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Mobilising voluntary resources to promote community health care

A report of a conference held at the King's Fund Centre on 30 March 1983 by

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King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

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The purpose of The Volunteer Centre is to encourage voluntary action in the services provided for the community by government and by independent organisations. In practice, its main effort has been in the fields of health, the personal social services, education, the police, prisons, and the probation and aftercare service. But the Centre aims to embrace the entire spectrum of voluntary action, whether it is carried out within the statutory services or within voluntary organisations, by self-help groups, or informally by individuals.

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Ann Hills is a freelance journalist who writes a regular column in the Guardian. She also writes for various magazines including 'Social Work Today' and 'Community Care'.

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MOBILISING VOLUNTARY RESOURCES TO PROMOTE COMMUNITY HEALTH CARE

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MOBILISING VOLUNTARY RESOURCES TO PROMOTE COMMUNITY HEALTH CARE

Report of a conference held at the King's Fund Centre on March 30 1983

1. WELCOME - David Hands

The conference was jointly organised by the King's Fund Centre and the Volunteer Centre. It was stimulated by last year's joint publication by the King's Fund and the Volunteer Centre of Mobilising Voluntary Resources. This book by Pat Gay and Jill Pitkeathley (Project Paper No. 29)* is a study of the work of voluntary service co-ordinators, whose job it is (whether they are paid or unpaid) to mobilise voluntary resources. Although this book was based on a survey in Berkshire, the conference took a wider focus both geographically, and in treating the subject from the point of view of speakers from a variety of settings.

David Hands, Assistant Director at the King's Fund Centre, welcomed delegates by indicating the topicality of the subject, and his appreciation of working on it with the Volunteer Centre, "who are our close friends and allies in developing health care".

2. CHAIRMAN'S INTRODUCTION - Foster Murphy

In thanking David Hands, Mr Murphy recalled that the King's Fund had given the Volunteer Centre support in its early days, including its first office space. The topicality of the day was partly based on the fact that volunteers are under the microscrope - their uses are being closely examined as a result of cut backs during the recession. But despite the pressures all is not doom and gloom - experiments can take place and it was about these that the packed audience would hear.

He introduced Stephen Hatch "who has done research on voluntary action, especially the lay role and community participation in health care".

3. VOLUNTEERS AND COMMUNITY CARE: A CONCEPTUAL FRAMEWORK FOR DISCUSSION - Stephen Hatch had a message to give about priorities in health care - but before delivering that he wanted to look at the different kinds of lay involvement. He quoted the Wolfenden Report's breakdown into four sectors of provision - statutory, private, commercial, voluntary and informal. "These have been taken on board by social services,

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* available from either the King's Fund Centre or the Volunteer Centre price £2.30 (including postage).

but less so by the health service". Mr Hatch wanted to talk of the voluntary and informal sections which receive less attention than the others - for instance help within families does not make headlines.

More broadly, looking at the voluntary and informal contributions he used slides to gather the titles of a whole range of people from hospital volunteers and members of health authorities to voluntary service coordinators - "there are about 300 of them in the health service". Those appointments result in quite a large amount of activity. The place of VSC in primary health care is a newer angle, noticed from example in Norfolk (referring to Dr Allibone's afternoon session) and in the Milson Road Health Centre, Hammersmith.

Stephen Hatch considered the role of community health council members, members of patients' groups and hospital friends. Research trusts dealing with illness or disease to cancer or asthma might also be included in this second section - people who are not quite the same as nominees of health authorities, working also outside the health service.

A third category would include self help groups, organisations like the Red Cross, Patients' Associations and pressure groups such as ASH (against smoking) or others against lead.

Back in the 1940s there were hardly any such groups - though AA had begun in America in the 1930s. Most started over here in the 1950s and gathered momentum in the 1950s and 1960s. Mr Hatch quoted statistics - "there are at least 50 self help groups concerned with health in half a million population in Nottingham. There are nationally at least 5000 such groups (projected from Nottingham figures).

Then there are community health projects, some concerned with inner city difficulties, others with women's health, maternity and child care. There is a London health action network and similar links exist in other towns - for instance Liverpool and Glasgow. It is, he added, easier to get people together for a specific issue, depression, migraine, rather than more broadly based matters such as women's health in general.

What about other volunteer groups? Mr Hatch asked the audience. The WRVS was a Crown Service he replied to one delegate. Housing associations were crossing boundaries with health and housing - even if resettlement of ex-mental patients was the point. English as a second language for immigrants was another possibility suggested - but this crossed education boundaries. "There are the usual problems of classifying voluntary actions". He accepted slimming clubs, perhaps trade unions campaigning for health standards and maybe family practitioner committee memberships.

Anyway, he moved on to break down the basis of involvement into categories - mutual aid for self help groups and neighbourhood projects, practice groups for hospital friends and, thirdly, philanthropic groups. Unlike Lord Beveridge, he wasn't sure about the distinction between mutual aid and philanthropy ("which implies rich people doing good"). He continued: "if you analyse why there should be a distinction you find that motives are mixed. Some people come to terms with a problem by helping others. There's reciprocity - you give something and get something back. There can be a psychological satisfaction: "there is no sharp boundary between a selfish group and a service group".

Mr Hatch looked at the usual division of priorities according to current values - and that is also where the glamour lies. Acute medicine - heart transplants and dramatic cures - get more attention than prevention and care. Where there is no cure the resources are spread thinner - in geriatric care and long stay. Yet this, added Mr Hatch, is despite work over the last decade, such as by Cochrane and McKeown, which considered the limited benefits of acute treatment. How many people lead healthy lives after transplants? The results don't relate to resources used logically. The speaker glimpsed back to the 19th century where improvements in health came about overwhelmingly from improved sanitation and better standards of living - yet they were attributed to the medical science of surgery and innoculation. TB was reduced through diet and healthier living. Prevention of smoking would have more impact than transplants - if it was achieved.

The time has come, said Stephen Hatch, to recognise the social components of health, and what people do voluntarily. "The voluntary organisation is a very important organisation to get through with messages to individuals

and privately - not just to patients who turn up at hospital for treatment and who are then passive listeners."

What has been achieved by this lay involvement so far has not been evaluated much. Most people are not clear about the quality of benefits of existing methods - "I'm asking for a critical approach". He wants, for example, a comparison of voluntary service coordinators' work to be weighed against self help. Self help groups may get closer to real issues. He mentioned a friend who is trying to recover from trigeminal neuralgia (pains in the cheek). She had an unsuccessful operation followed by more successful treatment, but none of the doctors (even in London teaching hospitals) gave sensible advice about the management of her condition, the use of drugs, what brought on attacks and the prognosis. These she could discover by finding others in the same position. "There is a major role for lay people to support each other in ways the health service can't. The extent of self help depends on professionals' encouragement - VSCs can push development further", he summed up.

4. MOBILISING VOLUNTARY RESOURCES - Jill Pitkeathley and Pat Gay

Jill Pitkeathley and Pat Gay explored the background of their book (mentioned earlier).

Pat Gay explained that the voluntary service co-ordinator has her origins in a veritable explosion of sitting services, hospital shops and so forth. But the VSC's function was not really understood by academics, professionals or the public - "they are just administrators" was no answer, because they had at least five main components in their role. That included administration/management, personnel, social work, community work and having an entrepreneurial function. A certain amount of office based work was essential - there was a general recognition that this was the basis of the job. The personnel side wasn't putting pegs in slots - a VSC would have to know the district well, provide counselling and advice. The social work side can have obscure definitions - perhaps assisting with social functioning and assessing social need and how it can be met.

The community development aspect means remaining on hand to support groups and often stop them collapsing, whilst the entrepreneurial side came as a surprise. That meant having the savoir faire to get schemes off the ground, even raising money and finding premises, badgering

officials, harnessing local resources - getting over obstacles: "they need a whole diversity of talents". There's a Tiny Rowlands face lurking behind the VSC's surface'.

Jill Pitkeathley, taking the middle section of the presentation, said that 71 per cent of the sample interviewed for the book thought there was a pool of volunteers 'out there', but the need for VSCs was apparent. Formal volunteering, far from militating against the informal, does the opposite - enables volunteers to structure their time. But she did agree there was a fine line between supporting and organising initiatives - VSCs have to be flexible. There is, she repeated, that pool of goodwill. The control exercised by the VSC is minimal, even in hierarchical structures it must not be tightly managed - the success in being a VSC depended on freedom of action. They have to bridge the gap between accepting the model of the agency and volunteers being stimulated to produce innovative work. This trend of mobilising volunteers means that the VSC must be considered as a separate occupation, or the role risks being given second place.

When the job is part of another (say in probation or nursing) the holders of these posts are first obliged to fulfill the professional and legal requirements. The recognition of the role of the VSC should be built into the training of other professionals, added Jill Pitkeathley.

The book was written over two years ago. Since then the numbers of VSC has been declining, and posts frozen - also hospital and community projects are being cut off. Posts are being discontinued and duties allocated to different units.

Unit administrators may call upon VSCs to do different things not concerned with developing volunteering. In the current climate in the health service there is a contraction, suspicion, looking over shoulders. "In such a climate we have to go back to being fillers of gaps and facilitators".

Pat Gay talked about the confused state of 'alphabetti spagetti' - with MSC - sponsored posts coming under a range of titles. VSCs may be appointed to recruit volunteers (there were, she thought about 50 such MSC posts with the staff being paid £89 per week maximum). The under 25s were

strongly represented, more males than females and over half had degrees. They were responsible for getting a mixture of schemes going from a mobile youth club in a rural area to working on a 'dustbin' housing estate, and helping the hard of hearing by visiting these patients coming out of hospital and assisting them with using their hearing aids.

The problem is that the one year limitation on these MSC jobs "shows a lack of recognition of the importance of continuity - "it is over to the policy makers for a rethink".

5. RECENT INNOVATION IN VOLUNTARY ACTION IN COMMUNITY CARE

(a) Working towards a preventive psychiatric service in the community - Kina Avebury

Lady Avebury explained her new job as "Resource Development Officer", which was just one component in the development of an integrated community psychiatric service in Tower Hamlets. Dr Colin Murray Parkes, Senior Lecturer in the Department of Academic Psychiatry at the London Hospital, who heads the unit of Social and Community Psychiatry, received a grant from the King's Fund last year for the project.

Dr Gillian Waldron took up her appointment as Consultant in Community Psychiatry at the same time as Lady Avebury. Both had already been involved in setting up the Crisis Intervention Service which had been in existence for the past 6 years. A major part of Gill Waldron's task now is to extend the coverage offered by the Crisis Intervention Service to all parts of the Borough, and to develop its potential yet further.

The related purpose behind the Resource Development post is to develop the contribution of the voluntary sector to psychiatric care, within the framework of prevention. The aim is to assist in the production of a plan for a 'model' of preventive community psychiatry at the end of three years, which could be capable of implementation in other areas.

Lady Avebury explained that the theoretical framework which largely determines the way she saw her work is based on the studies of Caplan in the United States and Professor George Brown and Colin Murray Parkes

in Britain. There is a particular connection with Colin Parkes' work on bereavement. The project is looking at individuals or groups of people who have experienced, or who may be likely to experience, some major loss, and therefore be more recognisably at risk of becoming mentally ill, or at least have very severe problems of adjustment. In this setting, 'loss' may mean a bereavement, but it also would include other forms of loss - radical surgery, becoming unemployed, being taken into care, arrival into an alien culture and so on.

Even if one sticks pretty rigidly to the criteria of severe loss, or major psycho-social transition, there is a great deal of scope for study and probably intervention. Ultimately, the intervention would be designed to prepare for crisis, to help through crisis, and to help adjustment when it has abated. In other words helping to build up coping mechanisms. It is in this area that volunteers are to be sought.

Helping with these kind of crises comes into the category of primary prevention - that is, working with people who will probably not have had any previous contract with the formal psychiatric services. There is also scope for secondary prevention, in considering the needs of people who have suffered from mental illness and who need extra support in the community for varying lengths of time. It is in this field, rather than in the first one of primary prevention, that the efforts of the voluntary movements in mental health have been largely directed. It is not hard to see why this is so. First, support of this kind may be a more easily definable task, and volunteers may be motivated by experiences which have given them a sense of identification or understanding of the problems. Second, it is slightly easier to quantify and evaluate the results, which in turn, may lead to a more readily acknowledged recognition of the value of the work from professional workers in mental health.

The near-unanimous view that prevention "is a good thing" is matched by an almost equally widespread view that it is so problematical an issue that it might be almost easier to resist any engagement with it. There are the methodological problems of assessing its efficacy and cost effectiveness. The feelings of impotence in the face of the larger environment and social factors which are associated with so much mental ill-health, and which seem to depend upon political change rather than helping the individual to cope with their effects.

Nevertheless, this was where we were starting in Tower Hamlets. The starting point, during the last two months, has been to visit as many people involved in the provision of services in the Borough as possible. These contacts have not been restricted to those working in preventive or any other form of psychiatry, but included many other groups and people who work either with the chronically mentally ill or in completely different settings, such as health visitors, community workers in the large number of settlements and neighbourhood projects.

Because of its political background and history, there is a lot of sensitivity in the Borough about voluntarism. There is no Council of Voluntary Service at present, and the amount of voluntary initiative, whether of the traditional kind, or the more recent innovative but possibly high structured kind, is thinly spread. Many of the professional workers in health and social services are keen to see a healthy voluntary sector emerge but many are sceptical about its chances. Many would not volunteer themselves, but hold back. There is an understandable suspicion in many quarters of volunteers who come into the area from very different places to improve the lot of the people who live there.

Self-help groups, functioning independently or linked to some more formal service, are more likely to thrive, than imported solutions however well-planned and supervised. Where more formally organised voluntary schemes are to be set up, offering for example, counselling for particular kinds of crises, or counselling in general, preparation and orientatation will still be needed, but it ought to be of a kind that has meaning in the context of the very distinct communities and cultures of the area. For example, the project is going to be concerned with the mental health of the very large number of Bengali people in the Borough - who make up over 50% of the population of two of the wards. Many of the women do not speak English, and many are not literate in their own languages. The departments of adult and child psychiatry are concerned about developing a service which is accessible and acceptable to this community, in the same way that the departments of paediatrics and obstetrics are concerned about the way their services are used.

In this latter situation, an MSC funded scheme using 5 liaison workers (4 Bengali and 1 Somali) which helps introduce mothers to the service and accompanies them to hospital appointments, acting as far more than

mere interpreters. It seems that this already has implications of mental health, and it may be possible to set up a service on similar lines to deal explicitly with the psychiatric side. One problem however is that there is no tradition amongst the Bengali community of voluntary service as we know it. The concept of some form of self-help, which may have a guiding spirit, does seem to have taken root, and instances are already to be found in places like the Montefiore centre, Toynbee Hall and so on. At the same time, it is in these same centres that a good deal of voluntary work in the more conventional sense is undertaken, and the proximity of one to another may foster greater understanding of the different roles.

The logical way to proceed seems to be to continue with the process of information gathering - about the population - about their perceived needs, about the gaps in provision, and the ideas which other workers have already begun to formulate. When all this material is assembled and examined, the priorities will begin to emerge. Some strong indications of what these may be are already available. Only when it has been decided where we are going to concentrate, will it be the time to try and find the helpers, discussing with these who are interested, the reasons underlying our plans. There are a number of strands which may well come together and suggest a particular target group. For example, Tower Hamlets has a number of children in care which is three times the national average. Many of these children come from single parent families, and may have one or more parents who are members of ethnic minority groups. A large number come from areas of large tower blocks, and whether we are talking about NAI or straight neglect, we are also talking about people who can no longer cope - and who have reached the end of their tether.

There may be other factors e.g. alcohol or drug abuse, and it is not hard to gain (confidential) information about the incidences of these, though not of course, about individuals. In cases like these, there are at least two sets of psychological warning-bells. The mental health of the mothers, during and after care proceedings is likely to be fragile, to say the least, compounded by guilt and isolation. The longer term prospects for their children are also not good.

Volunteers can be used in two ways at least - first, as information resources, and second as supporters possibly linked into the Local Authority Family Aides scheme.

The Tower Hamlets MIND steering group, after a very chequered start, now may be beginning to get somewhere. Their idea is to lease a redundant pub in Bow from the Borough, rent-free, to turn it into a community mental health resource, with different kinds of activities. One of these, awaiting result of a grant application to the GLC, is a counselling and information service. This project is called 'Help with your nerves' (a term to make the Department of Psychiatry wince), but which may mean more to users and helpers than the phrase "mental health". The success of such a project is going to depend heavily on the support of the neighbouring estates, and it is hoped that most of the helpers will be drawn from around about.

One of the problems which have been unearthed very early is the tension between the attitude of the large prestigious teaching hospital towards volunteers (fears of unprofessionalism, unreliability etc.) and the grass roots feeling of the need for ordinariness. How to reconcile these two perceptions is quite a task.

In conclusion, Lady Avebury said that her job is different from that of the Coordinator of voluntary services, though there are certainly common elements. There is certainly a coordinating role, but as much between the different and often conflicting elements within the statutory side as within the voluntary side. The shared element is that of enabler, to others trying to get things started. If this is successful the project will have gone a long way towards the model plan that is its three year target.

(b) "Contact-a-Family" - Helen Fraquet

"Contact-a-Family" had been formed 10 years ago in Wandsworth when a community worker found that families with handicapped children put far fewer questions to the social services department about benefits, and asked for far less support, when they began to meet with each other.

During that time, handicapped children seemed to be increasing because what used to be a spontaneous abortion is now a premature birth. Children in "Contact-a-Family" groups suffer from any handicap - from autism to a hole in the heart. The increased number of handicaps shows up in the

groups once the babies become two or three.

The scheme spread to Lewisham and Lambeth and has grown in local numbers - "Wandsworth has 140 families and is beseiged by demand". The group had a first rural offshoot in the Forest of Dean where families may be seven miles apart. Fathers are proving useful (unemployment has made a difference to the time available) to drive minibuses or repair toys. Brothers and sisters are voluntary helpers. "Fear is one of the prime difficulties in working with handicapped children - we need a one to one ratio for summer playschemes, especially for the hyperactive and autistic children".

The Saturday before a scheme starts, families and prospective volunteers meet. The volunteers tend to line up against the wall - but soon the barriers are broken. "Contact-a-Family" has grown with grants from Rowntree, Carnegie and the Mental Health Foundation. By this summer 15 local coordinators will be funded - MSC is providing five with one year grants; a further three will be joint funded (with cash from NHS and social services) and the rest paid for by industry.

The trust money will pay for, amongst other costs, a project over three years which is linking up parents' self-help groups which are specifically umbrella groups - "we know of 80 so far. These range from a group of four families in Folkestone to 120 in Leeds, in a group called Pace".

With the head office staff, "Contact-a-Family" will soon have 20 on the pay-roll. Already 2000 children are linked; that number will double.

Health visitors, doctors, parents and hospital workers are helped when they want to start groups: "We must have parents and professionals together. A mum may say I've had enough or all the volunteers have run away". The professional input helps and in some groups a parent link is appointed before a fully paid coordinator can be funded. That's hardest in a rural area.

One way round the cash problem is to advise mothers to register as unemployed so that when a parent link or coordinator job is available they can go to the job centre and apply.

But like other speakers, this one bemoaned the temporary nature of MSC cash - it takes a whole year just to establish someone in post.

Head office has different problems - maybe rushing round to Capital Radio before 9am (as Helen had done that morning) to collect donated equipment, or enabling a bereaved mother ("a lot of our children die") to come and work in a 'normal' office for a while. Then there is a conference once a year for parents with professionals - "I've just come back from Newcastle where we had one called "Is there life after school?". It wasn't a joke.

(c) Participation in Primary Care - Joan Mant and Joan Eastman

Joan Mant of the National Association of Patient Participation Groups gave a presentation with Joan Eastman of Whiteladies Health Centre, Bristol.

Joan Mant said that participation is for all patients on a doctor's list - not just chronic surgery attenders. All the existing patient participation groups (she reckoned there were about 70 to 80 of them) are based on primary care premises which provide the roots whether they are urban or rural. "We hope to produce a start-up package".

There are notices in waiting rooms or delivered by volunteers, or with repeat prescriptions to invite people to join. Local groups are invited to send representatives - from the WI to an Over 60s club or St John's Ambulance.

There is no set pattern or meeting - it could be four times a year or the first Thursday in the month; there is no blueprint.

Why bother? There is a growing feeling that patients and doctors should benefit from a partnership for health - we can share in our care, in the practice, in supporting the primary care staff. This, added Joan Mant, is particularly relevant when there is an ageing population with the stresses of degenerative diseases - the primary team can't cope without community support. The National Association has two roles - to support groups and to support the growth of the network.

There are plenty of small examples of useful outcome - "recently in Bath I found old ladies knitting for new arrivals with wool provided by others". The problem of doctors criticising interferring Hampstead trendies doesn't really hold water because outside the consulting room they are almost afraid of patients.

When groups organise brains trusts (amongst the most popular events) patients can voice complaints, ask questions. The groups can encourage special interests, or provide somewhere for the slimming club to meet (in Manchester there is a group for the over 60s who now meet fortnightly and provide their own talks).

A patient group has put slides in a waiting room in Kentish Town - the list of possibilities is endless, but they do have to fund-raise to keep themselves going. As far as doctors are concerned, these groups can be a forum for them and their staff and become a status symbol - practical participation for all to see.

Joan Eastman chairs a group in Bristol involving four GPs and a population of just over 10,000 - it is one of two practices at the Whiteladies Health Centre. ("the other is not interested").

Tim Paine was the GP who promoted the idea - he had studied systems theory and applied the notions to his practice. Today the committee of 12 meet monthly, with Dr Paine or one of his partners if possible (he is president of the group). Each year they plan a programme of lectures.

Doctors, for example, drafted a letter inviting men of 45 to 65 to a lecture on heart disease; then selected women aged 35 to 55 to hear about the prevention of breast and cervical cancer.

Joan Eastman explained the workings of the active group - from placing a suggestions box in the surgery, and monitoring responses to discussing with the doctors about issuing warnings on the side effects of certain treatments, to providing £50 for a rocking-horse and other toys and helping in patient surveys - for instance a questionnaire on satisfaction or otherwise with the time allowed for appointments.

She stressed both the uses of a computer in identifying age groups, or other divisions (perhaps the patients who live in a particular road), but at the same time emphasised the need for total confidentiality. Volunteers merely deliver messages and invitations. These volunteers (about 40 are active) may also help with transport to and from surgery and hospital, assist with a luncheon club and with child or baby minding.

Yes, she did admit in reply to a question, the practice group is largely middle class.

(d) The Nottingham Self-Help Groups Project - Judy Wilson

Judy Wilson, project worker with the Nottingham Self-Help Groups Project, which has been in operation since January 1982, is funded by the district health authority through joint financing as part of Nottingham CVS. She spoke about this post.

It is largely about tapping resources outside the pool of 'ordinary' volunteers, whether helping to launch a group of sufferers from a rare disease or helping parents of handicapped children get together to "stand up for our rights" (as one mother put the reason for the group).

The practical outcomes are numerous - a mastectomy group can voice opinions about prostheses; those involved in a stillbirth association have been furnishing a room at the hospital. "Volunteers can be willing guinea pigs for research into, say, eczema or tinnitus and challenge professionals about the encouragement and support they need".

Judy Wilson said she did not start groups - it was for professionals to see themselves as enablers. A hospital sister was the inspiration of a Burns Unit Self Help Group which is based in the hospital. But Judy does enabling and providing to new and existing groups, from publishing a directory to bringing specialist groups together. Thirty-five of them sent representatives to one meeting. The local newspaper now has a monthly "Self Help for Health" Diary of meetings.

She improves voluntary/hospital links. Noticeboards in outpatients can be used; so can display racks and meeting rooms - "a lot of resources are underused in the NHS".

Judy Wilson sees patient or self help groups as challenges to professional care, increasingly going into hospital, being constructive and realistic about their useful strength. She totally criticised the remarks of a consultant on radio that "a trouble shared is a trouble halved" - as if that was the only use of these groups. The movement was far more crucial than that - judging by the response the audience wholeheartedly agreed.

6. THE COST-EFFECTIVENESS OF VOLUNTARY CARE - Dr A Allibone

Dr Allibone, a general practitioner from North Norfolk, looked at the cost-effectiveness of voluntary care.

He was, he told the audience, sold on VSCs - "we've had one funded for three years". His scheme involves caring in the community for the elderly population in Glaven and surrounding villages in North Norfolk - a total of 12 communities with just under 3,000 population, 30 per cent of them pensioners. He has 200 clients and 250 helpers which means a large transport problem in taking them to the scheme's centre, built at a cost of £40,000 and recently enlarged with a new sitting room. He drew plenty of comparisons to show the cost effectiveness of Glaven's answer to day care and home nursing: each visit to the day centre costs under £2, which is far under the £3.58 visit to a local geriatric day hospital.

The patient/staff hours ratio is similarly economic. Two retired physiotherapists help with the continuing treatment. Apart from companionship, lunches and treatment, the scheme offers professional and voluntary home care - Dr Allibone is currently exploring the insurance cover needed when competent but not qualified housewives act as nurses (supervised by professionals). He hasn't yet found the answer.

Dr Allibone emphasised again the continuum of care that can keep elderly people in the community. With professional back up he has shown that community care does work; reduces demand on institutional places - consequently patients get more for their money.

On the one hand the Glaven scheme is open to criticism, Dr Allibone admitted. Some statutory staff claim that his elderly men and women are not as confused as their geriatric day hospital patients, but his research proves the two groups are similar. He implied that given similar circumstances elsewhere the scheme could be copied.

In reply to questions he said that of 52 voluntary nurses, two are SEN, ten are SRN, the rest are housewives. "We blend professional with volunteers to guarantee standards".

Abbeyfield, he said, is trying to do a 'mini Glaven' to reduce hospital admissions.

The unions are helpful, and youngsters on government training schemes are being used. So, in all he summed up a success story which has now being going for several years - one problem in years to come is that it relies on the young elderly as volunteers. Their numbers will decline.

7. CHAIRMAN'S SUMMARY

Foster Murphy summed up by considering volunteering in five main ways:

One: it is a major personal choice and freedom - no one compells people to volunteer.

Two: volunteering helps the State to meet obligations to citizens - volunteers are a resource in modern society.

Three: this resource is a means of rectifying an imbalance in the supply of services and a way of changing some priorities.

Four: it enhances the quality of life.

Five: volunteering allows participation in the public decision-making process.

But we all had to be involved if initiatives such as "Contact-a-Family" and patient practitioner groups were to be cloned. The conference, he reckoned, had given outlines of detailed practical experiences.

What came out of the day? Looking back it is clear that professionals have to be committed to self help or to patient participation to stimulate a response. The partnership is vital, as is continuing support. The nature of voluntary work means that a secretary or chairman may have to up and leave - unless the foundation of the body is firm it falls apart. Once GPs are committed to voluntary effort and actually regard the work of the community in harness, as a status symbol, then the way ahead is unlimited.

If volunteers feel they have the confidence of a doctor, a hospital nurse (as in Nottingham in the burns unit) or other statutory staff - then they can carry on working in the community from a secure base.

The conference emphasised that the voluntary service coordinator is a valuable animal, able to increase many-fold the amount of work produced by one person: but not all the powers-that-be realise the potential. Cut backs on this front are a false economy at a time when more and more we are all called upon to be part of a community resource. The ageing population, the large number of social ills, demand a voluntary effort, or rather a vast series of smaller self help projects, which must have the respect and backing of paid staff.

Ann Hills
King's Fund Centre
May, 1983.

APPENDIX 1

MOBILISING VOLUNTARY RESOURCES TO PROMOTE COMMUNITY HEALTH CARE

CONFERENCE HELD ON 30th MARCH 1983

List of Participants

MRS A ALLEN	Health Visitor	Huntingdon, Cambs.
MRS K C ALLEN	Caring Co-ordinator, Glaven District Caring Committee	Blakeney, Holt, Norfolk
* DR A ALLIBONE	General Practitioner (Founder and Chairman, Glaven District Caring Committee)	Blakeney, Holt, Norfolk
* LADY AVEBURY	Community Resources Development Officer	The London Hospital Psychiatric Project, Tower Hamlets Community Health Services
MR A C BAKER	Secretary/Assistant Co-ordinator Vol. Services	Leavesden Hospital, Leavesden, Watford, Herts.
MRS B M BASHFORD	Voluntary Services Organiser	Royal Earlswood Hospital, Redhill, Surrey
MRS A BASSINDALE	Voluntary Services Coordinator	Eaglestone Health Centre, Milton Keynes, Bucks.
MRS A BEETHAM	Voluntary Help Organiser	St Luke's Nursing Home, Sheffield
MRS I BELL	Voluntary Services Coordinator	Garlands Hospital, Carlisle, Cumbria.
MR C H BIRCH	Member of Southern Derbyshire CHC	Kingsway Hospital, Derby
MRS A BOWLER	Voluntary Services Organiser	Queen Mary's Hospital Roehampton, London
MRS S BRADFORD	Liaison Officer Voluntary Services	Amersham General Hospital, Amersham, Bucks.
MR K R BROWN	Chairman	Croydon CHC
MR H BROWNING	Member	Brighton CHC, Lewes, Sussex
MR D BUCK	Member	Peterborough CHC
MR D R BURDEN	Voluntary Services Co-ordinator	The Old Manor Hospital, Salisbury
MRS V BURNS	District Voluntary Services Organiser	Northwick Park Hospital, Harrow
MR N A CANTER	Deputy Unit Administrator	Community Health Services, London
MRS L CARTER	Co-ordinator of Voluntary Services	St Ebba's Hospital, Epsom Surrey.
MRS C CHILTON	Member, Central Nottinghamshire CHC	MIND
MRS E COOK	Member, E. Dorset Health Authority	Bournemouth Voluntary Workers Bureaux
MS K DAVIDSON	District Voluntary Services Co-ordinator	Parkwood Health Centre, Gillingham, Kent
MRS V E DAVIES	Nursing Officer	Mid-Essex Health Authority

MISS G M L DAVIS	Voluntary Services Organiser	Rainhill Hospital, Prescot, Merseyside
MR T DAY	Secretary	Exeter and District CHC
* MS J EASTMAN		Whiteladies Health Centre, Bristol.
MR N ENGERT	Area Voluntary Services Liaison Officer	Social Services Office, Yeovil, Somerset
MR C E FELTHAM	Administrator	Bournemouth Community Health Services
MR R FERGUSON	Assistant Unit Administrator	Eastbourne, Sussex
Mr J FOSTER	Joint Secretary	Greenwich CHC
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MR T M GANG	Principal	DHSS
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* MS P GAY	Researcher	Policy Studies Institute
MS J GOSLING	Researcher, Dept. of Community Health	University of Leicester
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MR D HALSE	Voluntary Services Co-ordinator	Guy's Hospital, London
MRS M HAMER-HARRIES	Chairman	North Bedfordshire CHC
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MISS M D HINKS	Member	Southmead CHC, Bristol
MRS W HOWARTH	Member	Bradford CHC
MS J HUGHES	Secretary	Bristol Folk House (Adult Education Centre)
MRS B HUSAIN	Voluntary Services Co-ordinator	Enfield Health Authority
MR J JEWSON	Member, North West Surrey CHC	St Peter's Hospital, Chertsey, Surrey
MRS J JONES	Voluntary Services	St Mary's Hospital, Burghill, Hereford
MR R W M JONES	Unit Administrator - Community Services	Community Health Office, Hounslow
MRS D M KULIKOWSKA	Member, West Lambeth HA	Bristol Red Cross Society
MRS J M LAWRENCE	Nursing Officer (Health Visiting)	Colville Health Centre, London W11.
MRS J LEWINGTON	Secretary	Aylesbury Vale CHC
MRS A K LINNEY	Health Education Liaison, NW Surrey	Addlestone Health Centre
MRS M A LONGRIDGE	Co-ordinator of Volunteers	Coney Hill Hospital, Gloucester

MRS B S LUCAS	District Voluntary Service Organiser	Stock Mandeville Hospital, Aylesbury
MRS G E MAIR	Voluntary Services Organiser	Fair Mile Hospital, Wallingford, Berks.
*MRS J MANT	Director	Central Information Service for General Medical Practice
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MRS J MARSH	Voluntary Services Organiser	West Kent General Hospital
MISS M MASON	District Voluntary Services Coordinator	St Thomas' Hospital, London
MRS D McCORMICK	Assistant Secretary	North East Essex CHC
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MR P B NURCOMBE	Community Liaison Officer	Brighton Health Authority
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MISS K OTTAWAY	Voluntary Service Organiser	St Mary's Hospital, London
MR B PAVITT	Coordinator of Voluntary Services	Croydon
* MS J PITKEATHLEY	Voluntary Services Coordinator	West Berkshire
MR N PFEFFER	Assistant Secretary	Haringay CHC
MISS J PITTS	District Voluntary Services Coordinator	Bristol & Weston HA
MRS J C POTTER	Coordinator of Voluntary Services	Long Grove Hospital, Epsom, Surrey
MRS C PRICE	Coordinator of Voluntary Services	Netherne Hospital, Coulsdon, Surrey
MR M J POWELL	Community Services Administrator	Milton Keynes HA
DR P PRITCHARD	General Practitioner	Dorchester-on-Thames
MRS I V RILEY	Voluntary Services Coordinator	Hill End Hospital, St Albans, Herts.
MRS S M ROBERTS	District Voluntary Services Organiser	Manor House, Uttoxeter Road, Derby
MRS D ROBERTSON	Health Visitor	Child Health Clinic, Huntingdon, Cambs.
MR H ROPER	Rural and Welfare Organiser (Member of Herefordshire CHC)	Rural Community Council of Hereford and Worcester
MR C SIMMONDS	Member	North Bedfordshire CHC
MRS M SMITH	Director of Nursing Services Community	Medway Hospital, Gillingham, Kent.
MR R SMITH	Senior Lecturer	School for Advanced Urban Studies, Bristol

MRS P SMITH	Secretary	Dartford & Gravesham CHC
MRS D V STANLAKE	Staff Officer and Deputy, Branch Operations	British Red Cross Society
MRS P M THOMPSON	Unit Administration - Community	West Essex HA
MS S TOWNS	Coordinator of Voluntary Services	Banstead Hospital, Surrey
MR G TUMBER	District Voluntary Services Coordinator	Charing Cross Hospital
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MR M WILLS	Director of Nursing Services (Psychiatry)	Leigh House Hospital, Eastleigh, Hants
* MS J WILSON	Project Officer	The Nottingham Self-Help Group
MRS A E M WILTSHIRE	Member (Leader of Elderly Working Group)	Salisbury CHC
MRS A WINWOOD	Voluntary Services Organiser	Rubery Hill Hospital, Birmingham
MR C WOOD	Training Officer	Volunteers Advisory Service, London
MRS M ZURICK	Member	NW Surrey CHC

THE VOLUNTEER CENTRE

MS M PLOUVIEZ - Development Officer

KING'S FUND CENTRE

MR D HANDS - Assistant Director

* denotes speaker