursing support and the authors of the report make the point that the data from this study confirmed

"that for these cases the roles of the local authority domiciliary staff and community nurses are to some extent equivalent" (Simons and Warburton 1980: 8).

Traditionally it has been assumed that elderly people with high dependency needs could only be looked after in residential care but new domiciliary service delivery systems are questioning this assumption. Some authorities are planning to bring services to the elderly in their own homes rather than the old person to the service. This philosophy is based on the assumption that the care assistant, home help, social work assistant and other domiciliary staff all provide substantially similar forms of help which differ only in intensity and setting. One authority, in an attempt to maximise the effectiveness and efficiency of care assistants and home helps created a single category of worker incorporating both roles (Young and Hadley 1984: 21). Lightup outlined a system of delivering 24-hour care to the elderly at risk in the community which incorporated a group of staff called Homecare Workers. These workers carried out a wide range of domestic and basic nursing tasks for clients. As this was an emergency service, the homecare workers, when not working with clients in their own homes, worked as residential care assistants (Lightup 1985: 17).

A similar attempt to provide a flexible service for the frail and handicapped, the Kent Community Care scheme, devolved budgetary responsibility to social workers at field level to 'buy in' services from other than the local authority. This allowed them to tailor support packages imaginatively to clients' needs within certain constraints which limited them to devote to any one client resources of a value not more than two-thirds of the marginal cost of a place in residential care. This flexible method of working allowed the social workers to become 'case co-ordinators' and utilise a wide range of workers including home help and volunteers (sometimes paid) who undertook many

of the personal and domestic tasks. Social workers in effect managed the domiciliary care team (Challis and Davies 1980).

Service delivery systems reported so far pose many questions concerning the role of the home help and auxiliary nurse but a Sheffield project highlighted the need for research into the work of the two groups. The Sheffield project has replaced the traditional divided structure of domiciliary, day and residential care services by providing domiciliary care from a center which serves a locality. This Elderly Persons Support Unit (EPSU) is the base for staff providing services to all the elderly people in a designated area. The building is equipped to prepare meals and has a communal dining room/hall for social activities, a couple of smaller lounges, a hairdressing room, a room which can be used for visiting chiropodist and district nurse, a bathroom with special equipment to deal with people who have major problems of mobility and a room which can be used for messy craft activities e.g. pottery, horticulture. Home help, home warden and meals-on-wheels are provided from this base to people in a designated area on a 24 hours, 7 days per week basis throughout the year, including public holidays. The EPSU intends to provide an integrated and flexible deployment of staff as well as services, there is no division of staff by function but rather a number of community support teams staffed by a new type of worker called a community support worker (MacDonald, Qureshi and Walker 1984: 28-30). This type of innovation means much blurring and expansion of traditional roles. There may well also be much overlapping of roles between the services of the EPSU and the community nursing service. It would be helpful to make a detailed study of the tasks carried out by

home helps and auxiliary nurses so as to identify the specific skills of each group and cut overlap to a minimum.

6.6 Flexibility of the home help.

Many of the new schemes have recruited new staff, few have utilised existing workers believing perhaps that existing staff might not be flexible enough to take on this extended role (Latto 1982). Is this assumption justified? The results of recent research projects looking at 'neighbourhood' or 'patch' schemes give some indication of the flexibility of the home help service and its willingness to integrate into social service teams.

The neighbourhood services unit at Dinnington was set up as a joint programme between the Local Authority and Area Health Authority whose aim was to develop an integrated pattern of health and welfare provision for the village of Dinnington near Rotherham (Bailey, Parker, Seyd and Tennant 1981: 111). Unlike the attempt at decentralisation of services in Normanton and East Sussex, which share many of the same aims as the Dinnington project, the latter formally involved the Health Service (Tennant, Bailey and Seyd 1984: 19). What part did the home help service play in the project? By 1983, three years after the start of the project

"there was no increase in contacts and co-operation between the home help service and other formal and informal carers, nor was there any evidence that the people were presenting problems sooner (generally meaning at a less severe stage). The home helps had not been drawn into the complex web of care that was being woven by the social workers, district nurses, the housing assistant and some wardens" (Seyd, Tennant and Bailey 1984: 53).

In early 1983, the authors of the report questioned whether the emphasis

upon the home help service had anything to contribute to "integrated formal and informal care making full use of community-wide resources" (Seyd, Tennant and Bayley 1984: 54). However, by the end of that year, three and a half years after the beginning of the project, home helps were beginning to participate in an integrated package of home help and nursing care. Contacts between the two services had been greatly facilitated by bringing together the home helps, nurses and team staff at a particular time each week. When the practice was interrupted by the transfer of the home help organiser, this integration fell away (Seyd, Tennant and Bayley 1984: 55-6). The inability of the home help workers to establish a close and more satisfactory working relationships was in part due to administrative problems but

"it also seemed to be due to the nature of the service that they give and the pressure under which they work. - The home help organisers form a close-knit team in order to get their job done and the very features which make them a good team make it difficult for one of them to become part of another team" (Bailey, Parker, Seyd and Tennant 1984: 138-40).

Was this so in other studies which attempted to introduce closer working relationships? Other projects have gone much further in attempting to integrate the home help service into the 'social service team'. The Normanton study highlights the importance of a flexible team structure in which the responsibility for the wide range of community caring services is shared by all workers in the team, professional and non-professional alike. To achieve this the Normanton area was subdivided into three patches of approximately 6,000 population, each led by a patch leader, a qualified social worker, supported by patch workers, wardens and home helps. The patch workers, half of whom had been home helps, had the opportunity to become involved in all aspects of the team's work, including supporting the domiciliary care workers.

Assessments for the home help service were carried out by the patch team. However, it proved more difficult to formalise contact between the home helps as a group and the team, with the result that fewer home helps appeared to have a good understanding of the overall function of the team or understanding of the role of the social worker. Nevertheless, communication between the team members and the home helps concerning individual clients was good. Longer serving home helps, in post before the advent of patch, were more likely to refer matters to the Domiciliary Care Organiser, who was responsible for some administrative areas of responsibility, than the more recently appointed helps who tended to look to the patch workers for support (Cooper and Stacy 1981: 15-17, Hadley and McGrath 1984: 154). Home helps carried out the usual domestic tasks, occasionally personal care was included but a quarter of the home helps interviewed, in the Normanton team, seemed to see their role solely in terms of domestic chores; two-fifths emphasised the variety of the work; and many emphasised the importance of establishing relationships with their elderly clients (Hadley and McGrath 1984: 147-148). One of the aims of the Normanton experiment was to make liaison between the various workers in the team more effective. By comparison, patch workers and home helps (in the patch) had more contact, home helps knew more members of the team and were better informed about the roles of field staff than their counterparts in the traditional team (Hadley and McGrath 1984: 158). The home helps were the less successfully integrated members of the group; many of them were not ready to enter into discussion of more general issues affecting the team (Hadley and McGrath 1984: 158, 173). This project and the Dinnington scheme indicate that it is possible and desirable to

integrate roles, a policy also attempted by other authorities. East Sussex Social Service Department since 1979 has been moving towards a patch system aiming to integrate field, domiciliary and residential services (Whitehouse 1982: 19). One patch team in Peacehaven, fairly typical of others in the County, consisted of social workers, social service officer, welfare assistant, home help organiser and home helps. The team manager also had responsibility for residential and day care services in the patch. A result of this experiment was that domiciliary and residential care workers saw themselves as very much part of the team and co-operation with the community nursing services improved (Whitehouse 1982: 19). Other patch teams in East Sussex reported increased co-operation and integration of the domiciliary services within the teams compared to the traditional Social Service Departments (Hadley, Dale and Sills 1984: 66, 69, 76).

The three schemes - Dinnington, Normanton and East Sussex - all highlight the problem in integrating the home help service into local teams. However, it would seem that the longer the projects run the more likely that closer co-operation and integration will take place. The nature of the home help task and the organisational system, rather than the staff themselves, would seem to be the obstacle to closer working relationships.

6.7 Summary and Conclusions

The respective roles of the home help and community nurse are not clear. The belief that nurses should be relieved of all 'non-nursing' responsibilities has been at the centre of most nursing reform in the

past 20 years. Since the 1950s and 60s it has been recognised that the assistant or auxiliary nurse had a large part to play in nursing the sick in their own homes. In the drive for more effective utilisation of trained staff and the professionalisation of the profession, more and more basic nursing tasks were delegated to unqualified nursing staff. Until 1972, the home help and auxiliary nurse continued to work under medical management; there is some evidence that even under the same manager there was some overlap of role and lack of understanding of each other's role. After the Social Service reorganisation in 1972 and the Health service reorganisation in 1974 the numbers of community auxiliary nurses increased rapidly.

This increase in auxiliary nurse numbers could be viewed as an attempt by the nursing profession to employ a 'home help' under another title thus returning to nursing and medical control an area of responsibility they lost in 1974. This development may also have helped overcome the sense of unease and insecurity in the profession at the delegation of this area of responsibility to another department (Hardie and Hockey 1978).

Some of this possible duplication may be due to the essential caring nature of both groups but the available evidence would indicate that each group has attempted to meet the needs of elderly clients without much consideration of the services provided by the other group. Much of the overlap has never been quantified or identified by either group although in the Cambridge study it was felt that the two roles were interchangeable even though they were unclear and blurred.

The precise duties of the auxiliary nurse have not been officially spelt out but it is clear from the evidence that the auxiliary nurse carries

out many of the tasks normally carried out by home helps such as assisting with dressing clients, making beds, helping to feed clients, bathing clients and helping with personal hygiene. The report of The Coventry Project hinted at an overlap of role but did not try to identify or quantify it but it was clear that the home help was substituting for the community nursing service at times as they did in the Cambridge study. Other studies hint at the difficulties of integrating the service with other groups in social service departments.

Most of the studies discussed in this chapter raise a number of questions. Just what does the home help and auxiliary do? Do auxiliary nurses carry out domestic tasks? Do home helps carry out basic nursing tasks? How do they perceive their roles? How flexible are they? Is there much difference in what they do in different authorities? These questions are discussed in the following chapters.

CHAPTER SEVEN

Introduction to Emperical Study: The Role of the Home Help and Auxiliary Nurse in the 1980s.

The inability of society in the late 19th and early 20th century to provide enough trained personnel to fill the growing number of nursing posts, coupled with this group's striving for the status of a profession, caused friction with other workers such as the relieving officer, the doctor, the untrained nursing 'assistant' and the 'handywoman' (Nightingale 1876, Rathbone 1890, Dowding 1894, Hodgkinson 1967, Flinn 1976) . Despite the shortage of skilled personnel, nurses succeeded in abolishing the 'handywomen', a situation which later affected the development of the home help and community nursing service. Nurses working with the sick poor in their own homes provided not only nursing support but also carried out domestic tasks, an aspect of their role (domestic) which caused debate within the profession because of its connotation with domestic service and household work, both unskilled areas of work. Attempts to professionalise the work of the nurse in time led to the raising of standards but these attempts also led in part to the profession eventually disassociating itself from the domestic role and delegating 'non nursing' tasks to 'assistants'. This ambivalence towards domestic work and the role of the untrained

assistant is still a concern of the profession today.

The gradual disappearance of the 'handywomen' and the nursing profession's reluctance to involve itself in the domestic role, left a gap in provision which after 1918 was filled in part by the home help, managed in most cases by either the medical or nursing profession. This solution by the nursing profession of the problem of how to rid itself of the domestic image and at the same time control the work of those who it delegated that role to was to extend the boundary of their role as well as embracing authority over the home help and assistant (Wilding 1982).

The duties of the home help between the two World Wars were restricted to simple domestic tasks but because of the service's connotation with domestic work, recruitment was slow, a problem which was not adequately addressed during the inter-war years. Many women in the first half of this century found it difficult to obtain domestic help, a situation it has been argued that had an adverse effect on women's health in times of illness or stress. Domestic support for mothers (and the elderly) in the home became of such importance by the 1940s that it was deemed a national priority. To try and remedy the problem of recruitment women were directed into the service, a national minimum wage agreed and the job presented as a new career for women in the public services. These attempts to improve the image of the home help were not a great success as highlighted by the report of the City of Oxford scheme.

The National Assistance Act 1948 emphasised residential care and little attempt was made to provide any form of substitute family care for old people (Brown 1972, Townsend 1964, Parker 1965). The 1950s and 60s could be perceived as a period of incremental progress for the

domiciliary services (Brown 1965) which was however hampered by the usual recruitment difficulties. Despite the development of domiciliary services the philosophy prevailed that the 'family' ought to care, and that domiciliary services should support the family not replace it (Municipal Review Supplement 1968, National Corporation for the Care of Old People 1969). The home help still provided a mainly domestic service ancillary to the medical and nursing services (MOH: 1968a), filling many of the gaps in client care not covered by the nursing or social work professions (Scammells 1971).

By the 1970s, it was thought that perhaps the service was changing its emphasis from a domestic to a more caring role. There were some suggestions that the role of the home help was changing and there have been attempts by a few authorities to shift the service towards 'personal care' or 'basic nursing', accepting that personal care must take priority over domestic care. The potential for the service to perform these roles had been recognised as early as the 1950s and this potential had been hinted at in Hunt's (1970) study. All the published research shows that domestic tasks such as cleaning, polishing, dusting, etc., are performed by home helps and are also considered a high priority; however, the amount of time spent on personal caring tasks is reported as minimal.

It has been recognised that the auxiliary nurse also has a role to play in supporting the elderly in their own homes. Since the Social Service reorganisation in 1972 and in particular the Health Service reorganisation in 1974 the numbers of community auxiliary nurses have increased rapidly. As discussed in chapter six the numbers rose from 1.184 in 1971 before the home help service was removed from nursing and

medical control to 2,391 by the reorganisation of the Health Service in 1974. One in ten of all community nurses were auxiliaries by 1982 (Dunnell and Dobbs 1982: viii). This increase in the auxiliary nurse population corresponded with a drop in amount of time spent supporting the elderly. This area of work may have been taken over by the home help service in some authorities (Latto 1982, Simons and Warburton 1980, Audit Inspectorate 1983, Dexter and Harbert 1983). Coupled with the expansion in numbers and the trend to downgrade the auxiliary nurse to a 'manual' worker raises the issue of what tasks do they carry out and how do they perceive their role. If as indicated the home help has taken on some of the workload of the community nursing service, what tasks do they carry out for the elderly today? Both the home help and auxiliary nurse's role have an essential caring nature but the evidence indicates that both groups have attempted to meet the needs of the elderly without much consideration of each other's role. The Cambridge study (Simons and Warburton 1980) indicated that the two roles might be interchangeable but the precise duties of the auxiliary nurse have not to date been spelt out. However, it is suggested that some may be carrying out many of the tasks normally carried out by the home help. The Coventry Project report hinted at an overlap of role indicating that home help was substituting for the community nursing service; this situation was also highlighted in the Audit Inspectors Report (1983) and the report of the Cambridge project. Other studies (Bayley, Parker, Seyd and Tennant 1984, Cooper and Stacy 1981) point to the difficulties of integrating the service with other groups in social service departments.

My empirical study was prompted by these suggestions that the role of

the home help may perhaps be changing and by the data which would seem to indicate that home helps and auxiliary nurses in some authorities may be carrying out similar tasks (West Berkshire H A 1975, Howell, Boldy and Smith 1977, Gwynne and Fean 1978, Latto 1980, DHSS 1981b, Goldberg and Connelly 1982, Dexter and Harbert 1983, Simons and Warburton 1980, Audit Inspectorate 1983). No recent research has examined in detail what tasks are carried out by the two groups of staff, nor has any study compared the work of the home help and auxiliary nurse. There has been no recent large study of the range of tasks carried out by each group since the placing of the home help in the Social Service Departments or of the tasks carried out by auxiliary nurses since their increase in numbers. Some concepts discussed in the first six chapters also raise a number of issues which need further clarification. Does the home help carry out personal or caring tasks? What tasks do the home helps and auxiliary nurses now carry out? What tasks are common to both groups? How do they perceive their role, in particular the home help, in view of the trend towards a more personal caring service? Do the tasks that each group carries out differ from authority to authority? Has the qualified nurse succeeded in delegating such tasks as bathing and washing clients, foot hygiene, dressing patients, - tasks which were identified in 1965 as suitable to be carried out by non qualified staff (CHS Council 1965: 7)? In the following chapters I set out to answer these questions. To help formulate this empirical research I reviewed the relevant literature (in relation to the tasks reported as having been carried out by both groups. see appendix) and held discussions with home helps, auxiliary nurses and senior managers of both services. The research methodology is discussed in chapter eight.

CHAPTER EIGHT

Empirical Study: The Role of the Home Help and Auxiliary Nurse in the 1980s.

8.1 Sources and Methodology.

To obtain the relevant data for an empirical study, a number of methods can be used, for example, interviews, questionnaire, observation. I wished to get as much information as possible about a whole range of tasks and activities from as many authorities as possible. Random sampling of authorities in England and Wales would have been the best way to do this if high take-up rates could have been assured [but as discussed later they could not.] Therefore, an attempt at a full census of authorities was the most sensible approach. A postal questionnaire from as large a sample and as many authorities as possible was decided upon to take into account problems which had arisen in past local research projects caused by different policies on assessment of need, perception of the home help task, variations in home help organisers' workloads and other issues such as the problem of providing a service in rural or urban areas (Goldberg and Connelly 1982: 67-71). Some of the distortions may also be lessened if the tasks listed in the questionnaire are clearly and simply identified and if the same

information is requested in the same format from all samples.

Sources for the first six chapters are discussed in the Introduction to the thesis. For the empirical study a literature review was undertaken in order to identify tasks carried out by home helps and auxiliary nurses. Arising from this review a number of questions arose. What actual tasks do the home helps and auxiliary nurses carry out? Does each group carry out many of the same tasks? How does each group perceive its role? How much variation is there between individual home help authorities and individual health authorities? I set out to try to provide some answers to these questions and other issues raised in the previous chapters. I discussed the topic with senior managers in Health, Social Service and Government Departments: five Directors of Social Service, 10 Assistant Directors, 20 District Directors of Community Nursing and 12 Community Medical Officers were interviewed as to the value of the research in relation to practice. All agreed that the project was feasible and that the results could be of value to them in planning and developing services. Many commented on the usefulness of a study of a number of authorities compared to the individual local research projects to date.

A large study involving as many authorities as possible was finally decided upon and a postal survey was considered to be the most appropriate and cost effective method of collecting the data, a method which is quicker and cheaper than others and avoids the problems associated with the use of interviewers (Moser and Kalton 1981: 257-258). The self - administered questionnaire has some positive advantages. People are more likely to express socially unacceptable attitudes and feelings when answering a questionnaire alone than when

confronted by an interviewer (Moser and Kalton 1981: 258, Ellis 1947: 541-553). The more apparent the anonymity the more honest the response, hence the need for confidentiality and anonymity in my survey (Evan and Miller 1969). Aside from the greater honesty that they may produce, self administered questionnaires also have the advantage of giving a respondent more time to think.

My questionnaire was of the 'fixed choice' type, with a finite number of choices and giving the appearance of objectivity. It also lent itself to translation into numerical representations. However, it was recognised that this method could be fairly inflexible and measure what a respondent says with no opportunity to probe beyond the answer (Moser and Kalton 1981: 260). The postal method was considered suitable for this study because my questions were simple and straightforward and could be understood with the help of minimal printed instructions. The specific problems associated with the use of questionnaires in determining peoples' behaviour is discussed in chapter 9 and in relation to attitudes and opinions in chapter 11.

Early in 1983 every Health District (Community Nursing Officer) and Social Service Department in England and Wales was invited by letter to participate in the study. (Authority had been obtained prior to this from the ADSS research committee.) Twenty Local Authorities (18%) out of a total of 112 and 81 health authorities (37%) out of 219 finally agreed to participate. As there was a low response rate and the fact that authorities were not selected according to the rules of statistical theory, inferences from this sample to population should not be made rigorously. However, had I tried to undertake a sample survey of authorities, in all probability I would have achieved a similarly low

response rate with a resultant devastating effect upon my sample size. The response rates were affected by the refusal of some authorities to take part in the study for a number of reasons. Health authorities had just undergone a traumatic reorganisation involving changes of personnel and some Social Services Departments were experiencing industrial disputes.

8.2 Pilot Study.

A questionnaire was designed, using (110) tasks, identified from the literature (see appendix), that listed the tasks carried out by home helps or auxiliary nurses. The questionnaire was also designed to obtain basic data such as age, sex, education, time in post, etc. (see appendix).

A local pilot study (postal) was carried out in late 1982. A sample of 50 home helps and 40 auxiliary nurses (49 home helps and 37 auxiliary nurses took part) was selected. In the pilot study several points were considered: ease of handling, the efficiency of the layout, clarity of definitions and adequacy of the questions themselves. As a result of the analysis of the completed forms and discussions with the participants it was decided to redesign the layout of the questionnaire but not change individual questions or the ordering of the questions. Participants did not find the questionnaire too long or the questions too ambiguous. Some of the questions (in the pilot study) were not answered by either of the groups because the task was not perceived by them as their job; for instance, home helps did not answer the questions relating to blood pressure or giving enemas because they thought it was obvious that it

was not their role. This matter was remedied in the main study by clearly asking the respondents (in the covering letter each participant received with the questionnaire) to answer every question, even if they felt that it did not seem to be their job. The participants in the pilot study supported the 'postal' questionnaire approach; it allowed them time to think about the questions and answer them with honesty and ease secure in the knowledge that their replies were confidential.

8.3 Validity

Validity is defined as the degree to which the researcher has measured what he set out to measure (Smith 1975: 61). Undoubtedly one of the most important questions that needs to be raised regarding any questionnaire relates to the validity of the questions, i.e. do the questions actually measure what they purport to measure? (Orenstein and Phillips 1978: 274). It can be argued the questions had face validity; face validity refers to what the questionnaire appears superficially to measure; it pertains to whether the questionnaire "looks valid" to the subjects who take it and the administrative personnel who decide upon its use (Anastasi 1961: 138, Orenstein and Phillips 1978: 274). The questions had been seen and discussed by home helps and auxiliary nurses who agreed that they were direct, obvious and unambiguous. The questionnaire was also seen by managers and users as relevant and appropriate. The questions therefore have face validity, Validity also provides a direct check on how well the questions fulfil their function, the determination of which usually requires independent, external criteria of whatever the questionnaire is designed to measure.

It is difficult to compare my findings with the results of other studies as the home help field is not comparatively well explored [particularly large scale studies]. In this instance criteria, were not available - "a 'true' answer simply does not exist" (Oppenheim 1976: 70).

Orenstein and Phillips point out "we cannot be satisfied with our gut feeling that our items are appropriate measures" (1978: 274). What I have got is data on what people say they do, not what they do. All of the questions used in my questionnaire have been taken from other studies or are tasks reported as having been carried out by one or both groups at some time (see Appendix). Questionnaires similar to mine have been used in other studies, notably Imber's study of residential care assistants (1977) (relevant details of the Imber study are discussed later). The questionnaire, the questions and concepts they were to measure were discussed with home helps, auxiliary nurses and social service research officers who had experience of the domiciliary services. One of the most satisfactory types of criterion measure is that based upon follow-up records of actual job performance. This was not possible in this instance because of the necessity of complete confidentiality of individual participants.

8.4 Reliability

Reliability should be distinguished from validity as it refers to consistency, to obtaining the same results again. Will the same methods used by other researchers produce the same results? In many instances 'true' answers do not exist. However, some sort of criterion is

available which could be applied to the realm of 'factual questions' such as mine (Oppenheim 1976: 70). Answers to questions such as 'is bathing clients in bed, part of your job'? or 'do you think that shaving clients is someone else's job'? should presumably produce a 'true' answer which could be found if sufficient time and trouble was taken. In similar cases, asking the same questions again ought to "yield consistent results (show high reliability)" (Oppenheim 1976: 71). Because of anonymity of study it was not possible to carry out Test-retest checks but the pilot study was used to sort out reliability problems. No attempt is made in the study to infer from the study-group to the population as a whole.

To increase the possibility of reliability, precise instructions concerning the method of distribution of the questionnaire to the individual participants and their returning them to me were agreed with the local government research officers and managers of community nurses from those authorities who took part. Each respondent had a letter explaining the objectives of the study and an explanation as to completion of the questionnaire. Questionnaires were distributed (to agreed sample) to senior managers in each district, each questionnaire had been placed by me in a sealed envelope along with a covering letter and an envelope with my name typed on it for return (sealed) through the senior manager. The participants could not be identified and were assured by covering letter, which each of them received through their senior manager, that the sealed envelopes would not be opened by the manager (the text of this letter was agreed by me and was the same wording for each authority). The participants were assured of anonymity and complete confidentiality.

8.5 Sample.

The representativeness of the sample (authorities, home helps and auxiliary nurses) is discussed later in this chapter. The sampling figures for each individual authority are given in the appendix.

Four Social Service Departments who had agreed to participate later withdrew because of an industrial dispute. A follow-up letter was sent to authorities who had not replied to the first request. This resulted in six more Health Districts and seven Local Authorities agreeing to participate. Telephone enquiries to all the remaining local authorities elicited the following reasons for non-response: industrial action in the authority; recent internal research project in the home help section; national discussions on regrading of home helps; no facilities (research officer) to carry out the work because of the sampling constraints placed on those wishing to take part.

TABLE 8.1
Response rate to request to participate in the project.

| Response | Health District | | Local Authority | |
|------------------------|-----------------|-----|-----------------|------|
| | Number | % | Number | % |
| Yes 1st. Letter | 75 | | 17 | |
| Yes 2nd. Letter | 6 | | 7 | |
| Withdrew | | | 4 | |
| Total Taking Part | 81 | 37 | 20 | 18 |
| No such grade of staff | 4 | 2 | | |
| No reply | 75 | 35 | 50 | 44.5 |
| Refused to take part. | 59 | 26 | 42 | 37.5 |
| Total | 219 | 100 | 112 | 100 |

Discussion (by telephone) with a random sample of the health districts

(22 out of 75 District Community Nursing Officers) who did not reply highlighted some reasons for their not wishing to take part; no senior personnel in post or not in post long enough because of the recent reorganisation; fear of causing disruption in the recently reorganised department; no facilities to carry out the research to the standard required. One nursing authority refused to recognise that such a post as 'nursing auxiliary' existed and two others had no auxiliary nurses in post. Because of the reluctance, for whatever reason, of many authorities to take part in the study, it cannot necessarily be assumed that the sample is representative of the home help and auxiliary nursing population as a whole. However, the sample certainly is a sub-population of authorities which were happy for their services to be scrutinised by an outsider.

TABLE 8.2

Type of Social Service Departments who took part.

| | Met Dist. | L. Borough | County C. | Total |
|---------------------|-----------|------------|-----------|-----------|
| All Authorities | 36 | 33 | 47 | 116(100%) |
| Participating Auth. | 9 (25%) | 4(12%) | 7 (15%) | 20(17%) |

In 68 of the participating Health Districts, all auxiliary nurses agreed to take part and in the remaining 14 districts a sample of auxiliary nurses was randomly selected. This sampling was carried out after discussion with the nursing manager and with my agreement. 1,961 questionnaires were sent to nursing auxiliaries, 1482 were returned (75%) of which 144 (8%) were not completed in enough detail to allow them to be used. The same procedure was carried out in respect of the local authority sample. (The sampling for each authority is listed in

the appendix).

In all local authorities but one a research officer distributed the questionnaire (in envelopes) and was responsible for forwarding the completed questionnaires (in individual sealed envelopes) on to me. In one authority (which did not have a research officer) a senior manager carried out this role. A total of 1,302 questionnaires were distributed to home helps of which 1170 (85%) were returned, 133 (10%) were not suitable for analysis.

TABLE 8.3
Individual Response rate: Questionnaires.

| | Home Help | | Auxiliary Nurse | |
|--------------------|-----------|------|-----------------|-----|
| | No. | % | No. | % |
| No. Q. Distributed | 1302 | 100 | 1961 | 100 |
| No. Q. Returned | 1170 | | 1482 | |
| No. Incomplete | 133 | | 144 | |
| Total Analysed | 1037 | 79.5 | 1338 | 68 |

It was possible to identify authorities with a low response rate but not individuals [in each authority] who did not respond, therefore no follow up of individuals was possible. However, for a 'mail' type questionnaire the response rate could be considered reasonable. The reasonably high response rate (individual questionnaires) in my study may have been because the questionnaires were distributed by a member of staff in the organisation and also because of confidentiality and ease of return. The survey was supported by a research institution, Sheffield University, and it also had the official blessing of the agency, the latter being possibly the most important factor (Moser and Kalton 1981: 263). The questions were concerned with matters relating to the every-

day job of the participants, a fact that may also have influenced the high response rate. Non-response is a problem in a survey such as this because of the likelihood that those who did not return the questionnaires differ from those who did. Did the better educated respond or was there an upwardly biased social class composition? Usually only the most interested fill in questionnaires (Moser and Kalton 1981: 263).

8.6 Representativeness of the Sample.

Authorities who took part may or may not have been more progressive than most but because of the constraints on this research of time, manpower and finance, it was not possible to attempt to ascertain if the authorities were representative or not. This would be a difficult if not impossible task even in favourable conditions. The results of the research may therefore be biased because of the low response rate and the type of authorities taking part (see Table 8.2).

Moser highlights non-response as a problem "no investigator of human populations can escape; his survey material is not, nor ever can be, entirely under his control and he can never get information about more than a part of it" (Moser 1969: 127). However, table 8.4 gives some indication of the representativeness of the local authorities taking part in relation to some aspects of the the home help service [no similar figures available for Health Districts].

TABLE 8.4

Local Authorities who took part: (Home Help Sections) Statistics.

| Authority | No. of H. Helps | Total Cases | Hours of Service | Average Hours per Case | Expenditure £'000s | Average Expenditure per Case |
|------------------------|--------------------|----------------|---------------------|------------------------------|-----------------------|------------------------------------|
| <u>London Boroughs</u> | | | | | | |
| Greenwich | 416 | --- | --- | ---- | 2126 | ---- |
| Croydon | 216 | --- | 318932 | ---- | 1274 | ---- |
| Westminster | 250 | 3634 | 377936 | 104 | 1755 | 483 |
| Hillingdon | 243 | 3806 | 355740 | 93 | 1472 | 387 |
| *Average | 281 | 3720 | 350869 | 98 | 1657 | 435 |
| **Average L. Bs. | 246 | 3142 | 363016 | 115 | 1596 | 508 |
| <u>Met. Districts</u> | | | | | | |
| Oldham | 341 | 4496 | 629978 | 140 | 1672 | 372 |
| Trafford | 253 | 6863 | 553489 | 81 | 1177 | 171 |
| Wigan | 499 | 6591 | 872536 | 132 | 2476 | 376 |
| Doncaster | 516 | 7967 | 772355 | 97 | 2289 | 287 |
| Rotherham | 420 | 5251 | 628462 | 120 | 1863 | 355 |
| Nth, Tynside | 252 | 4246 | 405005 | 95 | 1229 | 289 |
| Birmingham | 1378 | 19217 | 2043530 | 106 | 5879 | 306 |
| Dudley | 268 | 4473 | 507000 | 113 | 1219 | 273 |
| Kirklees | 506 | 11122 | 905592 | 82 | 2347 | 211 |
| *Average | 492 | 7802 | 813105 | 140 | 2239 | 293 |
| **Average M. Ds. | 423 | 5954 | 700610 | 117 | 2038 | 342 |
| <u>County Councils</u> | | | | | | |
| Cambridgeshire | 508 | 7999 | 789025 | 99 | 2446 | 306 |
| Cleveland | 505 | 9120 | 822663 | 90 | 2391 | 262 |
| Devon | 815 | 13361 | 1519362 | 114 | 3749 | 281 |
| Durham | 840 | 9404 | 1217693 | 129 | 3750 | 399 |
| East Sussex | 722 | 9121 | 959500 | 105 | 3482 | 382 |
| Nth, humberland | 441 | 5621 | 676102 | 120 | 1976 | 441 |
| Dyfed | 347 | 4485 | 674576 | 150 | 1697 | 378 |
| *Average | 597 | 8444 | 951274 | 115 | 2784 | 350 |
| **Average C. Cs. | 597 | 8890 | 983984 | 111 | 3049 | 343 |

* Average for type of authority taking part in study.

** Average are for all authorities in these groups in England and Wales.

(Source: Personal Social Service Statistics 1982/83 (1983) Ps 18+30 CIPFA)

[Two of the London Boroughs did not publish adequate figures for comparison and those two that did are below the average of all London Boroughs for average hours per case per year and also below for annual expenditure per case].

Oldham and Wigan Metropolitan Districts have much higher average hours and expenditure per case than the other Metropolitan Districts in my sample; Trafford and Kirklees having the lowest. In the County Council

sample the differences are not so noticeable apart from the counties of Durham and Dyfed who have above average figures for average hours and expenditure per case. These figures cannot give any information as to the role of home helps in these authorities but do give some indication of how representative the sample is in terms of the data illustrated in table 8.4. It is difficult to agree what is an average authority in terms of the home help service. The number of full-time equivalent (FTE) home helps (adjusted for age structure) per 1,000 of the elderly, age 65 plus in local authorities in England and Wales varies from 19 to 2 (Audit Inspectorate 1983: Exhibit 3.9) and in some cases adequate data is not available. For example, the work of the Audit Inspectorate was hampered by the fact that the authorities visited did not have adequate data (Audit Inspectorate 1983: 24), a problem which is discussed in more detail in chapter 10.

Figures 1 and 2 give some indication of the spread in England and Wales of the Local Authorities and Health Districts which took part. Figure 1 does not indicate the geographical area covered by the individual health districts; the illustrations (Fig 1+2) only serve to give some indication of the spread and location of the Health Districts in the sample.

If the characteristics of a population are to be inferred from those of a sample, the sample should ideally be randomly selected (Moser 1969: 171). This is not true of the authorities who agreed to participate. This aspect of the study has already been discussed but how representative were the home help and auxiliary nursing population?

There are a number of differences in my home help sample compared to Hunt's (1970) whereas my nursing auxiliary population sample differed

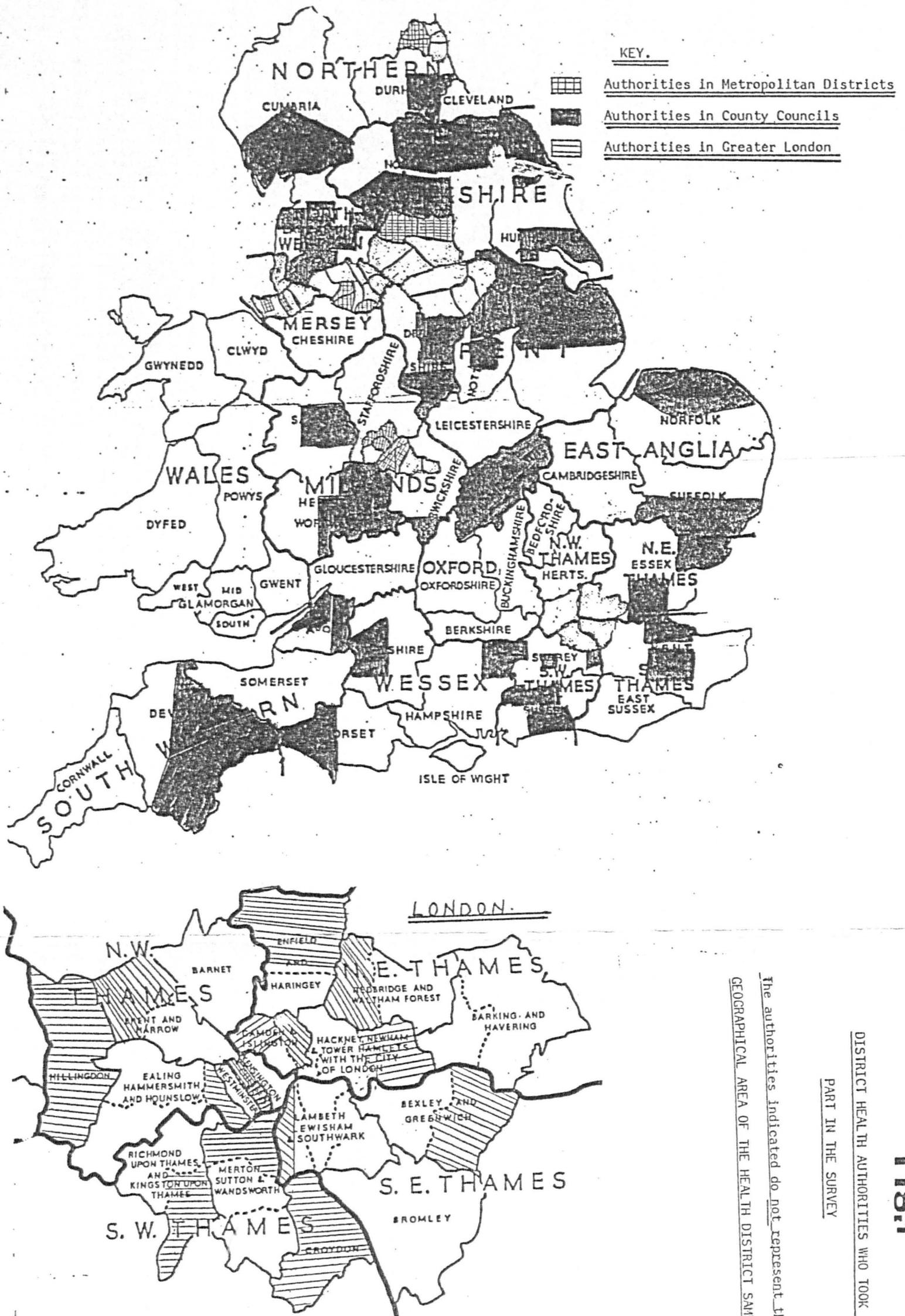


FIG. 1

DISTRICT HEALTH AUTHORITIES WHO TOOK PART IN THE SURVEY

The authorities indicated do not represent the GEOGRAPHICAL AREA OF THE HEALTH DISTRICT SAMPLED



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LOCAL AUTHORITIES TAKING PART IN THE SURVEY

Fig. 2

only a little from those in the Dunnell and Dobbs (1982) study - differences discussed in the following section (8.7). The nursing auxiliary sample in terms of age, sex, marital status, time in post and qualifications could be said to be representative; the slight differences in time in post is discussed in 8.7 (Dunnell and Dobbs used rigorous statistical sampling). In the case of the home help sample it cannot be assumed that mine is representative (when compared with her's); there have been substantial demographic and economic changes since 1967 which may have affected my results.

8.7 Discussion of Data.

(i) Sex.

Nearly all auxiliary nurses and home helps in my study were female (99 per cent in each). Hunt and the DHSS have indicated that some authorities employ male home helps; nevertheless Hunt's sample was all female (Hunt 1970, DHSS 1972). Dunnell and Dobbs (1982) reported one per cent of male community auxiliary nurses in England and Wales, the same percentage as in my sample.

(ii) Age.

Hunt reported 12 per cent of her home help sample in the age group 35-39; in my study the percentage was slightly higher but the percentage under 34 years of age was approximately the same. Hutchinson (1975) reported 95 per cent of the home helps in one authority as being over 30 years of age with 50 per cent over 35.

TABLE 8.5
Age structure of Home Helps: Two studies.

| Age | Clarke 1984 | Hunt 1970 |
|-------|-------------|-----------|
| 34< | 11 | 11 |
| 35-39 | 16 | 12 |
| 40-44 | 19 | 16 |
| 45-49 | 17 | 18 |
| 50-54 | 17 | 19 |
| 55-59 | 13 | 16 |
| 60> | 7 | 9 |

The ages of auxiliary nurses in my sample compared with the data in the Dunnell and Dobbs study shows little difference except in the age group 40-49 which indicates a slightly higher percentage. Dunnell and Dobbs' study was rigorously sampled and is therefore likely to be accurate. Given that 60 per cent of Dunnell and Dobbs' sample and 34 per cent of my sample had been in post for less than four years, the difference could be explained by a combination of (a) staff turn-over and (b) the four-year shift in ages of staff still in post.

TABLE 8.6
Community Auxiliary Nurses: Age (Percentage).

| Age | Clarke 1984 | Dunnell and Dobbs 1980 |
|----------|-------------|------------------------|
| Under 20 | 1 | 1 |
| 20-29 | 3 | 3 |
| 30-39 | 33 | 35 |
| 40-49 | 43 | 37 |
| 50-59 | 18 | 21 |
| 60> | 1 | 3 |
| Total | 100 | 100 |
| Numbers | 1353 | 609 |

(Number of missing observations 11)

(iii) Marital Status.

Five percent more nursing auxiliaries in my sample compared to those surveyed by Dunnell and Dobbs were married (see table 8.7).

Eighty six percent of home helps in my sample were married, a percentage similar to that found by Hunt (84%) in 1967 and later studies (Gwynedd County Council 1977, Hillingdon L.B. 1974: 13).

TABLE 8.7
Marital Status Nursing Auxiliaries.

| Status | Clarke 1984 | | Dunnell and Dobbs 1980 | |
|------------------------|-------------|-----|------------------------|-----|
| | No. | % | No. | % |
| Married | 1230 | 90 | 519 | 85 |
| Single | 68 | 5 | 18 | 3 |
| Widowed | 34 | 3 | 36 | 6 |
| Divorced/ Separated | 32 | 2 | 36 | 6 |
| Total | 1364 | 100 | 609 | 100 |

Those home helps who were widowed, divorced or single made up 13 per cent of the 1967 sample compared to 9 per cent of my sample.

TABLE 8.8
Marital Status Home Helps 1984 and 1970.

| Status | Clarke 1984 | | Hunt 1970. | |
|----------------------------|-------------|-----|------------|-----|
| | Number | % | Number | % |
| Married | 889 | 86 | 759 | 84 |
| Single | 53 | 5 | 34 | 3 |
| Widowed/div./ separated | 93 | 9 | 122 | 13 |
| Total | 1035 | 100 | 915 | 100 |

(Missing observations 2)

(iv) Age Left School.

The majority of home helps (95%) and nursing auxiliaries (80%) in my sample had finished their full-time education at age 16 or under. Similar results to those found in Hunt's study (Hunt 1970)

(v) Time In Post.

Although it cannot be assumed that both my sample and Hunt's are representative, it is interesting to note that over 66 per cent of home helps had been in post in 1967 for under five years; by 1984 this had dropped to 34 per cent. Twenty two percent had been in post between 5 to 10 years in Hunt's study; in my study this had risen nearly one-third. The biggest swing was in the number who had been employed for over 10 years which had risen from 11 per cent in 1967 to 35 per cent by 1984 (Hunt 1970: 41).

TABLE 8.9
Time in Post: Home Helps 1984.

| Years | No. | % |
|---------|------|-----|
| under 5 | 356 | 34 |
| 5-9 | 316 | 31 |
| 10-14 | 239 | 23 |
| 15-20 | 81 | 8 |
| 21> | 39 | 4 |
| Total | 1031 | 100 |

(Missing Observations 6)

Hunt reported that older home helps were more likely to have been in post for longer periods; in my sample 18 per cent who were between 41 to 45 years of age had over five years experience. Only one per cent of those over 60 years of age had been in post for less than five years.

Nursing auxiliaries in my study compared with the 1980 study were in post for longer periods. One-third had been in post for over 10 years whereas in the Dunnell and Dobbs' study about one in ten had been so. This is not surprising in view of the large increase in the number of auxiliary nurses in post since 1971 (see table 6.1). Most of the differences can be explained by the time lag between studies. The 1980 survey was carried out in 25 (9%) Health Districts over a very short

period in 1980. Six hundred and nine auxiliaries were sampled compared to 1364 in my sample in 81 (37%) Health Districts.

TABLE 8.10
Nursing Auxiliaries: Time in Post: 1980-1984.

| T. in Post | Clarke 1984 | | Dunnell & Dobbs, 1980 | |
|------------|-------------|-----|-----------------------|-----|
| | No. | % | No. | % |
| 1< | 99 | 7 | 98 | 16 |
| 1-4 | 351 | 26 | 268 | 44 |
| 5-9 | 453 | 33 | 183 | 30 |
| 10-14 | 321 | 23 | 49 | 8 |
| 15-19 | 108 | 8 | 12 | 2 |
| 20> | 32 | 2 | - | * |
| Total | 1364 | 100 | 609 | 100 |

(Missing observations 4) (Adapted from Dunnell and Dobbs 1982 : 9, * less than 0.5%)

(vi) Qualifications and Training.

Nursing auxiliaries obtained more GCEs than home helps who were the least academically qualified. Home helps in County Councils were more likely to have obtained GCEs than their colleagues in London Boroughs or Metropolitan Districts (see appendix).

TABLE 8.11
Number and percentage of Home Helps and Nursing Auxiliaries with GCEs, CSEs and 16+ qualifications.

| Qualification. | Nursing Aux. | | Home Help | |
|----------------|--------------|----|-----------|----|
| | No. | % | No. | % |
| GCE | 283 | 20 | 75 | 6 |
| CSE | 95 | 6 | 42 | 5 |
| 16+ | 63 | 5 | 18 | 2 |
| GCE + CSE | 32 | 2 | 19 | 2 |
| None | 927 | 67 | 883 | 85 |

The majority of workers in the sample stated that they had not received any training or held a qualification relevant to the post. Approximately 13 per cent of home helps had attended some form of inhouse training as

had 26 per cent of nursing auxiliaries. In three authorities all of the home help sample stated that they had no training opportunities and allowing for those the percentage of home helps in each authority who had received training varied from 2 to 26 per cent.

8.8 Analysis of Data.

The data was analysed using SPSS on a ICL 1906S computer and for ease of analysis the 110 tasks listed on the questionnaire were grouped into nine sections under the following headings: Domestic, basic nursing, rehabilitative, administrative, personal, professional nursing, advisory, miscellaneous and escorting.

Harris (1968), Burr (1948), Hunt (1970), Mark (1970), May (1970) Gwynne and Fean (1978) and others have all reported upon the domestic role of the home help but few have discussed basic nursing tasks in relation to the home help (LGTB 1978, Marks 1978, Hutchinson 1975). The majority of 'professional nursing' tasks listed were reported as having been carried out by nursing auxiliaries (Poulton 1977, Dunnell and Dobbs 1982) [see appendix].

The caring role of the home help has been alluded to in the recent past but only Dexter has pointed out that caring tasks may have been carried out by traditional home helps rather than staff in the new projects or schemes discussed in chapter six. The advisory role of the home help was first discussed by Hunt but this aspect of the role is not officially recognised in job descriptions. However, since the middle of the 1970s this aspect of the home help (Marks 1975, Latto 1981, Dexter and Harbert 1983) and auxiliary nurse role has been commented upon (Dunnell and

Dobbs 1983: 57). The possibility of the home help performing a rehabilitative or teaching role is a new concept (Malin 1980, Dexter and Harbert 1983).

It has long been recognised in the social work profession that report writing and record keeping are essential aids to good practice. Home helps or auxiliary nurses have not been encouraged to do these tasks but a few authorities now expect certain home help staff to attend meetings or read or write reports (Dexter 1981).

The individual tasks were grouped and defined as follows for analysis:

a. Domestic Tasks.

Domestic tasks are those tasks that a spouse, relative or friend would be expected to carry out for a sick or elderly person in their own home.

- Cook dinner/tea/breakfast,
- Clean furniture,
- Prepare food,
- Serve meals,
- Wash dishes,
- Wash bedclothes,
- Do ironing,
- Do laundry in client's own home,
- Do sewing,
- Hang curtains,
- Lock/unlock client's house,
- Water indoor plants,
- Make/light fires,
- Clean floors/windows,
- Carry wood/coal,
- Empty commode,
- Clean Commode,

b. Basic Nursing Tasks.

Basic nursing tasks are defined as those nursing tasks that a relative, friend, neighbour or spouse would be expected to carry out for a sick or elderly person in their own home.

- Get client out of bed,
- Bath client in bed/Give blanket bath,
- Bath client in bath,
- Shave client,
- Wash client's hair,
- Feed client,
- Dress/undress client,
- Change incontinent client,
- Cut client's finger/toe nails,
- Intimate care of client, (Wash private parts etc.)
- Assist with appliances,
- Help client with colostomy,
- Make client comfortable in bed/chair,
- Make bed,
- Assist client to/from toilet,
- Assist client to/from bedroom,
- Change client's clothes

c. Rehabilitative Tasks.

Rehabilitative tasks are those tasks which help or encourage the client change his/her behaviour.

- Encourage client to do own work,
- Encourage client to do own cleaning,
- Teach client to do things for themselves,
- Encourage client to make friends,
- Teach lifting techniques to relative/client,
- Help client to change his/her behaviour,
- Help client to walk,
- Encourage client to do exercises,
- Help child learn to talk,
- Toilet train child,
- Teach client-family to:
 - Cook,
 - Shop,
 - Budget,
 - Clean,
 - Understand H.P.,

d. Administrative Tasks.

Administrative tasks are clerical or administrative in nature which workers would be expected to carry out so as to facilitate effective care of the client.

- Write reports on clients,
- Complete written reviews on clients,
- Read reports on clients,
- Help train new staff,
- Attend supervision sessions,
- Talk to colleagues about the best way to help clients,
- Attend meetings to plan treatment programmes for client,

e. Personal Tasks.

Personal tasks are those tasks carried out which are directly related to the personal, individual care or support of the client in their own home.

- Collect pension,
- Collect pills and medicines,
- Do shopping,
- Fill hotwater bottle,
- Telephone on behalf of client,
- Complete forms on behalf of clients,
- Read letters for clients,
- Clean wheel chairs, aids etc.,
- Wash/dress/get up children,
- Give emotional support,

f. Professional Nursing Tasks.

Professional nursing tasks are defined as tasks for which nurse training would be necessary before they could be carried out properly.

- Give injections,
- Check medicines,
- Administer medicines,
- Administer ointments,
- Carry out urine test,
- Apply simple dressing,
- Help lay out dead client,
- Care of pressure areas,
- Apply eye drops,
- Give enema/douch,
- Syringe ears,
- Remove stitches,
- Take blood pressure,

g. Advisory Tasks.

Advisory tasks are defined as those tasks that place a member of staff in a position which enables him/her to offer advice to the client.

- Be adviser to client,
- Give advice on personal hygiene,
- Advise on sexual matters,
- Advise on safety in the home,
- Help client sort out bills,
- Help client make out will,
- Help client get into old people's home,
- Check on client's welfare benefits,

h. Escorting Tasks.

Escorting tasks are those tasks which involve taking the client outside their own home.

- Take client to:
 - Doctor,
 - Hospital,
 - Chiropodist,
 - Dentist,
 - Optician,
 - Bank,
 - Post office,
 - Library,
 - Supplementary Benefit office,
 - Council office,
 - Pub,
- Accompany client to supplementary benefit tribunal.
- Escort children to school,

h. Miscellaneous Tasks.

Miscellaneous tasks are those which do not relate to any of the other eight groupings. They are tasks that encourage the building of positive relationships between client and staff.

- Talk to client's visitors,
- Talk to client's relatives,
- Listen to client's troubles,
- Chat/talk to client,
- Keep in touch with client's relatives/friends,
- Be around at bath time,
- Be a companion to client,
- Be a friend to client,

8.9 Appendices.

The appendices in volume two contain a copy of the questionnaires used, relevant communications with authorities and participants, the distribution of questionnaires, sampling used in each authority and a list of the tasks reported as being carried out by the groups of staff. Tables analysing the collected data by a variety of variables are also contained in the appendix.

CHAPTER NINE

Analysis of the Role of the Home Help and Auxiliary Nurse.

9.1 Introduction.

This chapter is concerned with an analysis of the data collected in order to attempt to ascertain which tasks both groups (state they) carry out. Before discussing the data collected it is necessary to highlight some of the problems of validating the 'mail' questionnaire as a guide to actual behaviour. In this study home helps and auxiliary nurses stated what tasks they carried out and also if they perceived the tasks as their job or someone else's (see chapter eleven). What the answers might actually mean needs some clarification in order to place the results in context. With factual questions such as in my survey, the answers may in some cases be a mixture of wishful thinking, vague recollection or a desire by home helps or auxiliary nurses to give the answer they believe I am looking for (Moser 1969: 219). How valid my survey is will depend on the relationship between what a home help or auxiliary nurse says and what she does. One problem which arises is that of the 'response set' or the tendency of the participant to answer all the questions in a specific direction regardless of the questions' content. This could particularly cause bias in a study such as mine

where most of the questions refer to the same topic, and all have the same response format (Nachmias and Nachmias 1981: 222). In order to overcome this problem of 'response set' the questions were ordered by not listing, for example, all domestic or nursing tasks together.

Some of my questions could have been perceived as threatening by some home helps. A number of authorities give written instructions to home helps on what tasks not to carry out either because these could contravene the Health and Safety Regulations that have been deemed [in that authority] as the role of the community nurse e.g. changing a dressing or applying eye drops. There is considerable evidence that threatening questions may lead to a denial of the behaviour in question or to under-reporting. In general, the reporting of certain behaviours decreases as questions increase in their degree of threat. When a home help is presented with a question such as, do you cut finger/toe nails of clients or apply a simple dressing, the respondent is caught in a conflict between the role demands of the 'good respondent' who answers truthfully (if she has carried out these tasks) and the tendency to present oneself as carrying out the job as prescribed by the employer who may have forbidden such tasks to be carried out. "The conflict is usually resolved, not by refusing to answer, but by reporting that one did not engage in that particular activity when one, in fact, did" (Bradburn, Sudman, Blair and Stocking 1978: 226). One other factor to be taken into consideration is that the questionnaire responses may correspond to the subject's perception of reality (Pinneau and Milton 1958: 249-276). The fact that the home help or auxiliary nurse states or perceives that she carries out a certain task is of interest in that she says it. This phenomenon of 'response set' should be borne in mind

when reading this chapter; it may be that there is more overlap than reported or more tasks carried out by individuals than they are prepared to admit.

9.2 A Taxonomy of Home Help and Auxiliary Nurse Tasks.

Home helps and nursing auxiliaries [state that they] regularly carry out many similar tasks for their clients. At one end of the spectrum nursing auxiliaries say that they carry out many of the basic nursing tasks and at the other end very few domestic ones. Domestic tasks are predominantly a home help role and basic nursing predominantly a nursing role (see table 9.1). Tasks in the professional nursing, advisory, rehabilitative and administrative areas are however not carried out regularly by either group (see table 9.2) but for all of the other tasks there are many similarities. Table 9.1 shows those tasks which were predominantly carried out by either the nursing or home help sample and also highlights those common to both groups.

There was a significant number of tasks common to both groups, about 40 percent, particularly in the areas of the basic and professional nursing, advisory, personal, administrative and miscellaneous roles. However, if tasks 'occasionally' carried out are added to those reported in the table as 'regularly' carried out, then both groups are prepared to carry out the the majority of tasks at some time (see appendix).

Few home helps said that they carry out professional nursing tasks on a regular basis; however, they are willing to help with these on occasions. There was some overlapping for the individual tasks of

TABLE 9.1

MOST POPULAR TASKS REGULARLY CARRIED OUT (By more than 5% of sample)

| Predominantly Home Help % who carried out task | Tasks which overlap (carried out by both groups) | | OVERLAP | Predominantly Auxiliary Nurse % who carried out task |
|---|---|-----------------------------|---------|---|
| | Home Help % | Auxiliary Nurse % | | |
| <u>DOMESTIC TASKS</u> | | <u>DOMESTIC TASKS</u> | | <u>DOMESTIC TASKS</u> |
| Clean windows/floors 97 | | | | |
| Clean furniture 96 | | | | |
| Wash dishes 84 | | | | |
| Hang curtains 61 | | | | |
| Ironing 58 | | | | |
| Laundry in client's own home 55 | | | | |
| Wash bedclothes 50 | | | | |
| Cook dinner/tea/breakfast 43 | | | | |
| Serve meals 43 | | | | |
| Make/light fires 40 | | | | |
| Carry wood/coal 37 | | | | |
| Water/look after plants 24 | | | | |
| Sewing 22 | | | | |
| | 39 Empty commode 51 39 | | | |
| | 39 Clean commode 36 36 | | | |
| | 21 Lock/unlock client's home 27 21 | | | |
| <u>BASIC NURSING TASKS</u> | | <u>BASIC NURSING TASKS</u> | | <u>BASIC NURSING TASKS</u> |
| | 85 Make client's bed 45 45 | | | Intimate care of client 94 |
| | 47 Change incontinent client 39 39 | | | Bath client in bath 82 |
| | 37 Make client comfortable in bed or chair 92 37 | | | Bath client in bed/blanket bath 79 |
| | 21 Dress/undress client 94 21 | | | Assist client with surgical appliances 41 |
| | 19 Change client's clothes 90 19 | | | Help client with colostomy 21 |
| | 16 Assist client to/from bedroom 83 16 | | | Shave client 13 |
| Get client out of bed 15 | 15 Wash client's hair 35 15 | | | |
| | 12 Take client to/from toilet 70 12 | | | |
| | 7 Cut finger/toe nails 79 7 | | | |
| <u>P. NURSING TASKS</u> | | <u>P. NURSING TASKS</u> | | <u>P. NURSING TASKS</u> |
| | 25 Check medicines 32 25 | | | Care of pressure areas 89 |
| | 13 Administer medicines 16 13 | | | Apply eye drops 40 |
| | 7 Administer ointments 70 7 | | | Carry out urine test 16 |
| | 6 Apply simple dressings 53 6 | | | |
| <u>ADVISORY TASKS</u> | | <u>ADVISORY TASKS</u> | | <u>ADVISORY TASKS</u> |
| Help client sort out bills 28 | 28 Advise on safety in the home 29 28 | | | |
| | 25 Give advice on personal hygiene 32 25 | | | |
| | 26 Be advisor to client 21 21 | | | |
| | 14 Check if client is getting welfare benefits 10 10 | | | |
| <u>PERSONAL TASKS</u> | | <u>PERSONAL TASKS</u> | | <u>PERSONAL TASKS</u> |
| Shop for clients 90 | 41 Give emotional support 52 41 | | | |
| Collect pension 43 | 93 Collect pills and medicines 28 28 | | | |
| Read letter for client 29 | 36 Telephone on behalf of client 8 8 | | | |
| Clean wheelchairs etc. 20 | 21 Fill hot water bottles 19 19 | | | |
| | 13 Complete forms for client 6 6 | | | |
| <u>REHABILITATIVE TASKS</u> | | <u>REHABILITATIVE TASKS</u> | | <u>REHABILITATIVE TASKS</u> |
| Train client/family to: | 32 Encourage clients to make friends 36 32 | | | |
| Shop 15 | 19 Teach client to do things 47 19 | | | Teach client/family lifting techniques 29 |
| Clean 15 | 18 Help client to walk 74 18 | | | |
| Budget 10 | Encourage client to do: | | | |
| Cook 8 | 16 own work 13 13 | | | |
| | 19 own cleaning 12 12 | | | |
| | 7 exercises 32 7 | | | |
| | 7 Help client to change his/her behaviour 10 7 | | | |
| <u>ADMINISTRATIVE TASKS</u> | | <u>ADMINISTRATIVE TASKS</u> | | <u>ADMINISTRATIVE TASKS</u> |
| | 24 Talk to colleagues about the best way to help clients 74 24 | | | Write reports on clients 62 |
| | 10 Attend meeting to plan treatment programme 49 10 | | | Read reports on clients 55 |
| | 8 Attend supervision sessions 13 8 | | | Complete written reviews on clients 21 |
| <u>MISCELLANEOUS TASKS</u> | | <u>MISCELLANEOUS TASKS</u> | | <u>MISCELLANEOUS TASKS</u> |
| | 88 Chat or talk to clients 92 88 | | | |
| | 74 Listen to client's troubles 82 74 | | | |
| | 71 Be a friend to client 57 57 | | | |
| | 26 Talk to client's relatives 44 26 | | | |
| | 41 Be a companion to client 20 20 | | | |
| | 19 Talk to client's visitors 28 19 | | | |
| | 24 Keep in touch with client's relatives or friends 15 15 | | | |
| | 6 Be around at bath time 43 6 | | | |
| | 6 Prepare client for admission to Hospital or Old Persons Home 70 6 | | | |

TABLE 9.2
TASKS NOT REGULARLY CARRIED OUT (5% or less)

| Home Help | Common to Both Samples | Auxiliary Nurse |
|---|---|---|
| <u>DOMESTIC TASKS</u> | <u>DOMESTIC TASKS</u> | <u>DOMESTIC TASKS</u> Cook dinner/tea/breakfast Prepare meals Serve meals Wash dishes Clean furniture Wash bedclothes Ironing Sewing Laundry in client's own home Hang curtains Water/look after plants Clean windows/floors Make/light fires Carry wood/coal |
| <u>BASIC NURSING TASKS</u> Bath client in bed/blanket bath Bath client in bath Change client Intimate care of client Assist with surgical appliances Help client with colostomy | <u>BASIC NURSING TASKS</u> | <u>BASIC NURSING TASKS</u> |
| <u>P. NURSING TASKS</u> Carry out urine test Help lay out dead client Apply eye drops | <u>P. NURSING TASKS</u> Give injection Give enema/douch Syringe client's ears Remove stitches Take temperature | <u>P. NURSING TASKS</u> |
| <u>ADVISORY TASKS</u> | <u>ADVISORY TASKS</u> Advise on sexual matters Help client make will Help with admission to Old Persons Home | <u>ADVISORY TASKS</u> Help client sort out bills |
| <u>PERSONAL TASKS</u> | <u>PERSONAL TASKS</u> Wash/dress/get up children | <u>PERSONAL TASKS</u> Collect pension Read letters for clients Shop for clients Clean wheelchairs etc. |
| <u>REHABILITATIVE TASKS</u> Teach lifting techniques | <u>REHABILITATIVE TASKS</u> Help child to talk Toilet train child Train client to understand H.P. | <u>REHABILITATIVE TASKS</u> Teach client/family to: Cook Budget Shop Clean |
| <u>ADMINISTRATIVE TASKS</u> Write reports on clients Complete written reviews on clients Reca reports on clients | <u>ADMINISTRATIVE TASKS</u> Help train new staff | <u>ADMINISTRATIVE TASKS</u> |

checking and administering medicines. Many Auxiliary Nurses, on the other hand regularly carry out some of the professional nursing tasks but many more said they are willing to carry them out occasionally.

On average many more auxiliary nurses than home helps regularly carry out basic nursing tasks (of which many overlap but some not to any significant degree). However, such tasks as regularly making beds, making clients comfortable in bed or chair, dressing or undressing clients, changing their clothes, getting them out of bed, assisting them to or from bedroom or toilets and washing their hair, all are common to both groups (see table 9.1).

Apart from washing/dressing and getting up children most home helps carried out personal tasks for their clients such as filling hot water bottles, collecting pills and medicines and giving emotional support, in common with their auxiliary nursing colleagues. For some tasks it is common sense to expect overlap. In fact it would be disturbing to find none, particularly for such tasks as giving emotional support, listening to clients' troubles, talking to them, their visitors or friends or generally being a friend to clients.

There was significant overlap for one rehabilitative task only, that of encouraging clients to make friends. The results from both the national survey and from those authorities where the home help and nursing services had co-terminus boundaries all show that the majority of nurses regularly carry out most of the administrative tasks and that apart from 'talking to colleagues about the best way to help clients' there were few tasks in common with the home help service. Many home helps and nurses stated that they regularly carry out most of the miscellaneous tasks and apart from 'being around at bath time and being a friend to

clients' there was some overlap (see table 9.1).

When the advisory role of the groups is analysed there is little overlap except for the tasks of 'being adviser to client', advising on personal hygiene, safety in the home and helping with welfare benefits. Few nursing auxiliaries regularly carried out the remainder.

Many tasks which were regularly carried out highlight a pattern which indicates that there may be consensus among both groups about their role. Domestic tasks are definitely the sphere of the home help whereas the basic nursing and administrative ones are carried out predominantly by auxiliary nurses. However, many of the remaining tasks show some overlap particularly in the basic nursing, professional nursing and rehabilitative areas. Table 9.3 gives an indication of the major areas of overlap.

Evidence from those geographical areas [in common] where both nursing auxiliaries and home helps completed questionnaires indicates no consistent pattern, there is no relationship between the work of the home help and the auxiliary nurse in those areas. The results do indicate that it is unlikely that the roles of the home help and auxiliary nurse interlock in those areas.

In this section I have given an overview of the differences in role between the home help and the auxiliary nurse. In sections 9.3 to 9.10 each group of tasks is discussed in more detail.

9.3 The Domestic role of the Home Help and Auxiliary Nurse.

Most home helps say that they regularly carry out the majority of the domestic tasks listed in my survey. This result is not surprising as FIG

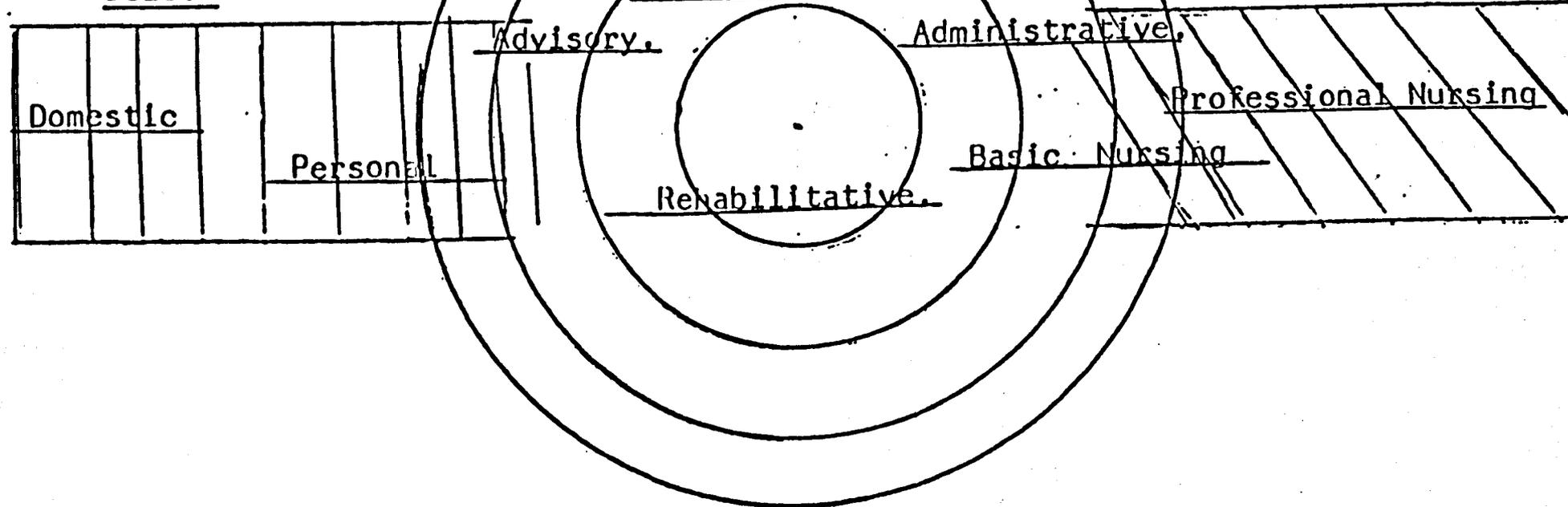
Table 9.3

Overlap of Role; Home Help and Auxiliary Nurse.

Tasks which overlap (By more than 5%)

Tasks which are
predominantly a Home Help
role.

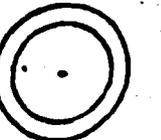
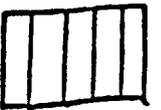
Tasks which are
predominantly a Nursing
Auxiliary role.



Predominantly Home Help Role

Tasks which Overlap

Predominantly Nursing Aux. Role



Harris (1971) and the General Household Survey (OPCS 1983a) highlighted the difficulties that many handicapped and elderly people experience with these tasks. My data is similar to the results of other studies. Marks and others have found that the majority of the home helps' time is spent on cleaning tasks (Marks 1975: 60). Other studies indicate that the home help gives support in the form of help with washing, ironing, cooking, shopping or lighting fires (May and Whitbread 1977: 17, Gwynne and Fean 1978: 18). Over a quarter of both groups regularly lock or unlock clients' homes which may be an indicator of the number of dependent immobile clients served by these two groups.

There is little disagreement that one important aspect of the home help role is domestic work. However, much discussion has centred on what roles can be and should be combined with the domestic one (Hedley and Norman 1982: 28, Goldberg 1982: 61).

A review of the most recent research however demonstrates that, apart from the most basic domestic tasks such as cleaning, dusting, sweeping or shopping, there seems to be little agreement as to what constitutes the home help role. What is clear is that it may be changing. Hunt in 1967 listed tasks that home helps had "sometimes done" which can be compared to my combined 'regular' and 'occasional' figures.

These results indicate that home helps are now more than ever carrying out domestic tasks for their clients. The percentage of home helps now stating that they carried out domestic tasks 'at some time' is double Hunt's for many of the tasks. In all but one, that of lighting fires, the results are higher. This latter result is probably due to an increase in the number of elderly and handicapped people living in accommodation with central heating.

When, therefore, the responses of home helps in 1967 (Hunt 1970) are compared to those of 1984 there is little evidence to support the thesis that home helps today do not carry out the traditional domestic tasks for their clients. Indeed, my evidence indicates that there is an increase in the number of home helps who do so. However, the amount of actual time spent carrying out these tasks was not analysed and therefore a categorical statement about an increase or decrease in the amount of time home helps actually spend on domestic tasks cannot be made (see table 9.4).

TABLE 9.4
Percentage of Home Helps who stated that they had ever carried out domestic tasks: 1970 and 1984.

| Task | Clarke 1984 | Hunt 1970 |
|---------------------------|---------------|---------------|
| Laundry in client's home, | 92 | 32 |
| Mending, sewing, | 77 | 43 |
| Ironing in client's home, | 94 | 58 |
| Empty commode, | 89 | 62 |
| Prepare meals/food, | 95 | 69 |
| Make fires, | 72 | 88 |
| Total Number | 1037 | 996 |

Few auxiliary nurses in my sample said they regularly carried out domestic tasks except for those of emptying and cleaning commodes, for which there was overlap with home helps. It is clear therefore when looking at the domestic tasks regularly carried out that home helps and auxiliary nurses share few domestic tasks in common (see table 9.1).

In the sample of home helps and nursing auxiliaries which shared the same geographical boundaries the results followed the national pattern with little or no overlap. The results for domestic tasks in those local authorities and Health Districts with co-terminus boundaries, support

the view that the home help service is providing domestic support with minimal overlap with the nursing auxiliary except for one or two tasks - locking/unlocking clients homes, or emptying or cleaning commodes. The auxiliary nurse stated that she is, if the occasion warrants it, ready to carry out many domestic tasks (see appendix).

9.4 Basic Nursing tasks.

TABLE 9.5

Basic Nursing tasks which overlap. (More than 5%)

| | Overlap Home Help | Nursing Auxiliary |
|-----------------------------------|-------------------|-------------------|
| Make client's bed | 45% | 85% |
| Change incontinent client | 39% | 47% |
| Make client comfortable/bed/chair | 37% | 37% |
| Dress/undress client | 21% | 21% |
| Change client's clothes | 19% | 19% |
| Assist client to/from bedroom | 12% | 12% |
| Wash client's hair | 15% | 15% |
| Take client to/from toilet | 12% | 12% |
| Cut finger/toe nails | 7% | 7% |

Early studies of the role of the home help or tasks they carried out concentrated on the more traditional domestic ones (Harris 1968, Hunt 1970) but more recent studies began to question if home helps carried out more personal or basic nursing tasks (Marks 1975, Howell, Boldy and Smith 1979, Barlow and Mathews 1978, Gwynne and Fean 1978, Dobinson 1982, Latta 1983). Harris (1968) listed 13 tasks, only two of these - making beds and helping clients to wash or bath - were 'personal' or basic nursing tasks which could be compared with any on my list.

Hunt found however that half of all home helps had supported clients at some time by washing or bathing them, over half helped them to dress and nearly all had made beds. About half of the sample stated that they had

carried out 'personal commissions' for their clients. The DHSS survey of the home help service later commented upon what they saw as a change in emphasis from domestic to a more personal service (DHSS 1973).

In previous chapters I have discussed evidence which supports the view that the present home help service is primarily a support to the elderly. The most recent data collected on the needs of the elderly in the community gives some indication how they cope in the area of personal care. The 1980 General Household Survey (OPCS 1982b) showed that those elderly who lived alone and were unable to bath, shower or wash were most likely to be helped by a nurse. No home help in the 1980 survey was reported as carrying out personal tasks for the elderly or such tasks as cutting toe nails, feeding or shaving. Many of the elderly surveyed were unable to carry out these tasks for themselves, for example, 28 per cent were unable to cut toe nails and their ability to do these became less as they got older (OPCS 1982b: 203). Hunt however reported a small percentage of clients with these needs receiving support from home helps (my definition of basic nursing tasks) (Hunt 1970: 75). Other studies indicated that home helps spend from 15 to 19 per cent of their time carrying out basic nursing tasks (Marks 1975: 70, Gwynne and Fean 1978: 18). Later studies support these findings (Foley 1983: 33, Lockey 1982: 12, Latta 1982: 19, Dobinson 1982: 9, Bond 1982: 9).

Some now argue that it is the responsibility of the home help service to support clients in their own homes by carrying out basic nursing tasks (Dexter and Harbert 1983). One local authority has gone so far as to make the provision of this type of support a priority (Hurley and Wolstenholme 1979) but others still have doubts about this aspect of the

role while some see this trend as a reflection "of the dominant ideology which undervalues housework" and emphasises personal or nursing care at the expense of housework (Central Personal Social Services Advisory Committee 1976: 6, Bond 1982: 24).

This theme of 'quasi-nursing' or basic nursing runs through a number of studies of the home help task and Howell questioned if these were appropriate ones for a home help. However, appropriate or not many in my sample stated that they carried them out. In her study Harris did not report any overlap between home helps and the district nursing service but her report does indicate that home helps and district nurses carried out similar tasks. Home helps helped with the washing and bathing of clients, many nurses also washed, bathed and cut the toenails of home help clients (Harris 1968).

In my sample there is a fairly large difference between the basic nursing tasks carried out by both samples. Many home helps carried out the tasks of dressing/undressing clients, making beds and making clients comfortable in their bed or chair. Very few home helps said that they regularly washed clients in their bed or bath compared to over three quarters of auxiliary nurses (who washed clients in bed) and 82 per cent who washed them in the bath.

Hunt listed four tasks which could be compared to any of my basic nursing care tasks. Just over half of her sample had ever helped clients to dress; in my sample 80 percent said they did so. By 1984, there was a slight percentage increase [6 per cent] for the task of making beds. About 44 per cent of home helps in 1967 (Hunt 1970) helped clients to wash or bath, only 15 per cent of my sample ever did so. Even if the task of washing and bathing is combined with washing hair the

percentage who carried out these combined tasks rises to just over 38 per cent which is still below Hunt's figure. This possibly reflects the increasing number of auxiliary nurses or bath assistants now being employed by health authorities. Hunt did not list any other basic nursing tasks but did report that nearly half of her sample carried out 'personal commissions' at some time for their clients. She did not explain what these 'commissions' were.

Very few home helps (3%) said they regularly assisted clients with surgical appliances whereas well over one-third of auxiliary nurses did so. The percentage of home helps who regularly changed incontinent clients was also very low. Writers have commented on the trend for qualified nurses to disown those tasks which could be called basic nursing. Cang observed that the basic work of caring for the sick has 'acquired the status of less important, menial work, unfit for true professionals and something of an embarrassment' to an aspiring profession (Cang 1978: 216). The work however still remains to be done and my results would indicate that much of it is being done by nursing auxiliaries [assistants] and to a lesser extent by home helps. Dunnell and Dobbs and Hockey's research would seem to indicate that qualified nurses may have succeeded in delegating many basic nursing tasks to other groups of workers. Recent research on the role of the district nurse would indicate that many basic nursing tasks have been delegated by qualified community nurses to auxiliaries (Battle, Moran-Ellis and Salter 1985: 23).

Many of the basic nursing tasks are carried out only by auxiliary nurses but many of the less specialised ones are also carried out by the home help. The largest overlaps were for the tasks of making clients' bed,

making them comfortable in their bed or chair and changing them when they are incontinent. However, only one basic nursing task can be identified as predominantly a home help task, that of getting clients out of bed which might reflect the the bedbound nature of home help clients.

9.5 Professional Nursing Tasks.

TABLE 9.6
Professional Nursing tasks which show overlap (More than 5%).

| | Overlap | Home Help | Auxiliary Nurse |
|------------------------|---------|-----------|-----------------|
| Check medicines | 25% | 25% | 32% |
| Administer medicines | 13% | 13% | 16% |
| Administer ointments | 7% | 7% | 70% |
| Apply simple dressings | 6% | 6% | 53% |

The 'professional nursing' role in my study is predominantly an auxiliary nursing one but as table 9.6 indicates there are some tasks common to both groups.

Home helps carry out such professional nursing tasks as checking medicines, pills, applying eyedrops, ointment (Howell, Boldy and Smith 1979), applying dressings (Harbridge 1979) and supervising medication (Simons and Warburton 1980). Home helps in at least two studies have ranked highest in their training needs the acquisition of such 'professional nursing' skills (Gwynedd C.C. 1978, Hutchinson 1975). The remaining eleven tasks were regularly carried out by very few home helps although seven per cent say they regularly administered ointments, applied simple dressings and two per cent less applied eye drops. The results are comparable with those of other studies (Howell et.al. 1979: 110, Rust 1985: 24).

Few home helps say they carried out professional nursing tasks on a regular basis but they did indicate that they were willing to carry out some of them on occasions. This observation supports the findings of Hutchinson (1975) and the review of the home help service in Gwynedd (1978). Some of the more specialised nursing tasks are not carried out by either sample (see table 9.2).

9.6 Advisory Tasks.

TABLE 9.7

Advisory Tasks which show overlap (More than 5%)

| | Overlap | Home Help | Auxiliary Nurse |
|---|---------|-----------|-----------------|
| Advise on safety in the home | 28% | 28% | 29% |
| Give advice on personal hygiene | 25% | 25% | 32% |
| 'Be adviser to client' | 21% | 26% | 21% |
| Check if client is getting welfare benefits | 10% | 14% | 10% |

The advisory role of the home help has been commented upon by a number of writers but few advisory tasks have been identified (Nepean-Gubbins 1958, Parker 1968, Hunt 1970, Latto 1982, Smith 1983) and many of them were not regularly carried out by either sample.

Dunnell and Dobbs first commented upon this aspect of the auxiliary nurse's role (Dunnell and Dobbs 1982: 57) but only Hunt has presented data on the number of home helps carrying out this role. She enquired of her sample if they were ever asked for advice by clients on matters like "cooking, shopping, housework". Over 29 per cent replied that they had been asked advice on cooking, over 40 per cent on shopping and over 22 per cent on housework (see table 9.8). The majority of home helps discussed personal matters with clients but not all were asked for advice (Hunt 1970: 63).

In an attempt to identify what advisory tasks if any are carried out today, eight advisory tasks were identified from the literature and incorporated into my questionnaire.

Just over one-quarter of home helps in my sample said that they carried out the task of 'be adviser to clients', five per cent more than auxiliary nurses. Advising clients on safety in the home and helping to sort out bills were tasks that a high percentage of home helps carried out. Twenty nine percent of auxiliary nurses advised on safety in the home but very few on sorting out bills. Nursing auxiliaries were more likely to advise on personal hygiene but few in either sample regularly advised on sexual matters.

TABLE 9.8
Percentage of Home Helps who advised clients 1970.

| Advice asked on:- | All Home Helps |
|---|----------------|
| Family problems. | 16.3 |
| Financial matters, insurance, pension. | 10.5 |
| Problems connected with filling in forms. | 8.8 |
| Recipient's health. | 8.0 |
| Housing. | 1.9 |
| Getting into Old People's Home. | 1.0 |
| Arrangements for funerals, wills etc. | 1.0 |
| All kinds of things 'anything' | 1.0 |
| Other things | 5.4 |
| Number of Respondents | 951 |

(Source: Hunt 1970; 63)

Home helps were more likely to regularly check if their clients were receiving the appropriate welfare benefits.

When the advisory role of the two groups in my sample is compared there is little in common except for the four tasks of being adviser to client, advising on personal hygiene, safety in the home and helping

with welfare benefits (see table 9.1). Few nursing auxiliaries regularly carried out the remainder of the tasks. In the three authorities where both groups serve the same population the results showed the same trend although more of both samples regularly carried out the tasks.

Approximately one-quarter of both samples identified themselves as 'being an adviser' to clients, little advice was given on a regular basis by either group. This is a disappointing result; however, some comfort can be taken from the finding that both groups offered advice some time on all but two areas: helping with wills and advising on sexual matters (see appendix).

9.7 Personal Tasks

TABLE 9.9

Personal tasks which show overlap (More than 5%).

| | Overlap | Home Help | Auxiliary Nurse |
|-------------------------------|---------|-----------|-----------------|
| Give emotional support | 41% | 41% | 52% |
| Collect pills and medicines | 28% | 93% | 28% |
| Telephone on behalf of client | 8% | 36% | 8% |
| Fill hot water bottle | 19% | 21% | 19% |
| Complete forms for client | 6% | 13% | 6% |

Some of the personal tasks listed were predominantly a home help role (see table 9.1); Those which are common to both groups are areas in which overlap might be expected (see table 9.9).

Although most of the personal tasks discussed in this section would not be found in many official written job description of a home help or auxiliary nurse, they have nevertheless been carried out by home help staff (Howell 1979, Hunt 1970, Lockey 1982, Prouse 1973, Buckinghamshire 1973, White 1974, Marks 1975, LGTB 1978, Latto 1982, Simons and

Warburton 1980, Rust 1985) and nursing auxiliaries (Hockey 1968, Poulton 1977, Dunnell and Dobbs 1982, Rust 1985). Though few nursing auxiliaries in my sample regularly carried out these tasks.

It is perhaps surprising that many more of them do not carry out these tasks in view of the medical and health connotations of their role compared to the home help. Tasks of filling hot water bottles, collecting pills and medicines and giving emotional support to clients are common to both groups.

9.8 Rehabilitative Tasks.

The role of the home help in encouraging post-operative and other rehabilitation, or at least in maintaining frail clients' existing levels of ability in self care, is potentially an important one (Dexter and Harbert 1983). Training the family or client to cook, budget, shop or clean were predominantly a home help role. However, many of the other rehabilitative tasks are common to both samples (see table 9.10). Neapean-Gubbins, as long ago as 1966, recognised the teaching and rehabilitative role of the home help but since then this aspect of the service has not been developed to any extent. Dexter has only recently highlighted this aspect of their role again and argued that certain home helps should be able to motivate and mentally stimulate clients, re-educate them, rebuild their confidence, carry out set rehabilitative programmes and keep a written daily report on their condition to enable ongoing assessment of the client's progress (Dexter 1981).

Many recently-introduced home help or home care schemes have involved a rehabilitative element (Hunt 1977, Payne 1977, Crine 1981, Malin 1980,

White 1983, Smith 1983, Rust 1985).

TABLE 9.10
Rehabilitative tasks which show overlap (More than 5%).

| | Overlap | Home Help | Auxiliary Nurse |
|--------------------------------------|---------|-----------|-----------------|
| Encourage clients to make friends | 32% | 32% | 36% |
| Teach client to do things | 19% | 19% | 47% |
| Help client to walk | 18% | 18% | 74% |
| Encourage clients to do own work | 13% | 16% | 13% |
| Encourage clients to do own cleaning | 12% | 19% | 12% |
| Encourage clients to do exercises | 7% | 7% | 32% |
| Help client change his/her behaviour | 7% | 7% | 10% |

Payne in 1977 was one of the first writers to point out that the home help, in a rehabilitative role, may be more acceptable to the client than a social worker, doctor or nurse, particularly with mentally ill or elderly confused clients (Payne 1977: 16-17).

According to White (1983) the home help service lends itself to the rehabilitative process because it is "the most intimate of services, relying on the relationship of friendship and intimate trust between provider and receiver". Others would disagree with this. Malin has argued that the nature of the home help task and the lack of home help training does not facilitate the rehabilitative aspect of their role. He found evidence that many home helps felt unqualified for this aspect of their job which led to a sense of isolation from other workers (Malin 1980: 169-173).

I have been unable to find any published research on this aspect of the role of the auxiliary nurse but there are indications that some nursing auxiliaries may carry out rehabilitative tasks (Dunnell and Dobbs 1982). In my sample, auxiliary nurses are the less likely of the two groups to carry out these tasks regularly. Encouraging clients to do their own cleaning was a task not carried out regularly by many staff in either

group but training clients to cook, shop, clean and understand H.P. were tasks carried out more often by home helps. Few home helps regularly toilet trained children and no auxiliary nurses did so. Helping clients to change their behaviour was a task that only about one in ten auxiliary nurses and seven per cent of home helps regularly carried out. Most home helps and auxiliary nurses never encourage clients to modify or change their behaviour. There was some overlap in seven of the rehabilitative tasks but in only one was it considerable - that of encouraging clients to make friends.

9.9 Administrative Tasks.

TABLE 9.11

Administrative tasks which overlap (More than 5%).

| | Overlap | Home Helps | Auxiliary Nurse |
|---|---------|------------|-----------------|
| Talk to colleagues about the best way to help clients | 24% | 24% | 74% |
| Attend meetings to plan treatment programme | 10% | 10% | 49% |
| Attend supervision sessions | 8% | 8% | 13% |

Many of administrative tasks were predominantly carried out by nursing auxiliaries but three were common to both groups (see table 9.11). It has been suggested that home helps should carry out certain administrative tasks; Dexter expects certain home helps to write daily reports on the condition of certain clients (see section 9.8). However, inadequate feedback from the home help has been remarked upon in a number of studies (Gwynne and Fean 1978, Marks 1975, Hedley and Norman 1982).

Nursing auxiliaries were much more likely to carry out these tasks on a

regular basis. Nearly two-thirds of nurses write reports regularly and 21 per cent complete written reviews, a task carried out by few home helps. Approximately half of the nursing sample read reports and attended meetings to plan treatment programmes but few home helps did so. However, three-quarters of the nurse sample and one-quarter of home helps stated that they talked to colleagues about the best way to help clients.

Some of the differences in the results between nurses and home helps might be accounted for by working practices. The nurse usually works from a central point such as a G.P.'s practice, medical centre or nursing administration centre where she would have many opportunities to talk to colleagues. Home helps, on the other hand, usually work from home and are consequently very isolated from their colleagues.

The results show that the majority of auxiliary nurses state that they regularly carry out most of the administrative tasks; apart from the task of 'talking to colleagues about the best way to help clients', there was little overlap with the home help service (see table 9.1). This result may be attributed to the perception that nursing staff and others have of the nursing role, compared to the home help role which is perceived as a domestic one, demanding few if any professional expectations. Auxiliary nurses on the other hand, although ancillary to the trained nurse, is nevertheless part of a highly professional service which sets and demands certain standards. The Health Service expects that nursing auxiliaries work only under the supervision of a trained nurse; however, the only study to date which looked at this aspect of the work found no evidence to support the view that auxiliaries are supervised (Poulton 1977).

One result which needs clarification is the response to the question, do 'you attend supervision sessions'? In my study only 38 percent of home helps and 51 percent of auxiliary nurses said that they had 'ever' attended supervision sessions. This question ignored other sorts of supervision such as 'on the job' supervision. Hunt commented on the lack of supervision in the home help service (Hunt 1970: 67-69); other studies have also highlighted this lack of formal supervision or facility for home helps to have access to their supervisors. Formal supervision is not carried out in the client's home (Hillingdon L.B. 1974, Gwynedd C.C. 1977, Hutchinson 1975 and Gwynne & Fean 1978). This lack may be because the home help service is perceived by many managers as a domestic one for which they do not see supervision as necessary (Simons & Warburton 1980). This lack of involvement of the home help in the assessment, planning and monitoring of client care programmes is an interesting result. Both samples work, in most cases, without formal supervision and with limited opportunities to feedback information on the client to their senior colleagues.

9.10 Miscellaneous Tasks.

The results show that most home helps and auxiliary nurses believe that they have some form of social relationship with many of their clients. Other surveys support my findings (Hunt 1970, Latta 1982, ACE 1974). An indirect indicator of the relationships between clients and home help and auxiliary nurses might be their knowledge and interaction with clients' relatives and friends. It is inconceivable that 12 per cent of home helps and 8 per cent of auxiliary nurses do not talk to clients; it

is perhaps that they do not see it as part of their work. Many of these tasks such as talking to clients and their visitors, keeping in touch with clients' relatives, help at bath time or prepare clients for admission to hospital or old persons' home, have been put forward as being part of the role of the home help (Hutchinson 1975, Payne 1977, LGTB 1978, Howell et.al. 1979, Simons and Warburton 1980, Crine 1981) but no evidence could be found in the literature to suggest that nursing auxiliaries ever carried out any of these tasks apart from chatting socially to clients (Dunnell and Dobbs 1982). Over one quarter of auxiliary nurses and 20 per cent of home helps in my sample regularly talked to clients' visitors. Approximately the same percentage in both samples regularly listened to clients' troubles and chatted and talked to them. A quarter of home helps regularly kept in touch with clients' relatives; less auxiliary nurses do so. It is reasonable that many of these tasks should be common to both groups of worker. It would be very difficult for either group to carry out their role effectively without talking to clients or their relatives and friends. It is even more important that they felt able to listen to clients' troubles.

TABLE 9.11
Miscellaneous tasks which overlap (More than 5%).

| | Overlap | Home Help | Auxiliary Nurse |
|---|---------|-----------|-----------------|
| Chat or talk to clients | 88% | 88% | 92% |
| Listen to clients' troubles | 74% | 74% | 82% |
| Be a friend to clients | 57% | 71% | 57% |
| Talk to clients' relatives | 26% | 26% | 44% |
| Be a companion to client | 20% | 41% | 20% |
| Talk to clients' visitors | 19% | 19% | 28% |
| Keep in touch with clients' relatives or friends | 15% | 24% | 14% |
| Be around at bath time | 6% | 6% | 43% |
| Prepare client for admission to Hospital or Old Persons' Home | 6% | 6% | 70% |

The relationships indicated in this study between home helps and their clients is impressive as Dexter and Harbert point out:

"She invests more of her personality into her relationship with clients than is common with other domiciliary care staff, and to that extent she is seen by clients as a friend rather than as a representative of an official agency" (Dexter and Harbert 1983: 35).

9.11 Summary and Conclusions

The data would seem to support the hypotheses that both groups of staff have some roles in common but the domestic role is predominantly a home help one. Many of the less specialised basic nursing and professional nursing tasks are common to both groups which indicates an overlap between home helps and nursing auxiliaries. Tasks such as shaving, bathing, helping with surgical appliances and intimate care are predominantly the role of the auxiliary nurse. Within the broad spectrum of tasks identified, a number of issues were highlighted.

Professional nursing tasks are carried out by few nursing auxiliaries or home helps and in a number of authorities these tasks are not performed at all (see appendix). Both groups stated that they carried out few professional nursing tasks, only those of checking and administering medicines, administering ointments and applying simple dressings, the latter two showing only a modest overlap.

The rehabilitative role was carried out regularly by all home helps to some extent; many of these tasks were not carried out by nursing auxiliaries though most of them were prepared to carry them out on occasions (see appendix).

Many more nurses than home helps stated that they carried out

administrative tasks. Auxiliary nurses work in a professional treatment - orientated service and because of this may be expected to keep records. Community nurses are expected to keep professional records of their work whereas home help organisers are perceived as managers and administrators of a domestic service more concerned with the allocation of work than the keeping of records of work planned or done for clients. Because of this, home helps are not expected to keep records of client's progress or have access to their records at head office. Formal supervision for each home help on a regular basis would be logistically impossible for many organisers because of the number of home helps they are responsible for and the number of clients they serve (Marks 1975, Gwynn and Fean 1978, The Home Help Service in Great Britain 1979, Hedley and Norman 1982, Dexter and Harbert 1983). However, other opportunities were provided for the home help and auxiliary nurse to receive support and advice through 'attending meetings to plan treatment programmes' and 'talking to colleagues about the best way to help clients'. In the nursing auxiliary sample there is evidence that such support systems do not exist to any extent, findings which support those of Poulton. She found no evidence to support the hope of the DHSS that auxiliary nurses are formally supervised in their work. Although few of the nurses in my sample were supervised on a regular basis nearly half of them regularly attended meetings to plan treatment programmes for their clients - something done by very few home helps. There is also some recent evidence to suggest that more of the work of the nurse may be supervised than my data would suggest. Battle and colleagues found that some district nurses check on the work done by the auxiliary nurse on visits to clients in the absence of the auxiliary nurse (Battle et.al.1985:

23).

There were some advisory roles common to both groups but the major areas of overlap would seem to be those in the basic nursing and miscellaneous task groups. However, within the basic nursing tasks there are some which are the role of the nurse, i.e. bathing clients in bed or bath, intimate care of client and assisting with surgical appliances. What is more clear is that auxiliary nurses carry out few domestic tasks. This is an area of work which would definitely seem to be the role of the home help.

CHAPTER TEN

Variation in Home Help and Auxiliary Nursing Practice between differing Authorities.

10.1 Introduction.

The publication of the Ten-Year Health and Welfare Plans in the 1960s highlighted for the first time the variation in the range and level of home help provision between differing authorities. Research studies have sometimes indirectly illuminated the issue in a limited and unsatisfactory way. Harris in the late 1960s reported some variation in the kind of tasks home helps carried out in different authorities but her research was limited in that she had identified only 13 individual tasks, most of them in the domestic sphere. The largest differences reported were for such tasks as collecting pensions, doing laundry and washing or bathing clients (Harris 1968).

A number of local studies since 1970 have examined the role of the home help but no study to date has collected data to enable a detailed comparison of the tasks carried out by home helps in differing authorities. The data in these studies does not allow comparisons between authorities because of the incompatibility of task definitions. However, discussion of the results does give some indication of the range of tasks carried out in the individual authorities.

Data from these studies point out that the tasks home helps carry out will depend on the philosophy behind their roles, the proportion of time spent in contact with clients and the availability of other services (Audit Inspectorate 1983: 43). For domestic tasks such as cleaning, dusting or polishing there is little reported difference between authorities in these studies. The largest reported differences were for the tasks of shopping; 55 per cent of home helps carried out this task in Devon and Cornwall, in Warwickshire 43 per cent, Cumbria 20 per cent and 16 per cent in Hillingdon. Slightly smaller differences were found for washing clothes in the client's own home. For cooking, the figures varied from 25 per cent in Devon and Cornwall to 3 per cent in Hillingdon. Making beds also showed such differences. The basic nursing or personal caring tasks were not analysed to any degree in these studies (Marks 1975, Hillingdon 1977, May 1977, Gwynne and Fean 1978, Cheshire 1980).

As indicated, large differences have been found between authorities so it is perhaps not surprising that differences should be found also between home help teams within individual authorities. Tasks such as cleaning, washing, ironing, cooking, lighting fires and collecting pensions showed most variation (May 1977, Gwynne and Fean 1978). The purpose of this chapter is to explore the extent of the variation in tasks carried out by home helps and auxiliary nurses in differing authorities.

Home helps in my sample carried out nearly eight times more domestic tasks (on my list) than the nursing sample. Nursing auxiliaries however carried out on a regular basis four times as many basic nursing and six times as many nursing tasks than home helps. The data in table 10.1

indicate that home helps rank their number one task as domestic whereas auxiliary nurses see their priority as basic nursing. Home helps see nursing tasks as their lowest priority and auxiliary nurses domestic tasks. Home helps carry out predominantly domestic tasks whereas basic nursing tasks would seem to be a predominantly auxiliary nursing role (see table 10.1).

TABLE 10.1
Ranking of task groups by Home Helps and Auxiliary Nurses (Number of tasks performed as a percentage of all tasks within the group).

| Home Helps | | | Nursing Auxiliaries | | |
|------------|----------------|------------|---------------------|----------------|------------|
| Rank | Task | Percentage | Rank | Task | Percentage |
| 1 | Domestic | 50 | 1 | Basic Nursing | 69 |
| 2 | Miscellaneous | 39 | 2 | Miscellaneous | 43 |
| 3 | Personal | 35 | 3 | Administrative | 39 |
| 4 | Basic Nursing | 15 | 4 | Prof. Nursing | 25 |
| 5 | Advisory | 14 | 5 | Rehabilitative | 15 |
| 6 | Rehabilitative | 11 | 6 | Advisory | 14 |
| 7 | Administrative | 6 | 7 | Personal | 9 |
| 8 | Prof. Nursing | 4 | 8 | Domestic | 7 |

10.2 Overall Trends in Home Help Sample.

A number of authorities regularly appear in the list of authorities which report either the highest or the lowest number of tasks carried out. Those authorities which appear in the six highest never appear in any of the six lowest for any task group (see table 10.4). No pattern emerges, however, whereby home helps in any one authority carried out, say, the highest number of domestic tasks and the lowest number of basic nursing or personal tasks.

East Sussex home helps regularly carried out most tasks in each group,

for all but the advisory and miscellaneous tasks, in which they appear third and second respectively. Cleveland, Wigan, Rotherham, Oldham and Westminster all appeared in the top six for the majority of task groups. None of the authorities in which the fewest number of tasks were carried out appeared in the top six authorities for any individual tasks (see table 10.4). Cambridge, Northumberland and Hillingdon home helps carried out the least number of tasks in the majority of task groups (see table 10.2). North Tyneside staff provided the most restricted service in terms of the number of individual tasks carried out overall (see table 10.4).

TABLE 10.2
Ranking of Home Help Authorities by the average number of tasks carried out regularly in each group.

| RANKING OF LOCAL AUTHORITIES BY NUMBER OF HOME HELP TASKS REGULARLY CARRIED OUT | | | | | | | | |
|--|----------|---------------|---------|----------------|----------|----------|----------------|---------------|
| AUTHORITY | DOMESTIC | BASIC NURSING | NURSING | REHABILITATION | PERSONAL | ADVISORY | ADMINISTRATIVE | MISCELLANEOUS |
| EAST SUSSEX C.C. | 2 | 1 | 1 | 1 | 1 | 3 | 1 | 2 |
| CLEVELAND C.C. | 1 | 2 | 3 | 2 | 2 | 1 | 13 | 1 |
| ROTHERHAM M.B. | 7 | 4 | 4 | 4 | 5 | 6 | 2 | 10 |
| WIGAN M.B. | 3 | 3 | 5 | 5 | 4 | 4 | 15 | 6 |
| WESTMINSTER L.B. | 12 | 7 | 18 | 7 | 3 | 2 | 5 | 4 |
| OLDHAM M.B. | 20 | 13 | 12 | 6 | 6 | 5 | 7 | 3 |
| DEVON C.C. | 19 | 14 | 10 | 3 | 8 | 7 | 3 | 5 |
| DURHAM C.C. | 6 | 9 | 8 | 8 | 13 | 13 | 8 | 8 |
| BIRMINGHAM M.B. | 15 | 10 | 7 | 9 | 7 | 8 | 11 | 11 |
| DYFED C.C. | 4 | 5 | 6 | 12 | 14 | 11 | 17 | 7 |
| DUDLEY M.B. | 16 | 11 | 14 | 11 | 9 | 10 | 14 | 9 |
| DORCASTER M.B. | 8 | 8 | 16 | 10 | 20 | 17 | 4 | 16 |
| CROYDON L.B. | 11 | 6 | 9 | 14 | 18 | 19 | 9 | 20 |
| KIRKLEES M.B. | 13 | 12 | 13 | 20 | 17 | 14 | 10 | 12 |
| NORTH TYNESIDE M.B. | 17 | 15 | 2 | 16 | 15 | 18 | 9 | 17 |
| TRAFFORD M.B. | 9 | 20 | 11 | 19 | 12 | 9 | 16 | 15 |
| GREENWICH L.B. | 10 | 17 | 20 | 15 | 11 | 12 | 18 | 19 |
| CAMBRIDGE C.C. | 14 | 16 | 15 | 13 | 19 | 16 | 12 | 13 |
| HILLINGDON L.B. | 18 | 18 | 19 | 18 | 10 | 15 | 6 | 18 |
| NORTHUMBERLAND C.C. | 5 | 19 | 17 | 17 | 16 | 20 | 20 | 4 |

It is difficult from the results to extrapolate an overall picture of the home help role. There is obviously no such person as an average home help or such a service as an average home help service. However, as the data in tables 10.2 and 10.4 indicate, a pattern does emerge. Home help authorities can be divided into those in which a high, average and low number of tasks were carried out overall. The results could indicate that some authorities are attempting to meet demand by diluting their services but as the data in table 8.4 shows, the average hours per case (per year) does not differ very much in those authorities where a high or low average number of tasks are carried out. The same pattern emerges to some extent when the percentage of staff carrying out the tasks in each authority is examined (see table 10.4).

What then is the home help role in these three groupings of authority?

In the four authorities in which the highest number of tasks were carried out, two stand out from the others, East Sussex and Cleveland, who scored very high for all the task groups (except administrative tasks in Cleveland).

However, a number of individual tasks had a high priority in all authorities, such as washing dishes, cleaning, making beds, filling hot water bottles, collecting pensions, talking to clients and listening to their troubles. Those tasks not carried out very often on a regular basis were the more specialist professional nursing tasks, administrative tasks, helping children, advising on sexual matters or wills (see table 10.4).

Clients in authorities such as East Sussex, Rotherham Cleveland, Wigan or Westminster are supported by a wide range of home help tasks. Clients in such authorities as Greenwich, Cambridge, Hillingdon and

Northumberland tend to be provided with a more restricted range of domiciliary home help support. The range and type of tasks carried out may reflect the initiatives and policies of the authorities to meet local needs (Hurley & Wolstenholme 1978, Audit Inspectorate 1983: 43).

Why should there be such large differences between authorities, particularly in the areas of domestic, personal and basic nursing tasks? Authorities with a high percentage of dependent elderly clients might have home helps carrying out domestic and/or basic nursing tasks more regularly compared to authorities with different population or socio-economic factors (Audit Inspectorate 1983: 45-50). Other less obvious factors may play a part in determining which tasks are carried out for clients. The lack of basic household equipment such as washing machines, fridges or freezers may mean that a home help has to shop more often or wash clothes by hand or perhaps take home client's washing. The lack of suitable storage, equipment or space could involve the help in cooking meals more often. This lack of basic equipment may necessitate more shopping trips or trips to local laundries by home helps. The non-availability of local shops, post offices or public transport may also hinder the elderly person's ability to carry out such tasks as shopping or collecting pensions. Clients in high rise flats may also experience similar problems (Hutchinson 1975: 35, Barritt 1978: 39).

It was not possible to check with all authorities who took part in the survey how far these factors play a part in determining why such differences occur. However, from discussion, with managers in Doncaster, Rotherham, Kirklees and Hillingdon it is clear that many of the factors discussed play some part in determining what tasks are carried out for clients. A local authority's home help assessment policy or lack of

policies or priorities also may determine which tasks a home help carries out (Hurley & Wolstenholm 1979: 52, Howell et.al. 1979, Hayman 1980, Audit Inspectorate 1983: 79). However, even if the authority has a domiciliary care policy the home helps' own perception of what needs to be done is a powerful influence on the tasks they eventually perform (Gwynne and Fean 1978, Rust 1985: 22-24).

The home help organisers ability to assess client's needs, allocate resources and monitor the work of the home help also affects the service offered (Hunt 1970: 340, Marks 1975: 80, May 1977: 18). In a recent study, every referral to a home help service was assessed as suitable for home help support. Carpenter and Paley under controlled conditions showed a batch of 80 home help referrals to five groups of workers - social workers, home help organisers, occupational therapists, day/residential staff, assistant social workers - and asked them to decide to whom the cases should be allocated. Each group was more likely to choose themselves but the home help organisers and occupational therapists were most likely to allocate the cases to their particular group (Carpenter and Paley 1985: 28). This raises the question, are the tasks that home helps carry out in a particular authority partially the result of which professional group carries out the initial assessment?

In my study the high level of involvement by East Sussex home help staff in rehabilitative and basic nursing roles may reflect just this situation. The sample in East Sussex was a 'patch team' which did not employ specialist domiciliary organisers. Assessments of clients were carried out by team members, mostly social workers, and the work allocated by them to home helps accordingly. Was this a reason why such a variety of tasks were carried out for clients in this authority? There

were too few home helps in the sample to draw serious conclusions but the results do indicate that perhaps the home help role is influenced by whoever manages the service, home help organisers or social workers (Amos 1975: 20). However, the other authority where many tasks were carried out, Cleveland, had a traditional structure of home help organisers and home help staff and was a random sample across the authority. Why such differently structured services should have similar results is puzzling. Without a detailed investigation of the policies, management structures, population structure and other domiciliary services any explanation can only be speculative. Even in authorities where the administrative policies and instructions to home helps militate against the provision of a basic nursing service, home helps carry out these tasks (Rust 1985: 22).

Although a high or low number of tasks may be carried out in authorities in each task group, when tasks within those individual groups are analysed tentative reasons can be put forward as to why particular tasks are carried out in some authorities. Localised social characteristics must be taken into consideration, for instance the need for a firelighting service in coal mining areas such as Doncaster, where council policy determines that open or coal burning central heating systems are installed in council housing. The tasks carried out may also be determined by the perception that the client, local councillors or organisers have of the role of the service. The results indicate that in some authorities the role of the home help is restricted and in others she is encouraged to carry out a wide and varied range of tasks (Hurley and Wolstenholme 1979).

Having discussed general trends between authorities I propose in the

next section to examine in some detail the trends between authorities within the different task groupings. In this section I shall be using two different measures. One is the average number of tasks performed by the average individual home help which will give an indication of the spread of tasks performed in authorities and the other the average number of home helps who regularly perform tasks.

10.3 Trends in Local Authorities by Task Groups.

a. Domestic Tasks.

There were only small differences between the authorities in which the highest average number of domestic tasks per worker were carried out and those with the lowest number (see table 9.3). The percentage of home helps who regularly carry out individual domestic tasks in each authority varied considerably. For instance, the number of staff who cooked varied widely. The highest scores were in East Sussex (83%), Rotherham (82%), Wigan (76%) and Doncaster (63%). The lowest percentages recorded for this task averaged 36 per cent in five authorities (see table 10.4).

In four authorities, over 80 per cent of home helps prepared and served meals; in many less than half did so. In five authorities over two-thirds of home helps washed bed clothes, in four under 40 per cent did so. In coal mining areas, the number of home helps who carried coal or lit fires was understandably high. Staff in East Sussex, Rotherham and Doncaster scored high for most of the domestic tasks but, for example, Doncaster was in the lower range for the tasks of washing dishes or bed

TABLE 10.3.
AVERAGE NUMBER OF TASKS CARRIED OUT BY HOME HELPS IN THE TOP SIX AND
BOTTOM SIX AUTHORITIES IN EACH CATEGORY.

| DOMESTIC TASKS | | BASIC NURSING TASKS | | PERSONAL TASKS | | REHABILITATIVE TASKS | | ADVISORY TASKS | | ADMINISTRATIVE TASKS | | P. NURSING TASKS | | MISCELLANEOUS TASKS | |
|---------------------|--------|---------------------|--------|---------------------|--------|----------------------|--------|---------------------|--------|----------------------|--------|---------------------|--------|---------------------|--------|
| Authority | Number | Authority | Number | Authority | Number | Authority | Number | Authority | Number | Authority | Number | Authority | Number | Authority | Number |
| Cleveland C.C. | 11.5 | East Sussex C.C. | 6.5 | East Sussex C.C. | 6.5 | East Sussex C.C. | 4.5 | Cleveland C.C. | 2.3 | East Sussex C.C. | 2.0 | East Sussex C.C. | 1.3 | Cleveland C.C. | 5.2 |
| East Sussex C.C. | 11.0 | Cleveland C.C. | 5.0 | Cleveland C.C. | 5.2 | Cleveland C.C. | 4.1 | Westminster L.B. | 1.9 | Rotherham M.B. | 1.2 | North Tyneside M.B. | 1.3 | East Sussex C.C. | 4.8 |
| Wigan M.B. | 10.3 | Wigan M.B. | 4.9 | Westminster L.B. | 5.0 | Devon C.C. | 3.3 | East Sussex C.C. | 1.8 | Devon C.C. | 1.2 | Cleveland C.C. | 1.3 | Oldham M.B. | 4.2 |
| Dyfed C.C. | 10.3 | Rotherham M.B. | 4.4 | Wigan M.B. | 4.8 | Rotherham M.B. | 3.3 | Wigan M.B. | 1.7 | Doncaster M.B. | 0.6 | Rotherham M.B. | 1.0 | Westminster L.B. | 4.2 |
| Northumberland C.C. | 10.2 | Dyfed C.C. | 3.5 | Rotherham M.B. | 4.7 | Wigan M.B. | 2.7 | Oldham M.B. | 1.5 | Westminster L.B. | 0.6 | Wigan M.B. | 1.0 | Devon C.C. | 4.1 |
| Durham C.C. | 9.5 | Croydon L.B. | 3.1 | Oldham M.B. | 4.3 | Oldham M.B. | 2.7 | Rotherham M.B. | 1.5 | Hillingdon L.B. | 0.5 | Dyfed C.C. | 0.9 | Wigan M.B. | 4.0 |
| MEAN | 8.5 | MEAN | 2.6 | MEAN | 3.9 | MEAN | 1.8 | MEAN | 1.1 | MEAN | 0.4 | MEAN | 0.5 | MEAN | 3.5 |
| Birmingham M.B. | 8.0 | North Tyneside M.B. | 2.1 | North Tyneside M.B. | 3.7 | Greenwich L.B. | 1.2 | Hillingdon L.B. | 0.9 | Wigan M.B. | 0.3 | Cambridge C.C. | 0.4 | Trafford M.B. | 3.1 |
| North Tyneside M.B. | 7.9 | Cambridge C.C. | 2.0 | Northumberland C.C. | 3.5 | North Tyneside M.B. | 1.1 | Cambridge C.C. | 0.7 | Trafford M.B. | 0.2 | Doncaster M.B. | 0.3 | Doncaster M.B. | 3.1 |
| Dudley M.B. | 7.8 | Greenwich L.B. | 1.9 | Kirklees M.B. | 3.4 | Northumberland C.C. | 1.1 | Doncaster M.B. | 0.6 | Dyfed C.C. | 0.1 | Northumberland C.C. | 0.3 | North Tyneside M.B. | 3.0 |
| Hillingdon L.B. | 7.7 | Hillingdon L.B. | 1.9 | Devon C.C. | 3.2 | Westminster L.B. | 1.1 | North Tyneside M.B. | 0.5 | Greenwich L.B. | 0.1 | Westminster L.B. | 0.3 | Hillingdon L.B. | 3.0 |
| Devon C.C. | 7.7 | Northumberland C.C. | 1.8 | Cambridge C.C. | 3.0 | Trafford M.B. | 1.0 | Croydon L.B. | 0.4 | North Tyneside M.B. | 0.0 | Hillingdon L.B. | 0.2 | Greenwich L.B. | 3.0 |
| Oldham M.B. | 7.6 | Trafford M.B. | 1.2 | Doncaster M.B. | 2.2 | Birmingham M.B. | 1.0 | Northumberland C.C. | 0.4 | Northumberland C.C. | 0.0 | Greenwich L.B. | 0.2 | Croydon L.B. | 2.8 |

clothes, ironing or sewing, laundry in client's home and looking after plants. The data in table 10.4 clearly indicates the range and variation of domestic tasks carried out by home helps in differing authorities.

b. Basic Nursing Tasks.

On average between two and three basic nursing tasks were carried out in each authority by home helps. However, East Sussex staff carried out three times more tasks than the majority of other authorities. Clients in North Tyneside, Cambridge, Greenwich, Hillingdon, Northumberland and Trafford were least likely to have basic nursing tasks carried out for them (see table 10.3).

Twenty one per cent of home helps in Cleveland said that they bathed clients in bed or gave a blanket bath compared to few if any in other authorities. Nearly all home helps in East Sussex helped get clients out of bed on a regular basis compared to only just under half in other authorities.

The percentage of home helps regularly carrying out basic nursing tasks in differing authorities also varied widely. For example, in five authorities about one-third of home helps got clients out of bed but in six less than eight per cent did so. Washing client's hair was a task only carried out to any extent in four authorities (see table 10.4).

In a quarter of authorities home helps never carried out 'intimate care' of clients and in many authorities few home helps stated that they carried out such tasks as bathing clients in bed or bath, giving blanket bath, assisting with surgical appliances or colostomy and shaving clients.

c. Professional Nursing Tasks.

Professional nursing tasks were not regularly carried out in a number of authorities. However, despite the low number of home helps regularly carrying out these tasks, five authorities in which the highest average number of tasks were carried out had over double the number of tasks compared to the mean (see table 10.3).

For many tasks there were large differences between authorities. In three authorities, for instance, about one-third of staff stated that they applied simple dressings, in five less than two per cent. Removing stitches, taking blood pressure, syringing ears, giving enema or douch and helping to lay out the dead were tasks not carried out in any authority to any significant degree.

d. Personal Tasks.

The average number of personal tasks carried out in East Sussex was three times higher than for Doncaster and about twice as high as for Northumberland, Devon, Kirklees or Cambridge (see Table 10.3). However, many tasks such as those of washing, dressing and getting up children and telephoning on behalf of clients were not regularly carried out by home helps in many authorities.

The percentage of staff in differing authorities who stated that they carried out the tasks also varied considerably. Collecting pensions was a task carried out by practically all staff in the top three authorities but by less than two-thirds in the bottom three. Collecting pills and medicines was carried out by most of home helps but in Doncaster only one in five did so. Shopping was a task also carried out by most home helps in every authority.

e. Advisory Tasks.

Many of the advisory tasks, particularly those of advising on sexual matters, helping clients to make a will, helping with admission to old persons' home or checking on welfare benefits were not carried out in a number of authorities but the average number of advisory tasks performed varied considerably between authorities.

There were large differences between authorities for the tasks of regularly 'be adviser to clients' and advising on personal hygiene. In the three top authorities about half of the home helps saw themselves as being adviser to clients. However, few staff in Rotherham, Northumberland and Cambridge said they advised on admission to old persons' home, personal hygiene, welfare benefits or wills.

For all but the task 'be adviser to clients' there were many authorities where no staff carried out advisory tasks regularly (see table 10.4).

In most authorities home helps did not carry out the tasks of helping with admission to old people's homes, advising on sexual matters, welfare benefits or wills. The authorities who had the highest percentage carrying out these tasks were East Sussex and Sutton. In only two authorities, Durham and Enfield, did staff ever advise on sexual matters.

f. Rehabilitative Tasks.

Cleveland and East Sussex provide a significantly different rehabilitative service than most authorities. In these two authorities four times as many rehabilitative tasks were regularly carried out compared to just over one-third of the authorities in the sample.

Most of the tasks however were stated to have been carried out to some

degree in the majority of authorities, the most popular being those of encouraging clients to make friends and to do their own work.

The tasks of training clients to shop, cook, budget, and clean were carried out by between 17 and 33 per cent of home helps in five authorities but in the remaining authorities few home helps carried out these tasks (see table 10.4).

g. Administrative Tasks.

Few administrative tasks were carried out but three authorities, East Sussex, Rotherham and Devon, had double the frequency of other authorities. Talking to colleagues about the best way to help clients was a task carried out in many authorities (see table 10.3). Writing or reading reports or completing written reviews on clients were only carried out by few home helps in a number of authorities.

The largest percentage of staff carrying out the task of writing reports were in Devon (17%) and Dyfed (11%). One in ten home helps stated that they read reports in Devon. Staff in East Sussex, Rotherham and Doncaster were most likely to receive regular supervision from organisers but in the majority of authorities this form of support was not regularly offered (see table 10.4); but over half of the home help staff in East Sussex, 41 per cent in Rotherham and one-quarter in Devon attended meetings to plan treatment programmes for clients.

h. Miscellaneous Tasks.

On average few miscellaneous tasks are carried out by home helps. The highest number was in Cleveland and the lowest in Croydon (see table 10.4). There were not large differences between authorities in the

number of tasks carried out but there were wide differences when individual tasks are analysed.

Home helps in a number of authorities were not regularly involved in preparing clients for admission to hospital or old people's homes or staying around while the client was having a bath. A large percentage carried out the remaining tasks in some authorities but apart from chatting or talking to clients, listening to their troubles or being a friend the number of home helps carrying out the tasks was fairly low.

10.4 Overall Trends: Auxiliary Nursing Sample.

There is no consistent pattern, such as appeared in the home help sample, for the nursing auxiliary sample when health districts are analysed for overall trends.

Few health districts appear more than once in the top six districts with the highest number of tasks carried out in them or in the lowest group. This is in part explained by the number of health districts sampled. However, there is in many of the task groups a large difference between the number of tasks carried out by the higher and lower grouping of health districts. The district of Paddington and North Kensington appears in the top six for the domestic and basic nursing tasks and in the six lowest for the professional nursing tasks. West Birmingham appears in the top six districts for the domestic and basic nursing tasks but in the lowest six for the miscellaneous tasks. Domestic tasks were regularly carried out by few auxiliary nurses and the differences in the number of tasks carried out in each health

district was not as large as for the home help sample. Most of the basic nursing tasks were carried out by some auxiliary nurses; however, those of shaving, feeding clients and helping with colostomies were not carried out in many health districts. Although some health districts appear two or three times either in the group of districts with the highest or lowest number of tasks carried out, the results indicate that most health districts have a consensus as to the role of the auxiliary nurse.

There were large differences between health districts for individual professional nursing tasks but a number of them were not carried out on a regular basis in many health districts. Nursing auxiliaries were less likely, compared to the home help sample, to carry out rehabilitative tasks but were more likely to carry out the administrative ones.

However, for many of these tasks (administrative) there were large differences between health districts; for example; completing written reviews, attending supervision sessions and helping to train new staff were not carried out in many districts. However, completing written reviews on clients was carried out by all nursing auxiliaries in one district and in a number of districts over 80 per cent of staff said they write reports on clients. Few nursing auxiliaries state that they receive regular supervision, attend meetings or talk to colleagues about the best way to help clients.

Talking to clients' visitors was a task not carried out by many auxiliary nurses in a number of districts, nor was the task of keeping in touch with clients' relatives, friends or visitors. Auxiliary nurses see their role as task orientated and so many do not see the value of supporting relatives and friends who look after dependent clients. Home

helps by chatting and talking to relatives and friends of the client provide much needed emotional support to carers. Nurses in only a few districts saw themselves as companions or friends to clients. In very few health districts did auxiliary nurses say that they help prepare clients for admission to old people's homes or hospital.

10.5 Summary and Conclusions.

It is clear from the average amount of home help time allocated per client that the home help coverage of clients in the community is very different for differing authorities (Personal Social Service Statistics 1982/3 1983 and Audit Inspectorate 1983: 49). However, most of the tasks identified in this study are carried out in every home help authority. Substantially different services are not provided in differing authorities. Those in which a high percentage of home helps carry out more tasks than other authorities might seem to be offering a more concentrated service. Those in which a lower percentage of home helps are carrying out tasks could be said to be offering a more diluted but similar service. What is clear, however, is that authorities offer a wide range of home help support (see table 10.4).

My results provide evidence to support the argument of Dexter and Harbert that in the face of increased needs, in many authorities home help cover has been a "more highly prized goal than intensity" (1983: 90). Authorities in the bottom group all offer the same service but the various tasks are not carried out as regularly as in the top group. For instance, most home helps in the top group regularly help clients to or from the toilet, make beds, get clients out of bed and change their

clothes. On the other hand home helps in the bottom group seldom carry out these tasks. This situation also applies for many other tasks.

However, this is not the full picture, as I have discussed. Some small success has been achieved in developing specialist services to meet the particular needs of certain clients.

My results provide evidence for the argument that some authorities are providing a home help service as part of a programme of care which in many instances has a rehabilitative, educative and basic nursing element.

The home help and auxiliary nursing service has to be seen as an integral part of the personal caring services. The extent, diversity and quality of care provided is determined not just by the level of public expenditure or the skills of the staff concerned but by the extent to which the home helps and to some extent the nursing auxiliary perceive their role and are perceived by other professionals (Gwynne and Fean 1978). Little relationship has been found between client need, as indicated by the clients personal capacity and circumstances of living, and service received (Gwynne and Fean 1978, Howell et.al. 1979 and Hurley and Wolstenholme 1979). The provision of services has been found to differ in each health district and local authority to the same extent as in my study. The 'social fabric' of a particular authority is an important consideration in deciding what tasks should be carried out for clients. Such key indicators as population, economic activity, transport or housing policies determine to some extent the type of home help service but more localised social characteristics must also be taken into account. I have pointed to the need for home helps to light fires in mining areas, a fact also commented upon by Osbourn (1978). The Audit

Inspectorate in their study of a number of authorities found no relationship between the home help service and residential care; they found a lack of relationship between residential places and the provision of home helps (Audit Inspectorate 1983: 69).

Other factors in certain areas influence the type of service offered. The London Borough of Barnet highlighted the self help capacity of the local Jewish and Asian communities, Harrow the high concentration of elderly owner-occupiers and Bradford the decaying industry and surrounding rural hills with their diverse population (Hedley and Norman 1982: 17). The support that a family can give its handicapped or elderly member differs from area to area dependent on the population structure. The sex of the recipients or whether they pay for the service or not, are factors in determining what tasks are carried out for the client by the home help (Howell, Boldy and Smith 1979, Hayman 1980).

These considerations do not seem to play such an important part in the level or diversity of service offered by the auxiliary nurse. There are few differences in the service provided in differing health authorities although in some, certain basic nursing tasks are not carried out (see appendix).

Reading or writing reports on clients was only carried out regularly by small groups of home helps in two or three authorities. However, the percentage in each authority who stated that they attended supervision sessions varied from 67 per cent to nil. Whether home helps received this form of support did not seem to affect their rehabilitative role. A high percentage of staff in East Sussex and Rotherham stated that they attended supervision sessions and carried out many rehabilitative tasks regularly. On the other hand, many home helps in Cleveland

regularly carry out rehabilitative tasks but do not attend supervision sessions.

My discussion on the data in this chapter has shown that the work of the home help, unlike the auxiliary nurse, varies appreciably from authority to authority. In some the service is still perceived as simply providing a domestic service; in others it provides a wide range of services. It is possible that these developments have occurred in many cases without any systematic analysis of what the home help actually does or how she perceives her role. A group of home helps emerged, usually specially recruited for their extra tact and flexibility, participating in special projects. Has enough notice been taken of the views of existing home helps? Are they prepared to or able to offer a wider spectrum of services to their clients? These issues are discussed in the next chapter.

Studies have highlighted the range of jobs home helps carry out in their own time for their clients (see Howell, Boldy and Smith 1979). There is also some evidence that many managers, for various reasons, refuse to recognise the wide range of tasks carried out (Simons and Warburton 1980). As a result, only part of the home helps' role is recorded and communicated to managers and other workers in the social services field. A few studies have recorded, in passing, home helps' views about the tasks they carry out. Hutchinson highlighted the satisfaction that some home helps got from carrying out domestic work, cooking and shopping. Others derived satisfaction from getting their clients out of bed and helping them to dress. However, a number stated that they had difficulty with these tasks. Many objected to emptying and cleaning commodes (Hutchinson 1975: 35).

A study in Gwynedd found that just over half of the home helps in the authority thought that heavy manual work was someone else's job. Only 14 per cent did not see basic nursing care as their job. Teaching clients to do domestic jobs was seen by over 80 per cent as their role. The study concluded "home helps appeared to be very flexible in their feelings about how they could be 'used' and, apart from one or two obvious examples, the range of tasks or roles which they theoretically take on board appears to be quite expansive" (Gwynedd County Council 1977: 11).

One of the problems also highlighted by my study is that of definition of tasks. I have in this study taken into account this difficulty but until a common definition of tasks is agreed and used, discussions as to the role of the home help or nursing auxiliary will remain at an ill informed level which makes it difficult to conceptualise some of the fundamental and important items needing debate, one of which is how do they see their role. This aspect of the study is discussed in the next chapter.

CHAPTER ELEVEN

Home Helps and Auxiliary Nurses Perception of their Role.

11.1 Introduction.

Hunt's study is the only study up till now to investigate what perception home helps had of their role. Her results showed that in the late 1960s many home helps saw their role as a domestic one. I wish to examine the home help and auxiliary nurses' perception of their role so as to obtain some indication of their flexibility, willingness to change and reaction to client need. The home helps' and auxiliary nurses' willingness to carry out a task is analysed. This is not the same as stating that the participant would actually carry out the task if the situation warranted it.

In this chapter what is actually measured is the home help's or auxiliary nurse's stated opinion or attitude towards whether a specific task is her job or someone else's. The study of this opinion is of interest only in so far as it is a symbol of the participant's attitude towards the task. No pretence is made that my survey gives a definitive analysis of attitudes; it merely counts how many home helps or auxiliary nurses chose to express certain views about certain tasks. It has not

been possible to go beyond this approach and measure extremity and strength of the underlying attitude. The chief difficulty of assessing the validity of the attitudes expressed is the lack of criteria. I do not have groups of home helps or auxiliary nurses with known attitude characteristics, so that I can see whether or not my questions can discriminate between them (Oppenheim 1976: 75). The most expedient and direct way of determining a home help or auxiliary nurse's interest in different types of tasks would be simply to ask them in a straight forward manner (Oppenheim 1976: 77). However, there is also evidence which shows that answers to direct questions about interests, attitudes or opinions may be unreliable and unrealistic (Anastasi 1961: 529). To ask a home help if a task is the responsibility of an auxiliary nurse or social worker would be unsound as the home help may not have sufficient information about their role to form an opinion. A second factor is the prevalence of stereotypes regarding these groups of workers. It was for these reasons that I asked the participants whether they thought the task was their job or someone else's and not just that of the auxiliary nurse or home help.

However, certain writers, notably Lieberman, have suggested that changes in role can lead to changes in attitude which leads to changes in actions (Lieberman 1975: 414). If this is true it in effect means that the more the role of the home help changes the better the chance for attitude change. This change could, however, be for or against a particular aspect of the role change.

Measuring opinions is an easier task than measuring attitudes. (Nachmias & Nachmias 1981: 209-210). The measurement of attitudes is a subject of recurrent controversy and debate. Whether expressed opinions can be

regarded as indicators of 'real' attitudes has frequently been questioned. Discrepancies between expressed attitudes and overt behaviour have been noted in a number of studies (Corey 1937: 271-280, LuPiere 1934: 230-237, Oppenheim 1976: 105-154). Behaviour as pointed out by Oppenheim does not have a simple one-to-one relationship with one type of inner determinant such as attitude; the "relationship is complex and will involve both other attitudes and character traits and environmental determinants" (Oppenheim 1976: 153). One way to partly overcome this problem is to obtain an indication of attitudes by providing anonymity and confidentiality to the participants (Anastasi 1961: 544). These two factors operated in my study, but we still cannot presume that attitudes and actions are identical.

There is no one correct answer to any of my questions. The answers given will depend on the aspect of the issue that is uppermost in the participant's mind - "quite possibly because the wording of the question, or the context created by the previous ones, has put it there" (Moser 1969: 221). There is much evidence that the order of questions may affect the answers obtained, especially so when one is concerned with opinions (Moser 1969: 232). One method of overcoming this problem is to randomise the questions. In many surveys this is not possible but in my case it was. However, the problem of 'social adjustment' or 'social desirability' also influences opinions. By holding certain views people identify with, or, indeed, differentiate themselves from various 'reference groups' within the population, groups in terms of whose standard the individual judges himself, with which he identifies or feels kinship (Smith, Bruner and White 1975: 367, Oppenheim 1976: 117). Therefore home helps will be expected to answer these questions in such

a manner which will say 'I am like other home helps', the participant may tend to answer the question so as to identify with home helps and not auxiliary nurses. This factor must be taken into account when discussing the results.

11.2 Perception of Domestic Role.

Studies indicate that many home helps worked in the domestic field before taking up the post. Others became home helps because of their liking for housework (Hutchinson 1975: 28, Marks 1975: 30). About half of Hunt's sample in 1967 stated that they perceived their role as a domestic one. Table 11.1 shows that the majority of home helps in my sample also saw domestic tasks as their job. It is obvious from their replies that many see these tasks as very much part of their role.

The largest discrepancies between aspiration and actuality in the home help sample were for the tasks of cooking, preparing food and serving it, sewing and watering plants, lighting fires and carrying coal. As table 11.1 shows, for most of these tasks there was a substantially greater number of home helps compared to auxiliary nurses who saw these tasks as their role.

Apart from the tasks of cleaning and emptying commodes, which the majority of both groups saw as their job, home helps were more likely to see their role as a domestic one compared to auxiliary nurses. Clearly home helps are regularly carrying out domestic tasks and see it as their job to do so. On the other hand, very few auxiliary nurses do so and only slightly more see it as their role. With two or three exceptions,

virtually all home helps saw all the tasks as their role but, again with two or three exceptions virtually none of the auxiliary nurses did.

TABLE 11.1
Difference in percentage of Home Helps and Auxiliary Nurses regularly carrying out Domestic tasks and those who stated that tasks were 'their job'.

| Task | Home Help | | | Auxiliary Nurse | | |
|----------------|-----------|--------|------|-----------------|--------|------|
| | * Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Cook dinner | | | | | | |
| Tea/Breakfast | 43 | 95 | 52 | 3 | 9 | 6 |
| Prepare Food. | 49 | 96 | 47 | 2 | 7 | 5 |
| Serve Meals. | 43 | 93 | 50 | 2 | 8 | 6 |
| Wash Dishes. | 84 | 98 | 14 | 1 | 3 | 2 |
| Clean | | | | | | |
| Furniture. | 96 | 99 | 3 | 0 | 0 | 0 |
| Wash Bedcloth. | 50 | 84 | 34 | 0 | 2 | 2 |
| Iron. | 58 | 96 | 38 | 0 | 1 | 1 |
| Sew. | 22 | 80 | 58 | 0 | 1 | 1 |
| Laundry in | | | | | | |
| Clients' Home. | 55 | 92 | 37 | 0 | 1 | 1 |
| Hang Curtains. | 61 | 95 | 34 | 0 | 1 | 1 |
| Water/Look | | | | | | |
| after Plants. | 24 | 77 | 53 | 0 | 3 | 3 |
| Clean Windows/ | | | | | | |
| Floors. | 97 | 99 | 2 | 0 | 1 | 1 |
| Make/light | | | | | | |
| Fires. | 40 | 92 | 52 | 2 | 9 | 7 |
| Carry wood/ | | | | | | |
| Coal. | 37 | 87 | 50 | 1 | 3 | 2 |
| Lock/unlock | | | | | | |
| Clients Home. | 21 | 57 | 36 | 27 | 51 | 24 |
| Empty Commode. | 39 | 84 | 45 | 51 | 84 | 33 |
| Clean Commode. | 38 | 82 | 44 | 35 | 62 | 26 |
| Total | | | 1037 | | | 1368 |

(* Reg. = Regularly. My Job = Stated that it was their job. Dif. = Difference in percentage of those who stated that they regularly carried out the task and stated that it was their role).

11.3 Perception of Basic Nursing Role.

TABLE 11.2

Difference in the percentage of Home Helps and Auxiliary Nurses who stated that Basic Nursing tasks were 'their job' and who regularly carried them out.

| Task | Home Help | | | Auxiliary Nurse | | |
|--|-----------|--------|------|-----------------|--------|------|
| | Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Get client out , of bed, | 15 | 67 | 52 | 3 | 8 | 5 |
| Bath client in bed/blanket bath, | 2 | 8 | 6 | 79 | 96 | 17 |
| Bath client in bath, | 2 | 7 | 5 | 82 | 91 | 9 |
| Shave client, | 2 | 15 | 13 | 13 | 63 | 50 |
| Wash client's hair, | 15 | 52 | 37 | 55 | 84 | 29 |
| Feed clients, | 10 | 65 | 55 | 4 | 34 | 30 |
| Dress/undress client, | 21 | 72 | 51 | 94 | 98 | 4 |
| Change incontinent client, | 9 | 39 | 30 | 39 | 99 | 60 |
| Intimate care of cl., | 4 | 15 | 11 | 94 | 98 | 4 |
| Assist with surgical appliances, | 3 | 24 | 21 | 41 | 93 | 52 |
| Help client with Colostomy, | 1 | 6 | 5 | 21 | 72 | 54 |
| Make client comfortable in bed/chair, | 37 | 94 | 57 | 92 | 100 | 8 |
| Make client's bed, | 85 | 99 | 14 | 45 | 76 | 31 |
| Take client to/from toilet, | 12 | 78 | 66 | 70 | 97 | 27 |
| Assist client to/from bedroom, | 16 | 83 | 67 | 63 | 97 | 14 |
| Change client's clothes, | 19 | 78 | 59 | 90 | 98 | 8 |
| Cut finger/toe nails, | 7 | 23 | 16 | 79 | 89 | 10 |
| Total | | 1037 | | | 1368 | |

All the basic nursing tasks listed were thought by some home helps to be their job. Over half stated that getting clients out of and making beds, dressing or undressing them, washing them, washing their hair, making them comfortable in either bed or chair and helping to feed them was their role. Many home helps who did not see these tasks as their role were prepared to carry them out occasionally (see appendix).

What is interesting is that although many of the tasks are not regularly

carried out by home helps, many are prepared if necessary to do them. For example, only two per cent of home helps stated that they regularly shaved clients but 15 per cent expressed a willingness to do so. Nine percent regularly changed incontinent clients but 39 per cent agreed it was their job (see table 11.2).

Tasks such as bathing, shaving, cutting finger/toe nails and helping clients with their colostomy are more likely to be carried out by auxiliary nurses who also see these jobs as very much being their role.

The tasks which show the largest discrepancies between those who stated that they regularly carried them out and those who saw it as their role to do so were in the areas of dressing and undressing clients, taking them to/from toilets, changing and making clients comfortable in their bed or chair and feeding them. Few auxiliary nurses regularly helped clients out of bed. This result may be accounted for by the fact that the auxiliary nurses clients may be more likely to be bedbound than those of the home help.

The results indicate that many staff in both samples see basic nursing tasks as their job but home helps are less likely to see the more 'specialised' basic nursing tasks as their role (see table 11.2).

11.4 Perception of Professional Nursing Role.

Few home helps say that they regularly carry out or see it as their role to give injections, test urine, give enema or douche, syringe client's ears, remove stitches, take client's blood pressure or lay out dead clients. Slightly more auxiliary nurses saw it as their role to carry out these tasks.

TABLE 11.3

Difference in the percentage of Home Helps and Auxiliary Nurses who stated that Professional Nursing tasks were 'their job' and who regularly carried them out.

| Task | Home Help | | | Auxiliary Nurse | | |
|-------------------------|-----------|--------|------|-----------------|--------|------|
| | Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Give injection. | 1 | 1 | 0 | 0 | 3 | 3 |
| Check medicines. | 25 | 50 | 25 | 32 | 59 | 27 |
| Administer medicines. | 13 | 40 | 27 | 16 | 59 | 43 |
| Administer ointments. | 7 | 42 | 35 | 70 | 97 | 27 |
| Apply simple dressing. | 6 | 65 | 60 | 53 | 94 | 41 |
| Carry out urine test. | 0 | 2 | 2 | 16 | 54 | 38 |
| Help lay out dead. | 0 | 5 | 5 | 5 | 35 | 30 |
| Care of pressure areas. | 2 | 12 | 10 | 89 | 97 | 8 |
| Apply eye drops. | 4 | 36 | 32 | 40 | 86 | 46 |
| Give enema or douch. | 0 | 1 | 1 | 3 | 15 | 12 |
| Syringe clients ears. | 0 | 1 | 1 | 0 | 2 | 2 |
| Remove stitches. | 0 | 1 | 1 | 0 | 3 | 3 |
| Take blood pressure. | 0 | 1 | 1 | 0 | 7 | 7 |
| Total. | | | 1037 | | | 1368 |

For the majority of the tasks, many more home helps and auxiliary nurses were prepared to carry them out than stated they regularly do so. A higher percentage of home helps and auxiliary nurses who perceived the tasks of checking medicines, administering them and applying simple dressings as their role did not regularly carry them out (see table 11.3).

11.5 Perception of Advisory Role.

Less than one-quarter of home helps stated that they saw it as their role to 'Be adviser to clients'; however, many more saw it as their role to give advice on specific matters like personal hygiene and safety in the home. For only one task (Be adviser to clients) was there less who saw this task as their role than who said that they regularly carried

it out. Hunt (1970) found that almost half of her sample saw it as their role to offer advice.

TABLE 11.4

Difference in the percentage of Home Helps and Auxiliary Nurses who stated that Advisory tasks were 'their job' and who regularly carried them out.

| Task | Home Help | | | Auxiliary Nurse | | |
|---|-----------|--------|------|-----------------|--------|------|
| | Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Be adviser to client. | 26 | 21 | - 5 | 21 | 51 | 30 |
| Give advice on personal hygiene. | 25 | 50 | 25 | 32 | 59 | 27 |
| Advise on sexual matters. | 0 | 5 | 5 | 0 | 4 | 4 |
| Advise on safety in home. | 28 | 79 | 51 | 29 | 69 | 40 |
| Help client sort out bills. | 28 | 77 | 49 | 2 | 8 | 6 |
| Help client make will. | 1 | 6 | 5 | 0 | 1 | 1 |
| Help with admission to OPH. | 1 | 15 | 14 | 2 | 14 | 12 |
| Check client is getting welfare benefits. | 14 | 42 | 28 | 10 | 23 | 13 |
| Total. | | 1037 | | | 1368 | |

(the only minus result was for the task of 'be adviser' to clients in the home help sample).

Both groups saw helping with the problems of personal hygiene as their role, an acute problem for many elderly dependent people living alone in ill-equipped housing.

Many more auxiliary nurses "gave advice" at 'some time' compared to home helps (see appendix eight). Seventy eight percent of home helps saw this task as their role, 52 percent more than who stated that they regularly carried out the task (see table 11.4)

11.6 Perception of Personal Role.

Most home helps saw it as their role to carry out the tasks of collecting pills and medicines, pensions, shopping, filling hotwater

bottles, telephoning, reading letters and giving emotional support to clients. Nearly two-thirds saw the remaining tasks as their job.

TABLE 11.5

Difference in percentage of Home Helps and Auxiliary Nurses who stated that Personal tasks were 'their job' and who regularly carried them out.

| Tasks, | Home Help | | | Auxiliary Nurse | | |
|--------------------------------|-----------|--------|------|-----------------|--------|------|
| | Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Collect pension, | 43 | 93 | 50 | 2 | 8 | 6 |
| Collect pills and medicines, | 93 | 93 | 0 | 28 | 28 | 0 |
| Shop for client, | 90 | 99 | 9 | 1 | 4 | 3 |
| Fill hot water bottles, | 21 | 91 | 70 | 19 | 69 | 50 |
| Telephone on behalf of client, | 36 | 97 | 61 | 8 | 61 | 53 |
| Complete forms, | 13 | 67 | 54 | 6 | 24 | 18 |
| Read letters for client, | 29 | 90 | 61 | 5 | 50 | 45 |
| Clean wheelchairs etc, | 20 | 63 | 43 | 4 | 17 | 13 |
| Wash/dress get up child, | 4 | 64 | 60 | 1 | 5 | 4 |
| Give emotional support, | 41 | 91 | 50 | 52 | 88 | 36 |
| Total, | | | 1037 | | | 1368 |

There was a large variation between home helps and auxiliary nurses although the extent to which their perception of tasks are complementary is fairly large. Auxiliary nurses were less likely to see it as their role to carry out tasks such as collecting pension, shopping and washing or dressing children. Collecting pills or medicines was the only task, in both samples in the project for which the percentage who regularly carried it out was the same as the percentage who saw it as their role to do so.

11.7 Perception of Rehabilitative Role.

TABLE 11.6

Difference in percentage of Home Helps and Auxiliary Nurses who stated that Rehabilitative tasks were 'their job' and who regularly carried them out.

| Tasks, | Home Help | | | Auxiliary Nurse | | |
|---------------------------------------|-----------|--------|------|-----------------|--------|------|
| | Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Encourage clients to do own work, | 16 | 81 | 65 | 13 | 49 | 36 |
| Encourage clients to do own cleaning, | 19 | 83 | 64 | 12 | 36 | 24 |
| Encourage clients to make friends, | 32 | 89 | 57 | 35 | 79 | 43 |
| Encourage clients to do exercises, | 7 | 41 | 34 | 32 | 78 | 46 |
| Teach client to do things, | 19 | 74 | 55 | 47 | 84 | 37 |
| Teach lifting techniques, | 1 | 15 | 14 | 29 | 72 | 43 |
| Help client change behaviour, | 7 | 42 | 35 | 10 | 44 | 34 |
| Help client to walk, | 18 | 68 | 50 | 74 | 96 | 22 |
| Help child to talk, | 2 | 22 | 20 | 6 | 2 | - 4 |
| Toilet train child, | 2 | 26 | 24 | 0 | 2 | 2 |
| Train client/family to cook, | 8 | 45 | 37 | 0 | 2 | 2 |
| Train client/family to budget, | 10 | 42 | 32 | 0 | 2 | 2 |
| Train client to shop, | 13 | 50 | 37 | 0 | 2 | 2 |
| Train client to clean, | 15 | 52 | 37 | 1 | 4 | 3 |
| Train client to understand H.P., | 3 | 26 | 23 | 0 | 3 | 3 |
| Total, | | | 1037 | | | 1368 |

(the only minus result is for the task of helping children to talk in the auxiliary nurse sample)

Home helps were much more likely than their nursing colleagues to see rehabilitative tasks as their role; I can offer no explanation for this. In my experience very few, if any, training courses emphasise the treatment, teaching or rehabilitative role of the home help, yet only 19 per cent of home helps did not see it as their job to encourage clients to do their own work, only 17 per cent did not agree that it was their

role to encourage clients to clean and only 11 per cent did not see it as their job to encourage clients to make friends. Apart from the tasks of encouraging clients to do exercises, walk, 'do things' and teach lifting techniques home helps were more likely to see most of the tasks as their job compared to their nursing colleagues.

Auxiliary nurses were however twice as likely to see encouraging clients to do exercises and nearly five times more likely to see teaching lifting techniques as their role compared to home helps.

Home helps were, on the other hand, more likely to see helping clients to talk, toilet training child, teaching the client or family to cook, budget, shop, clean and understand H.P. as their role. For some of the tasks in both samples there were fairly large increases in the percentages who saw tasks, such as encouraging clients to work, do cleaning, making friends, doing exercises, changing client's behaviour, teaching lifting techniques and helping clients to walk, as their role compared to those who regularly carried them out (see table 11.6).

11.8 Perception of Administrative Role.

Auxiliary nurses were much more likely also to see these tasks as their job compared to home helps.

Nursing auxiliaries were 62 per cent more likely to agree that reading reports and 56 per cent more likely to see writing reports as their role. They were also 30 per cent more likely to see attending meetings to plan treatment programmes as being their role.

Eighty per cent of home helps did not agree that writing reports or

completing reviews was their job; half did not agree that attending supervision was necessary and 54 per cent did not agree that attending meetings to plan treatment programmes for clients was their role (see table 11.7).

TABLE 11.7

Difference in percentage of Home Helps and Auxiliary Nurses who stated that Administrative tasks were 'their job' and who regularly carried them out.

| Tasks, | Home Help | | | Auxiliary Nurse | | |
|---|-----------|--------|------|-----------------|--------|------|
| | Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Write reports on client. | 1 | 20 | 19 | 62 | 76 | 14 |
| Complete written reviews on clients. | 1 | 14 | 13 | 27 | 33 | 6 |
| Read reports on clients. | 2 | 18 | 16 | 55 | 80 | 25 |
| Attend supervision sessions. | 8 | 50 | 42 | 13 | 52 | 39 |
| Attend meetings to plan treatment programmes. | 10 | 46 | 36 | 49 | 76 | 27 |
| Talk to colleagues about the best way to help cl. | 24 | 77 | 53 | 74 | 95 | 21 |
| Help train new staff. | 3 | 35 | 32 | 4 | 26 | 22 |
| Total, | | | 1037 | | | 1368 |

These findings are consistent with the results from other studies. Hunt found little time spent on these types of tasks. Because of the lack of supervision by managers, home helps themselves decided what tasks to carry out for their clients. She found marked differences between local authorities in the amount of time spent by managers in supervising home helps. Very few were seen in the client's own home (Hunt 1970: 67-69).

In later studies it was found that this isolation of home helps is on the increase. In Hillingdon home helps were seen only about once a month by their manager and some were so isolated that they did not know any other home helps by sight. It is not surprising that home helps have ranked highest in studies in expressing a wish for more communication

with managers and regular home help team meetings (Hillingdon L.B. 1974, Gwynedd C.C. 1977, Hutchinson 1975, Gwynne and Fean 1978). My results confirm these findings. Seventy seven percent of my sample would like to talk to colleagues about clients' treatment programmes and half of the sample would favour supervision sessions with managers. However, certain authorities such as Rotherham and East Sussex do provide supervision, or at least home helps in those authorities state that they regularly receive it (see chapter 10)

11.9 Perception of Miscellaneous Tasks.

TABLE 10.8

Difference in percentage of Home Helps and Auxiliary Nurses who stated that Miscellaneous tasks were 'their job' and who regularly carried them out.

| Tasks, | Home Help | | | Auxiliary Nurse | | |
|---|-----------|--------|------|-----------------|--------|------|
| | Reg. | My Job | Dif. | Reg. | My Job | Dif. |
| Talk to client's visitors, | 19 | 82 | 63 | 28 | 82 | 54 |
| Keep in touch with client's friends or relatives, | 24 | 70 | 46 | 15 | 47 | 32 |
| Talk to client's relatives, | 26 | 88 | 62 | 44 | 90 | 46 |
| Chat or talk to clients, | 88 | 98 | 10 | 82 | 98 | 16 |
| Listen to client's troubles, | 74 | 95 | 21 | 82 | 95 | 13 |
| Be a companion to client, | 41 | 72 | 31 | 20 | 35 | 15 |
| Be a friend to client, | 71 | 96 | 25 | 57 | 83 | 26 |
| Be around at bath time, | 6 | 39 | 33 | 43 | 53 | 10 |
| Prepare client for admission to Hosp/OPH., | 6 | 15 | 11 | 12 | 56 | 44 |
| Total, | | 1037 | | | 1368 | |

The majority of both groups saw it as their job to talk to client's visitors and relatives, listen to client's troubles, be a friend and chat or talk to them.

Over half of auxiliary nurses and 15 per cent of home helps saw it as

their job to help prepare clients for admission to hospital or old persons' home. Half of the auxiliary nurses and 59 per cent of home helps thought it was someone else's job to be around at bath time. The latter result could be the result of home help's attitude towards work. They may feel that they are carrying out their job only if they are actively doing something practical.

11.10 Variation in Home Help's perception of their role in differing authorities.

In a number of authorities such as Northumberland, L.B. Westminster and Greenwich and the M.B.s. of Trafford and North Tyneside many home helps perceived their role as varied and wide. However, two of these authorities had a low percentage of home helps carrying out the majority of tasks regularly, apart for domestic tasks. The authorities in which staff had a more restricted view of their role were the L.B. Croydon, M.B.s of Rotherham, Dudley and Kirklees. Why this state of affairs should be is difficult to understand. Apart from Westminster, those authorities in which home helps had a wide perception of their role all had a low average number of tasks carried out by their staff (see table 11.2). However, the reverse is not true for those authorities in which home helps had a restricted view of their role. These authorities, apart for Rotherham, were dispersed in the middle of the range (see table 11.2).

Home helps' perception of their role in relation to different tasks varied also within authorities. For instance, two of the authorities in which staff on the whole had a wide view of their role, Westminster and

Trafford, had the highest number of home helps who agreed that many of the advisory, rehabilitative and administrative tasks were not their job.

There was much variation between authorities for the different groups of tasks. In Trafford few home helps thought that administrative tasks were their job whereas in the L.B. Westminster many thought most of the tasks were in their remit. Few in the L.B. Greenwich saw rehabilitative tasks as their job whereas in Devon many agreed it was their role.

There does not seem to be a relationship between those authorities in which many home helps carried out tasks and the perception staff have of their role. What can be said is that many more staff see tasks as their job than regularly carry them out.

It is likely that there is much room for change in the home help service. Many staff say that they are prepared to carry out a wide range of tasks for their clients and also accept supervision and guidance. Compared to their nursing colleagues home helps are more prepared to offer a wider range of services to clients in their own homes.

11.11 Summary and conclusions.

There was some similarity between the tasks carried out by home helps and auxiliary nurses and the tasks perceived by each group as their role. Many in each sample saw it as their role to carry out a wider spectrum of tasks than they carried out regularly at present if taken at face value. This finding would point to a degree of eagerness and potential for flexibility and change in both groups.

It is clear that there is in some areas of work, such as the domestic

and nursing sphere, strong agreement on behalf of each group as to their role. Auxiliary nurses did not perceive it as their role to carry out domestic tasks but home helps did. Many home helps also stated that they saw it as their responsibility to carry out basic nursing and professional nursing tasks.

My results would seem to indicate that home helps are carrying out a wider range of personal and basic nursing tasks than ever before. My data would also point to an expressed wish for change, especially by the home help group. Home helps carry out a wide variety of personal and basic nursing tasks but, perhaps more important for the development of the service, they also perceive a wide range of tasks as their role. The home help would seem to perceive themselves as a domestic worker, nurse, motivator and to a lesser extent a rehabilitator, adviser and friend to clients.

CHAPTER TWELVE

Conclusions.

Questions concerning the roles and functions of the home help and auxiliary nurse, remains a live issue today (UKCC 1982: 6, Nursing Mirror 1982: 7, Nursing Times 1987: 8, DHSS 1987, Nursing Times 1988: 14)). Indeed, they were critical factors in the initiation of this study, for in planning future developments as part of the management process one should be reasonably clear of the role of the workers in the service and the perceptions they have of that role. The fundamental issue of whether the home help is a 'domestic' or a 'carer' appear to underpin many of the arguments and discussions which have taken place since the 1950s (DHSS 1987). Similar arguments about the creation of an all-embracing helper in the health service are to some extent affecting the development of the auxiliary nursing role (Nursing Times 1987: 8, Dickson and Cole 1987: 24-26, Hardie 1987: 26-27). To suggest that the answer can be found either in the job which the home help or auxiliary nurse does, or in the characteristics of the organisations which employ them, appears to be an over simplification of the issue. The early district and community nurses undertook many domestic and household duties that would now be viewed as legitimate tasks of the home help service. The Victorian era saw a ban on what in present day nomenclature would be termed 'statutory domiciliary services', while

residential services underwent a rapid development. However, by the end of Queen Victoria's reign, a network of voluntary domiciliary services had been created and the general principles of the community nursing and home help service were being established. Domiciliary care today has adapted and developed philosophies of care and ideas and practices formulated when residential care was in its heyday. Tracing the history of the home help led to the conclusion that the health of the mother and child had a relatively low priority as an issue for social policy except during manpower shortage, particularly during war. The home help service through its identification with domestic work and maternity and child health services has therefore never appeared as a major issue. Consequently, it enjoyed low status as an occupation (Miller 1979). Later, as the service became predominantly a support service for the elderly, this low status was reinforced; it is argued that elderly people were and are a low priority for resources in a capitalist society because of their lack of a direct role in either production or the reproduction of the labour force (Cole 1977-8).

Bond, however, sees the service as founded upon women workers, employed as part-timers who act as substitute housewives representing an extension of the traditional role within the family (Bond 1982: 13). Others have questioned if the preponderance of frail elderly women over men in the community could help to explain the slow overall development of welfare services for the elderly (Means and Smith 1985, Essex 1986: 7).

Indeed, some home help managers have described the service as the "dumping ground for the elderly" (Bond 1982: 21). However, the importance of gender also needs to be taken into account when

considering service development for elderly people (DHSS 1987: 90). The service relies on the recruitment of housewives; only three per cent of my sample were single (see table 7.8). Work in the auxiliary nursing and home help services is quintessentially women's role and many home helps in particular see their role as that of a housewife (Hunt 1970, Merton L.B. 1976, Bond 1982). Assumptions about family care and the elderly were also considered important. Although it is not possible to draw firm comparisons with the past, much of the evidence points to the fact that prevalent ideology which argued against state involvement in family life was not tenable in the face of a society which industrialisation and urban living had created.

The development of the home help and auxiliary nursing services runs parallel to attempts during the end of the last century and most of the present one to place greater responsibilities on both central and local government for the health and well-being of the population. In the absence of adequate state or voluntary domiciliary care (in the early part of this century) many women, particularly in the poorer sections of society, were supported by the 'handywoman' during childbirth or in times of illness. The Midwives Act of 1902 outlawed this form of support which eventually led to the handywoman's disappearance. The attempts by the medical and nursing professions in the late 19th and early 20th century to control and outlaw the 'handywoman' led to the realisation that as a consequence some other form of domestic and basic nursing support was needed to help the qualified nurse in the client's home in order to free her for more specialised responsibilities. The medical profession and others had, by the early part of the 20th century also awakened a recognition in government of the problem of infant and

maternal mortality, which resulted in many local authorities implementing child health schemes including some form of domestic support in the home. This mounting concern about infant and child welfare led to the introduction of the 1918 Maternity and Child Welfare Act including the introduction of home helps supervised by nurses working in the community.

The developments of the Liberal government of 1906 represented new inroads into family responsibility but there was still much support for charities for the sick poor who could demonstrate their worthiness. The First World War broke down many social barriers; women were less content to accept the long hours, drudgery, and poor pay of domestic service and the restrictions it placed on personal and social life. The growing emancipation of women opened up new employment opportunities for women which also created a resistance to domestic work, which was still associated with low social and economic status, a problem which the home help service is even today trying to overcome (Bond 1982, Dexter and Harbert 1983).

The First and Second World Wars brought about many changes in society and also stimulated public debate about the kind of society that should develop. The Maternity and Child Welfare debate after the First World War led to the development of domiciliary services for the mother and child in which the home help service played a small part. During the Second World War many plans were laid in economics, welfare and education, a momentum of social change which was to revolutionise social welfare services by the end of the 1940s. The war had an immediate effect upon family life; mobilisation and the effect of women working in the factories and on the land left fewer than before at home

to care for members of the family who were elderly or ill. The demand for hospital beds could not be met and even minor influenza epidemics put a strain on health and social services. A new power to establish a domestic home help service for the elderly and ill in 1944 assumed that the female provided care while the husband was at work or at war. This concept was not seriously challenged in the provision of social and health services for another 25 years.

Money to expand public services was limited in the years following the Second World War but despite this the home help service grew steadily. It has been argued that the domination of the home help service by sections of the nursing and medical professions until relatively recently resulted in the absence of any development of theoretical models for practice by the service itself (Dexter and Harbert 1983). This placed the service in a vulnerable position when it was transferred from the Health Department to the new Social Service Department dominated by the emergent social work profession, struggling to break free of medical authority. The role of the home help and home help manager was viewed as an area of work regarded as requiring less skill than that necessary for other workers in the social services field (Miller 1979, Barclay 1982: 39, Essex SSD 1986: 7). However, others argue that one of the strengths of the home help service is that it is a practical service, as a recent policy paper from Essex SSD states;

"ordinary people understand what it does and can immediately appreciate its benefits. Its pretensions have been limited in scope and it has failed to attract the support that the more glamorous activities have enjoyed" (Essex SSD 1986: 7).

The reorganisation of the Personal Social Services in 1972 had a profound effect upon the development of the home help service and to

some extent the community nursing service, which was reorganised later in 1974. The 1970s saw a government policy favouring a modest growth in health service expenditure and a reduction in the personal social services. The government's plan was for an increase in expenditure in health spending of three percent between the years 1978 and 1981 and during the same period a reduction in personal social service expenditure of 4.7 per cent (Treasury 1979: 7. 11). In such circumstances home nursing services expanded to meet the needs of the elderly. However, experimental and innovative home help schemes also were introduced but little was done to examine the problems caused by the variation in standards and quality of service in differing authorities. The different research criteria used in local home help studies make them unacceptable as evaluation tools, whilst the range of tasks which they describe and the lack of clearly defined boundaries to these tasks (Bond 1982:20) only serve to make more difficult a national definition of the role of the home help.

Since the reorganisation of the health service in 1974 much discussion has centered upon the role of the home help and community auxiliary nurse. The home help service had in many cases become isolated from the community services (DHSS 1987: 118) and had begun to substitute for services such as the auxiliary nurse (Latto 1980: 21, Bond 1982: 22). The nursing profession does not have a clear idea of what nursing auxiliaries should do; their " role in providing care is seldom alluded to and the profession has coped with their existence by attempting to distance itself from them and their concern" (Dickson and Cole 1987: 24). However, in 1977 the community 'auxiliary' nurse had been introduced officially and their numbers expanded rapidly. Since then

reports have hinted at the similarity in tasks carried out by over 60,000 home helps and 4,500 nursing auxiliaries; others have argued that their roles are interchangeable, unclear and blurred (Audit Inspectorate 1983: 70, Cumberlege 1986). It has been pointed out that many home help clients receive support from the community nursing service (Audit Inspectorate 1983: 75), but the boundary between home help and nursing roles still causes concern, summed up by the following quote from a home help manager:

"The nursing service can demand a lot more of the home help service than what is really necessary, they could be asking for a lot more of our home help to really release them and it is not necessarily our remit, it really is a health case, so sometimes we've to say "well no, that's really a health problem and we really don't want to do that" (Leslie and Fowell 1987: 10).

Many of the tasks that home helps in my study have stated they carry out have been identified in some authorities as definitely the role of the nurse. In a recent study in Derbyshire, for instance, application of dressings, care of colostomies, assisting and teaching relatives lifting procedures, applying eye drops and giving a client a bath have been agreed as the role of the auxiliary nurse (Derbyshire SSD 1987). Essex SSD, in 1986, argued that bathing and changing dressings are the role of the community nursing service but administering medication is a task that can be carried out by the home help (Essex SSD 1986: Annex B). It is clear that there is still some confusion as to the role of the two services. As discussed earlier, many professional organisations for the most part are isolated from one another, each organisation seeing itself as central to the care of the client (Amos 1975). Others have commented on the compartmentalism caused by bias of different professions arguing that "the individual client, however, should be

viewed as a whole person. The system splits up the problem, not the client" (Stone 1987: 28). It becomes important to find out what each service actually does for their clients. Difficult boundary issues need to be resolved if local community care is to be a reality (Mitchell 1987: 18). My work has thrown light on one small aspect of this boundary issue.

The low status afforded to domestic work has affected the image of the home help placing, it in a subordinate position to the nursing and social work professions. Some believe that recognition for the service will only come if a shift is brought about from domestic to a more personal caring service (Dexter and Harbert 1983: 200). In view of this debate about the swing towards 'personal' care at the expense of 'domestic care' it is surprising to find that more home helps than ever before state that they are now carrying out domestic tasks. In my study most do so and, for instance, in Essex, 98 per cent of clients receive 60 per cent of the total home help allocation for cleaning tasks (Essex SSD 1987). Clearly it is certainly a task that is still important to both the home help and client (Cheshire SSD 1984, Kent SSD 1986, Calderdale SSD 1987, Fife SSD 1987). In respect of domestic tasks (in my study), most home helps but few auxiliary nurses stated that they carried out or saw it as their role to offer domestic support to clients in their own homes. However, few of the home helps and nursing auxiliaries in my sample stated that they do not carry out many of the 'personal' tasks but both groups carried out many of the basic nursing ones. Although more of the auxiliary nurses carry out these tasks, however, the younger home helps in particular also see it as their role to do so. Many of the basic nursing tasks were carried out (presumably

in the client's own home) by home helps but the Audit Inspectorate found (in their study of eight authorities) that many tasks such as bathing (home help clients) were carried out by the district nurse (Audit Inspectorate 1983: 43).

The personal relationship forged between home help and client is a vital component in providing appropriate and effective care. In many cases the home help is expected to befriend or offer advice. The quality of relationship is seen as important to the client's well being. It is an area of work, like the domestic role, that clients and home helps agree is important (Essex SSD 1986, Fife 1987: 11, Gordon and Hutton 1987: 23). Home helps in recent studies have indicated that they have a social relationship with their clients (ACE 1974, Essex SSD 1986, Gordon and Hutton 1987) and my data would support these findings; many home helps saw it as their role to befriend the clients and to keep in contact with their relatives and friends.

Both home helps and auxiliary nurses in my sample stated that they advise clients on practical matters but older staff in each sample were less likely to see these tasks as their role. A review of the literature would indicate that the advisory role of either group has as yet not been recognised to any extent (Parker 1968, Hunt 1970, Latta 1982, Smith 1983). Only one recent study has highlighted the home help service as a "supportive service and an advisory one" advising clients on various services and finances (Lislie and Fowell 1987: 11). The rehabilitative role of the home help and auxiliary nurse, or at least the maintaining of the client's existing levels of ability in self care and home care, is potentially an important role and has now been recognised by some as such (Murphy and Rapley 1986: 25). A few studies

point to the fact that some home helps see this as an important aspect of their job. In one study as many as 83 per cent of home helps agreed with this proposition, findings not dissimilar to mine (Gordon and Hutton 1987). In my study fewer home helps than nursing auxiliaries stated that they regularly carried out rehabilitative tasks but many more of the home help sample saw it as their role to do so. These findings again are similar to those of Gordon and Hutton who found that many home helps feel it is right to encourage clients to do things for themselves; however, few clients said that they experienced such encouragement (Gordon and Hutton 1987: 22). Some of these differences may be due to the differing perceptions of 'encouragement' and 'help'. One interesting observation of Gordon and Hutton was that many clients had no opinion on the matter but 20 per cent preferred not to be encouraged to help themselves (Gordon and Hutton 1987: 23).

Auxiliary nurses (in my study) were most likely to state that they carried out administrative tasks which may not be such a surprising result in view of the lack of case recording practices in the home help service, which perhaps illustrates the lack of tradition of detailed recording, for example, reasons for allocation decisions by managers. Home help case records are not usually used as a tool of case management; considerable emphasis is put on managers holding information about clients in their heads (DHSS 1987: 15). This lack of case recording is an area of concern in the home help service, particularly where home helps work in small teams, arrange cover for each other and decide on what tasks to carry out for clients. Some form of recording and communication system other than verbal is necessary to record care plans and work done, a lack of expertise which makes collaborative care

planning with other workers more difficult. It has been argued that this lack of recording may contribute to the low level of good working relationships and systematic collaboration with other workers in the construction of care packages for clients (DHSS 1987: 16).

The physical effort involved in housework and the emotional stress of supporting the frail elderly place a considerable strain on home helps who have few opportunities for access to their manager for advice, consultation and supervision. The manager to home help ratio in many authorities is so low that satisfactory formal individual supervision arrangements are difficult to establish. In none of the authorities in the 1987 DHSS sample had a policy been defined as regards supervision; this had led to no satisfactory supervision or support structures operating (DHSS 1987: 126). The Social Service Inspectorate found 'supervision' occurs more or less fortuitously through managers and home helps visiting clients at the same time, "or opportunistically at meetings or convenient visits by the home help to the office" (DHSS 1987: 18). Home help organisers have persistently failed to provide adequate supervision and consultation to home helps (Dexter and Harbert 1983: 161). Formal supervision is also an area of concern for many organisers themselves who feel that they receive less than they consider necessary (DHSS 1987: 17). My results [questions relating to 'attend meetings to plan treatment programmes' and 'attend supervision sessions'] are along the same lines as indicated by the DHSS research and Dexter and Harbert's comments.

The data collected in my study indicates that many of the tasks, particularly the basic nursing, advisory, personal, rehabilitative, and miscellaneous tasks, are common to both groups. My data would also

indicate that the role of the home help may be changing to some extent, from a purely domestic role to a more personal and basic nursing one, roles which, as indicated in chapter eleven, home help and auxiliary nurses perceive as theirs and are also willing to take on. However, an issue that needs further examination is who will take on the responsibility of providing domestic support if this swing continues?

One other important theme which emerges is the increasing advisory and rehabilitative role of the home help (Bond 1982: 29, Murphy and Rapley 1986) - a role which in my study they perceive as very much theirs. However, it should be pointed out that this role is not carried out in all authorities.

The home help service is still predominantly made up of part-time female staff; however, it is not possible to make a statement as to what the average role of the home help is; there is much variation in the type of tasks carried out in differing authorities. To understand why this pattern has occurred necessitates further research on the total provision of services in each area analysed against the social, economic and political background in each authority. Many of the differences between authorities can be explained by different levels of cost, such as for residential care, the age structure of the population, private sector care, variations in the philosophy behind the home helps' role and expectation of clients and other agencies (Audit Inspectorate 1983:8, Essex SSD 1986, Mitchell 1987:17, 40-44, Calderdale 1987).

I have discussed the many diverse ways in which home help and auxiliary nurses stated that they support clients in their own homes. The variety and range of tasks carried out is very wide although in a number of authorities the home help carries out a limited range of tasks. In some

her role is restricted, in others she is encouraged to carry out a wide range of tasks. However, recent research data suggests that this support is only available for an average of just over three hours per week per client (DHSS 1987: 28).

The high priority given to domestic and personal tasks by home helps reflects their perception of the service as a caring as well as domestic one. The manner in which home helps or auxiliaries perceive their roles may differ from practice. In fact this is borne out by my data; many in each sample were willing to carry out tasks that they would not normally carry out supporting the statement that the

"strength of the home help service lies in the ability of individual home helps to discard their own perceptions, and those of staff as a whole, and to vary the content of their job to suit the client" (Gordon and Hutton 1987: 19).

To reach the level of a more flexible service offering a caring role, emphasis on the need for radical change in the 'image' of the home help is considered necessary (DHSS 1987: 26). However, the DHSS indicate that this strategy may be liable to demoralise and confuse the workforce if change is not then produced (DHSS 1987: 27). My data would indicate that most of the home helps in my sample at least state that they are willing to carry out many caring and basic nursing tasks. The home help, in particular, perceives her role as rather wide and although in many cases she clearly did not normally carry out certain tasks she saw it as her role to do so.

The DHSS believe that if the increasing numbers of elderly people are to be enabled to live in the community, either a high volume of domiciliary care will be necessary or the available resources will have to be targeted more specifically to those in most need. They also argue

that the nature of the service should change and move towards a more basic nursing and befriending service (DHSS 1987). My data would suggest that this is possible; home helps and to some extent nursing auxiliaries are willing to carry out a wide range of tasks. It could be perhaps, as the DHSS suggest, that it is the "other powerful stakeholders who are liable to resist radical change" - the clients, informal carers, local politicians, social workers, community nurses and GPs - who must change their perceptions of the service (DHSS 1987: 31).

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