

# The Future of Adult Social Care: Lessons from Previous Reforms

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## Abstract

*In 2005, the adult social care Green Paper, Independence, Well-being and Choice, set out a 'new vision' for the future of social care in England. Throughout the document, there was a strong emphasis on greater choice and control for service users, a more strategic, preventative approach, working with other services and promoting independence, well-being and inclusion. As the formal consultation process closes (in July 2005), this paper reviews three previous reforms – the Seebohm Report (1968), the Barclay Report (1982) and the community care reforms (1990-1993) – all of which set out very similar ideas and demonstrate considerable continuity in thinking over time. Given that the Green Paper feels that a 'new vision' is needed for adult social care, this paper questions the extent to which any of these proposals are indeed 'new' and questions how these changes are expected to work when previous reforms are perceived not to have delivered desired outcomes.*

## Keywords

Legislation; policy; social care; New Labour

*Hegel was right when he said that we learn from history that man can never learn anything from history.*

(George Bernard Shaw, 1856-1950)

*Those who cannot remember the past are condemned to repeat it.*

(George Santayana, 1863-1952)

*There is nothing new under the sun.*

(Ecclesiastes, The Bible)

## Introduction

In 2005, the English Department of Health issued a Green Paper on the future of adult social care. Entitled *Independence, Well-being and Choice*, the paper proposed a series of changes to the future organisation and delivery of adult social care, seeking responses to a series of 26 formal consultation questions (Department of Health, 2005). In particular, the document sets out a series of desired outcomes that adult social care should be seeking to achieve, and makes a series of proposals that it believes will lead to greater choice, control and personalisation. These aspirations were

summed up by the then Health Secretary in his foreword to the Green Paper (Department of Health, 2005, p.7):

*Our vision is one where the social inclusion of adults with needs for care or support is promoted by:*

- Ensuring that, wherever possible, adults are treated as adults and that the provision of social care is not based upon the idea that a person's need for that care reduces them to total dependency;
- Ensuring that people using services, their families and carers are put at the centre of assessing their own needs and given real choice about how those needs are met;
- Improving access, not only to social care services, but to the full range of universal public services;
- Shifting the focus of delivery to a more proactive, preventative model of care;

- Recognising that carers also need support and that their well-being is central to the delivery of high-quality care; and
- Empowering the social care workforce to be more innovative and to take the risk of enabling people to make their own life choices, where it is appropriate to do so.

In setting out this vision, the Green Paper is upbeat about the new agenda that it puts forward, describing this as “a new vision” (p.9) and “an opportunity to create a framework for social care which meets the requirements of the 21<sup>st</sup> century” (p.10). In doing so, the Green Paper emphasises the current and future challenges that services face, including demographic changes (especially the rising number of older people living alone and the increasing number of older people with mental health problems), rising public expectations, increased geographical mobility and changes in the structure of families and communities. As a result of this, the Green Paper argues:

*It is not realistic to plan to continue to deliver care in the way we have in the past. These challenges – the increased public expectation that people should be able to live with their own risk; increased geographical mobility, leading to the diminution of the support of the extended family; and the increased demand for organised social care – can only be met by reassessing the way in which social care is delivered.*

(p.23).

Interestingly, the Health Secretary’s foreword acknowledges that, “some of the ideas in this paper are new and build on examples of good practice from up and down the country. They are innovative ‘pilot projects’ where we can catch a glimpse of the future and many of these have informed our vision” (p.7). Presumably, this also means that some of the ideas in the paper are not new, although this is not acknowledged explicitly. However, the argument put forward in this paper is precisely this – that some of the proposals (and almost all of the underlying ideas and aims) put forward in the 2005 Green Paper are very similar in

nature to the aspirations for social care set out in previous consultations and reforms in every decade since the late 1960s. Despite the government’s programme of ‘modernisation’, much of the Green Paper simply repeats previous ideas (which arguably did not work first time round) and owes much more to history than ‘New’ Labour acknowledges. Clearly this raises very real issues about the likelihood of meaningful change as a result of the Green Paper: if similar reforms in the past did not lead to the outcomes that the Green Paper espouses, then why should we expect this policy initiative to succeed?

In order to explore these issues in more detail, the paper reviews key proposals in three previous reviews and reforms of social care, before drawing out links to the current Green Paper. These previous documents include:

1. The Seebohm Report of 1968. Commissioned by the Secretaries of State for the Home Department, Education and Science, Housing and Local Government, and Health, the Seebohm Committee was tasked “to review the organisation and responsibilities of the local authority personal social services in England and Wales, and to consider what changes are desirable to secure an effective family service” (Seebohm, 1968, p.11).
2. The Barclay Report of 1989. Commissioned by the Secretary of State for Social Services, this Working Party was established by the National Institute for Social Work in 1980 “to review the role and tasks of social workers in local authority social services departments and related voluntary agencies in England and Wales and to make recommendations” (Barclay, 1982, p.vii).
3. The *Caring for People* community care White Paper of 1989 (Department of Health, 1989a). Based on a review by Sir Roy Griffiths, this led to the passage

of the NHS and Community Care Act 1990, which has been the underpinning legislation for adult social care for the whole of the 1990s (until the 2005 Green Paper). Griffiths' terms of reference were to "review the way in which public funds are used to support community care policy and to advise [the Secretary of State] on the options for action that would improve the use of these funds as a contribution to a more effective community care" (Griffiths, 1988, p.iii).

In many ways, each of these reforms were the product of very different political and economic contexts, with faith in centralised planning and services in the 1960s giving way to the economic crises of the 1970s and neo-liberal attempts to 'roll back the frontiers of the British welfare state' in the 1980s. As a result, the 1990 community care reforms placed significant emphasis on private sector innovation and managerial approaches, before giving way to New Labour's 'modernisation' and 'third way' agenda post-1997. Despite these changes, the underlying ideas and aims set out in all four reforms show significant consistency over time, and it is this analysis that forms the majority of the rest of this paper.

### **The Seebohm Report (1965-1968)**

Prior to the Seebohm Report, social work functions were spread across various different local authority departments and fell under the remit of various central government departments. For the Seebohm Committee, key criticisms of this system included inadequacies in the amount, range and quality of provision, poor co-ordination, difficult access and insufficient adaptability to changes in social need. This was exacerbated by a wider range of underlying issues such as lack of resources, inadequate research and organisational fragmentation. In response, Seebohm recommended "a new local authority department, providing a community based and family orientated service, which will be available for all"

(p.11). When this recommendation was implemented in 1971, it led to new generic Social Services Departments, bringing together services for children and families and for adults (for example, people with mental health problems, people with physical impairments, people with learning difficulties and older people). For the Committee, this would enable a more comprehensive and co-ordinated approach, would be able to attract greater resources and could plan ahead to identify and meet the social needs of an area more effectively.

In reaching this recommendation, however, Seebohm made a number of comments about current and future social work practice that were to have considerable significance for the subsequent policy documents reviewed below. First and foremost, the Committee rejected proposals to create a separate children's and adult's department, arguing that this would make it difficult to treat the needs of an individual or family as a whole, interrupt continuity of care, split responsibility for social care across different departments and perpetuate a symptom-based approach to social need. Second, there was strong emphasis placed on close working with other services, such as housing, health care and education. Third, the Committee emphasised the need for a preventative approach, reducing the risk of social distress, supporting families through times of change, and concentrating on particular geographical areas most at risk. To do this, the Committee recognised, required decisive action:

*Only when the imperative demands made by the casualties [that is, current social casualties in the late or final stages of "dependence, disintegration and despair"] are diminished can prevention become possible; but the number of casualties can only be reduced by preventive action. It is crucial, therefore, that this vicious circle is broken by a forceful and widespread commitment to prevention.*

(p.141)

As part of this process, the Committee emphasised the need for research (to

understand the issues at stake in more detail) and the central importance of community development:

*We see our proposals not simply in terms of organisation but as embodying a wider conception of social service, directed to the well-being of the whole community and not only of social casualties, and seeing the community it serves as the basis of its authority, resources and effectiveness.*

(p.147)

As a result, social services departments should engage in community development work, focusing resources on areas of special need, promoting citizen participation in the planning, organisation and provision of services, reducing stigma, promoting voluntary action, encouraging informal 'good neighbourliness' and organising services around local area teams. Additional proposals suggested attaching social workers to schools, health centres, courts and hospitals, improving career development structures, the creation of a central body to promote training of social care staff, improved workforce planning, a central body to advise government on social care issues, and a central government inspectorate to act in a promotional, educational and consultative manner.

### **The Barclay Report (1980-1982)**

In 1982, the Barclay Report published findings of its two-year review of the role and tasks of the social worker. In its opening line – “too much is generally expected of social workers” (p.vii) – it began to paint a picture of relatively young profession, struggling with work of increasing range and complexity, confused about its role and remit, and facing unrealistic expectations and intense media scrutiny when things go wrong. In particular, the Report noted that social workers “operate uneasily on the frontier between what appears to be almost limitless needs on the one hand and an inadequate pool of resources to satisfy those needs on the other” (p.vii). As a result of these pressures, “there is confusion about the

direction in which they are going and unease about what they should be doing and the way in which they are organised and deployed” (p.vii).

Having analysed what social workers do and issues of social work staffing, the Report focused on the ongoing need for social workers to fulfil a range of functions, including to (pp.35-51):

- “See people and their needs as a whole and to take account of their views about what services, if any, are to be provided.”
- “Acknowledge the value of individuals and recognise their right to self determination.”
- Promote community networks and engage in “social care planning” (that is, work to alleviate existing and future social problems through responding to individual need, planning responses for a local population, working with other agencies and strengthening voluntary organisations).
- Act as a “broker and negotiator” with a knowledge of local community resources, balancing case work with wider patch-based community work.
- Work with other services, negotiating and advocating on their clients’ behalf.
- Act as “rationers and gatekeepers” of “scarce resources.”

However, the Report also noted a range of criticisms of social work, including the accusation (which the Committee noted had “a great deal of truth”), that “social services departments have taken a reactive stance towards social problems, dealing with those needs which are forced upon their attention but failing to develop overall plans which link the voluntary, volunteer, statutory and private services in an area into a coherent plan” (p.38).

In a chapter on the voluntary sector, the Barclay Report emphasised “the vital

importance of knowing, understanding and taking account of informal caring”, recognising the need to make sure that the role of carers is not “taken over” by formal services, but also that they are not “left to struggle unsupported” (p.75). Social workers also have a key role to play in supporting and stimulating voluntary activity, and the Working Party called for a more preventative approach to social problems and for social services to view the voluntary sector as “an equal partner” (p.85). During this chapter, the voluntary sector is seen to be flexible, innovative and an important component of providing choice to service users.

In a chapter on the economic context, the Working Party acknowledges that “the present situation is one in which the struggle is to maintain the existing levels of expenditure rather than to consider the possibility of increase”, adding that “increases in the future will have to be tenaciously argued and fought for” (p.97). However, the needs facing social care were predicted to increase as a result of an ageing population, changes in family structure and medical advances. Despite this, the Working Party was clear that “there is continuing scope for improvement of services within existing resources” and that more can be done by working with the community (“bringing into play the full potential of individuals, families, groups and neighbourhoods”, pp.99-100), devolving more to local areas, reducing management overheads and developing a more preventative approach. In making this assessment, however, the Barclay Report recognised that short-term funding may be required to help local authorities develop a more preventative approach whilst still continuing existing crisis intervention work.

In addition, there is a need for social services to work closely with other services (“and to make frequent call on their resources”, p.113), developing collaborative relationships with a network of key

stakeholders (including the person, their family, the community and wider services). This can be problematic as social services has a targeted approach (unlike universal services such as health, education, housing and the police). This can result in a lack of understanding of social workers’ role and to people perceived as “troublesome” (p.114) being referred to social services. Professional and organisational barriers also make joint working difficult, as do differences with regard to accountability, geographical boundaries and a lack of understanding of each other’s roles.

In order to make some of its recommendations a reality, the Barclay Report called for greater delegation to the front-line and a greater acceptance of risk. In particular, the Report noted that, “things are bound to go wrong from time to time, and this needs to be accepted by management, elected members, and the general public. We are not convinced that the imposition of rigid hierarchical controls can actually prevent accidents and tragedies: on the contrary, if such controls inhibit good practice or undermine individual responsibility, as we believe they may, it is more, not less, likely that disasters will occur” (p.131). Also significant was the underlying value, skills and knowledge base of social care, with a commitment to support self-determination wherever possible and appropriate, a call for widening post-qualifying training and a recognition of the need for a new balance of skills required to help staff work more effectively with local communities. To protect service users against bad practice, a range of different mechanisms are discussed, including the potential establishment of a General Social Work Council (to maintain a register of social workers), the possibility of an independent inspectorate to monitor the practice of workers and their employing agencies, and a formalisation of clients’ rights to participate in decisions, receive information, have access to a channel of

appeal or complaint and access to a second opinion.

Above all, the Barclay Report's emphasis is on a community social work approach, devolving power to local communities and using workers with a detailed knowledge of the local area to enable local communities to take part in the caring process. In particular, "The Working Party believes that if social needs of citizens are to be met in the last years of the twentieth century, the personal social services must develop a close working partnership with citizens focussing more closely on the community and its strengths" (p.198). In making this recommendation, the Working Party recognised that "we are doing little more than repeat the recommendations made by the Sebohm Committee in 1968 for a community approach" (p.203), but felt that there may be more chance of success this time round due to a general trend away from centralism and a greater belief in the capacity of ordinary people to make decisions on their own behalf. A community social work approach would require workers to see individual clients in the context of their local communities and networks, perhaps adopted a patch-based approach using local resource centres or attaching social workers to health centres and schools. Another approach would be to focus on shared concerns, establishing multi-disciplinary teams to work with particular groups. Overall, this would require a new set of skills and attitudes, including an ability to work in partnership, to understand local communities, and to negotiate and develop networks. This would also need decisions about resources to be devolved to a local level or even to individual workers, allowing carers and communities direct influence over how resources are used.

### **The community care reforms (1990-1993)**

Following the 1988 Griffiths review, the *Caring for People* White Paper emphasised the need to promote greater choice, to help people live "full and independent lives" and

to "stimulate public agencies to tailor services to individuals' needs" (Department of Health, 1989b, foreword). Published alongside an NHS White Paper, *Working for Patients* (Department of Health, 1989b), the government emphasised its desire to "enable people to live as normal a life as possible in their own homes or in a homely environment in the community", "help people achieve maximum possible independence" and "give people a greater say in how they live their lives and the services they need to help them do so" (p.4). Equally important was support for carers, who were recognised as providing "the great bulk of community care" (p.4). Key objectives were to promote the development of community services, provide practical support for carers, improve assessment and care management, promote independent service provision, clarify agency responsibilities and secure better value for money. This was to be achieved via a range of mechanisms, including the publication of plans for the development of community services and legislation to make local authorities responsible for assessing individual need, designing care arrangements and securing their delivery within available resources. However, in making these recommendations, the White Paper was clear that "community care [should not] be seen as the prerogative of public services. People like to take responsibility for their own needs wherever possible. We are fortunate to have a thriving voluntary sector, and a rapidly growing private sector. The Government believes that people welcome this mixed provision of care, that it encourages innovation, diversity, proper attention to quality and the interests of consumers" (p.13).

Under the new system, the White Paper emphasises the role of the case manager (later called a care manager) to provide a single point of contact and monitor people's needs, perhaps with delegated responsibility for budgetary management to enable those closest to the individual to make the best possible use of resources. In meeting needs,

the local authority will be very much an enabler, with a mixed economy of public, private and voluntary providers. This should lead to a wider range of choice of services, more flexible and innovative provision and better value for money. Where it does not already exist, local authorities may well have a key role in stimulating such provision and encouraging greater diversification. In delivering changes, social services will need to work in partnership with the independent sector, with housing, and with the NHS. Thus, in a chapter on collaborative working, the White Paper emphasises “a fresh approach to collaboration and joint planning” (p.49), which seeks to clarify who does what, develop a greater emphasis on joint planning and simplify the statutory framework.

In the future, the community care plan will be a key document, assessing the needs of local communities, setting out strategic priorities (over the next three years) and consulting with other local services. Quality will also be improved by the development of independent inspection units for residential care, national monitoring of quality via bodies such as the Social Services Inspectorate, and ongoing research. In particular, many of these changes are set against the backdrop of an ageing population and rapidly increasing demand for social care. Under the White Paper, responsibility for funding residential and nursing care will pass to social services departments, who will receive additional grant funding in the short-term, but who will eventually have to meet the needs of local people from existing cash-limited budgets. As these changes are implemented, workforce development is recognised as crucial, with the government summarising previous measures taken to improve training and expressing a desire to develop post-qualifying training opportunities.

In subsequent practice guidance, many of these initial announcements are set out in more detail (Department of Health, 1991a-1991c). With regard to assessment, for

example, there is strong emphasis on tailoring services to individual needs, the empowerment of users and carers, a focus on outcomes, a wider choice of services and better integration of services. Above all, guidance stresses the need for “a partnership in which users/carers play a more active part alongside practitioners in determining the services they receive” (Department of Health, 1991a, p.15). This may involve sharing information and enabling users and carers to take a full part in decision-making. Within this, the care management function may involve a range of different models, including a single worker co-ordinating a range of practitioners or even users acting as their own care managers. Crucial to a genuine shift in power might be the devolution of responsibility to allocate resources to practitioner level, increasing the scope for more responsive and innovative services. Also underpinning this, should be a series of shared values, including respect for citizen rights, the promotion of independence, a regard for privacy, dignity and individuality, the maximisation of individual choice and a desire to promote the realisation of an individual’s aspirations and abilities.

Although much of the community care documentation focuses on an individual case work approach and seeks to target scarce resources on those with the greatest needs, there is still recognition of the need for community development and prevention. As practice guidance notes:

*All of this work should be conducted in the context of interacting with local communities. The more communities can be helped to develop their own mechanisms for giving and receiving care, the less will be the demand for interventions by statutory agencies. It is particularly important to preserve the community dimension at a time when services are becoming increasingly specialist in nature, with the attendant danger of a narrowing, or fragmented, focus on individual needs. The emphasis on targeting those in greatest need may also be seen to pose a threat to preventive/promotional community work. However, it should be remembered that none*

*of the permissive powers under previous legislation has been reduced or diminished... Indeed, the requirement to prepare community care plans, based on an analysis of community needs, should give a boost to a holistic approach to the community.*

(Department of Health, 1991a, p.102)

According to the guidance, this will involve developing “seamless services” (p.81) with other agencies (such as the NHS, housing, employment, leisure, social security, criminal justice and the independent sector), as well as staff with an in-depth understanding of community needs and resources. Crucial to this will be “community awareness” (p.103), understanding the general community context, community networks and individual’s own care networks. As a result:

*The challenge for practitioners is to remain alert to the changing pattern of local community life, so as to be able to make creative linkages between identified individual needs and local community resources. In this way, the practitioner is not only taking advantage of what currently exists but contributing to future community development. Practitioners should also bear in mind that helping people to belong to and feel part of their local community is the best form of community care in terms of both costs and likely therapeutic impact.*

(p103)

### **Implications of the adult social care Green Paper (2005)**

In 2005, the adult social care Green Paper reiterated many of these previous themes and issues. Like previous reforms, it justified the need for a new approach on the grounds of ongoing social and demographic change, with concerns that services will become unsustainable without a radical overhaul of current provision. Like previous changes, a fundamental element of the ‘new vision’ was to put people in control. Like other policy documents, this includes a recognition of the need for a more open and mature approach to risk so that people are able to retain more responsibility for and control over their lives. As with other changes, people should be “put

at the centre of assessment” (p.30), with users’ views and wishes central, with a recognition of the need to place people in the context of their families and communities, and with a range of different models proposed to ensure more person-centred and holistic assessments.

While some elements of this agenda (for example, discussion of scope for self-assessment) seem slightly different to what has gone before, the underlying aspirations seem very similar to Seebohm, Barclay and the community care reforms. Similarly, while the emphasis placed on direct payments and individual budgets as a means of giving individuals greater choice and control could signal a significant change, the underlying concern to devolve financial decision making to an individual level so as to make best use of resources and encourage greater flexibility, innovation and responsiveness is similar to the previous policies reviewed above. In the same way, suggestions of new roles such as care navigator or care broker seem new, but underlying principles behind such concepts (and indeed sometimes the language itself) runs through a series of previous reforms.

In addition to recommendations about individual assessment and services, the Green Paper also discusses broader issues such as the role of the wider community, the importance of rebalancing existing crisis focused intervention towards a more preventative approach, and the need to work both with the NHS and with broader universal services. The voluntary and community sector is also seen as a crucial part of future services, and social care is portrayed as having more a well-being and community leadership role that helps to pull together all relevant services for local people:

*In future, greater focus should be placed on preventative services through the wider well-being agenda and through better targeted, early interventions that prevent or defer the need for more costly intensive support... More*

*use of universal services could help people remain better integrated in their communities, prevent social isolation and maintain independence.*

(Department of Health, 2005, p.45)

To achieve this, the Director of Adult Social Care should undertake regular strategic needs assessments to plan ahead for the next 10-15 years and develop a strategic commissioning framework which promotes community development, prevention and inter-agency working. Amongst a number of promising service models put forward is the concept of a Connected Care Centre to meet the needs of people with complex needs in deprived areas via co-located, community-based services. Elsewhere in the paper is a section on workforce development, which stresses the importance of culture change, training, improved leadership, rewarding staff and improving recruitment and retention, but which has little to say about these tasks in detail.

In many ways, each of these aspirations could have come from any or all of the three previous policies reviewed in this paper, and there has been an ongoing emphasis over considerable time on community development, prevention, the role of the voluntary sector, the importance of the workforce and the need for greater choice and independence. Interestingly, both the Green Paper and many of the previous reforms reviewed here are also relatively silent on resources, recognising the need to release resources by moving towards a more preventative approach, but often suggesting that this may need to take place within existing budgets. Just as significantly, the Green Paper does not discuss previous reforms at all – while the Barclay Committee in 1982 recognised that they were reiterating Seebom's recommendations about a community-focused approach, the Green Paper seems much less aware of previous social care changes. In particular, there is little recognition that this adult social care document (and its children's services equivalent, *Every Child Matters*, HM

Treasury, 2003) effectively spells the end of the generic Social Services Department established in 1971, and no discussion as to why the separate adult and children's approaches specifically ruled out by Seebom are the right way forward now.

Against this background, it is very difficult to be confident that the aspirations of the 2005 Green Paper will succeed. Over time, there have been regular calls for more community-focused, preventative social care services which focus more on community development than on individual crisis work, and which are based on financial devolution and a knowledge of local communities rather than on centralised and inaccessible services. In particular, there have been repeated calls to improve support for carers and to give the individual much more control over what happens to them. Typically, these calls have not been matched by additional funding to develop new ways of working or pump-prime the system as it moves towards a longer-term preventative approach.

Despite this continuity, the 2005 Green Paper repeats longstanding concerns that "sometimes we ask people to adapt to the services we can offer, rather than adapting services to better meet their needs" and that "too often the services we provide reduce, rather than increase, the control people have over their own lives" (Department of Health, 2005). From the establishment of the Seebom Committee in 1965 to the adult social care Green Paper in 2005, therefore, there is a strong sense that many of the aspirations highlighted in this paper have not yet been successfully implemented, and that many remain as elusive as ever. As a result, the key challenge for policy makers was not to produce the Green Paper 'vision' in the first place, but to be clear about the implementation mechanisms that they will use to make sure that these proposals deliver desired outcomes (and in particular why this will work when previous changes may not have). Unfortunately, the current Green Paper is relatively silent on these issues, and

it remains to be seen whether these shortcomings are resolved as the ideas in the Green Paper are refined and enter the legislative process.

Although this paper began with a series of quotations about our tendency to neglect the lessons of history, it ends with another quote attributed to Albert Einstein in which insanity is defined as:

*doing the same thing over and over again, and expecting different results.*

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