
10 Information about Residential Care: The Key Issues

The views expressed in the preceding sections represent the perspectives of all the groups involved in the issue of information about residential care. They cover the experiences and opinions of existing and potential residents, of their carers, and of the wide range of professionals who have a role in providing information. The survey will contribute towards the design of information materials and mechanisms that will be capable of satisfying the requirements of all these groups. In order to inform this design, it is necessary to draw out the main themes that emerge from the interviews, and to place them in the context of recent legislation, and of related research.

What do potential clients, and their carers, need to know about residential care?

People considering the move into residential care will be in widely varying circumstances, and will consequently have a very wide range of information needs. Implicit in much of the discussion of these needs is the idea that the information is required so that the people concerned can choose their preferred option. This assumption will be examined in some detail later - for the moment, the important point is that enabling choice is only one reason why people need information. Just as important is the role information plays in preparing the client and their carers for what is obviously a major transition.

Many people will need to know about alternatives to residential care, in order to assess whether or not moving into a residential home is the preferred or necessary option. Assuming that the client is going to move into a home, they and their carers will then need a great deal of information. As a first step, they will need to know what homes are available. This will cover homes run by voluntary organisations and private companies as well as those run by the local authority. It may also include homes in other areas.

Having established what homes there are, potential residents will need a great deal of detailed information about them, in order to form an idea of what life in the home will involve. This detailed information can be divided into a number of categories. People will need factual information about regulations and procedures, and about what facilities are available. This will include information about meal times and menus, and about activities in the home, for example. They will also need to know about the 'quality of life' in the home. This is a fairly vague idea which encompasses the atmosphere of the home, the standard of care, what the staff and other residents are like, and so on. Carers are particularly likely to need confirmation that the quality of care will be as high as the care they have been providing.

Somewhere between these two categories is a need for information about the level of independence that residents will be able to maintain, or about the extent to which they will be able to continue with their own lives. These concerns raise questions about residents having their own rooms, keeping their own possessions and being allowed out of the home.

The final distinct requirement is for financial information. Clients will need to know whether they will be expected to pay anything towards the cost of their place in the home, and if so how much. They will also need to know about the implications of having savings or owning property. In relation to concern over the level of independence, many clients will need to know how much spending money they will receive.

Within these categories there is an extensive range of information needs. Some will apply more or less universally, while others will be relevant only to people with specific circumstances or characteristics. Moreover, different groups which share the same information needs will have different priorities. For example, people with learning difficulties, physical handicaps or mental illness will be particularly concerned about the standard of care that is available, and the qualifications of the staff.

People from black and ethnic groups will also have specific information needs and priorities. These include information about food and activities, and in many cases about measures to circumvent any difficulties over language. It may be particularly important to know about links with the community and other questions relating to independence and continuing with their own lives.

Young people are an obvious example of clients for whom information is not required in order to enable choice. In the vast majority of cases there will be no question of choosing between alternative homes. Information is, rather, provided in order to prepare the young person, and his or her parents, for the move into the home. The aims in providing information will be to dispel anxiety by countering misconceptions, and to provide the young person with the basis for getting on with life in the home. There are a number of other considerations which are peculiar to young people in care, and these will have implications for their information needs. For example, it is more likely that young people will need to be told why they are there and how long they will be staying.

In conducting this survey, we were not simply concerned with establishing clients' information needs - we also endeavoured to find out what information they wanted about residential care and other services. We found that clients wanted a great deal of information about all the aspects of life in the home mentioned above. Again, different clients wanted different information, reflecting individual circumstances and concerns. Financial information was also important. There was much less evidence of a desire to know about what homes were available, or about alternatives to residential care -although this might be partly due to the way in which questions were structured.

How do people go about meeting their information needs?

The underlying pattern that emerged from the survey was of three distinct sets of circumstances from which clients would be approaching the task of finding out about residential care. One group consists of independent people who are not being cared for by family or friends, and who are not receiving support from the formal system of the health and social services. The other two groups are both of people who are more dependent. One consists of those who are receiving support from the formal system - ranging from visits from home helps, district nurses and so on, to attendance at day centres and respite care; the other consists of those who are not in touch with the formal system, and rely on the support of family and/or other informal carers.

This is not to suggest that these are strictly defined, mutually exclusive characterisations. Some people who would fall most naturally into the 'independent' category may be receiving a limited amount of formal support, from meals-on-wheels, for example. Again, the distinction between the two types of dependent client is one of degree, with people who are receiving no formal support at all at one extreme of a continuum. The important point is that people's levels of dependence and support will play a major part in determining their access to information and their information-seeking behaviour. These factors in turn will have significant implications for the mechanisms which must be developed to provide the information they need.

One of the strongest messages from the interviews with the various professionals was the importance of people being 'in the system'. In other words, it was the initial step of establishing contact somewhere in the formal sector that was crucial. It would be misleading to suggest that there would be no problems once this contact had been achieved - the emphasis is more that without this contact it will be very difficult to obtain the required information.

This picture is re-enforced by the attitudes and behaviour of the clients and carers who were interviewed. There was a widespread reluctance to approach sources that were not already known to the client - people were far more likely to turn to informal sources such as friends and family, and to practitioners from the formal sector with whom they were already in touch. This finding is in line with previous research into information seeking behaviour, which indicates that people generally turn first to informal sources, and then to professionals with whom they are already familiar, irrespective of whether they are the best placed to provide the information.

People from black and ethnic groups were particularly dependent on informal sources of information. Other studies have demonstrated a particularly low awareness of the availability of social services among ethnic groups. To some extent, these factors are interdependent - informal sources themselves may have a low awareness of services, and lack of knowledge of services will re-enforce the tendency to turn to informal sources.

Potential clients who had not tried to find out about residential care had little knowledge of potential sources of information, and many would not know where to start if they wanted to get information.

The alternative to obtaining information from formal and informal sources is for the clients to rely on their own initiative. This approach typically involved obtaining a list of homes from the social services department and then finding out the rest for one's self. An element of this approach was also relevant to some of the clients who were in touch with the formal caring services, in that they received lists from their social worker, for example, but were then left to their own devices.

It is vital to distinguish between independent clients who would choose to follow this path, and those who are in need of assistance but do not receive it. Any system for providing information will have to take both these requirements into account. In other words, it is not simply a case of deciding who in the formal sector is best placed to provide information. The system will also have to tackle the problem of how to provide information to people who do not want assistance from or involvement with the formal sector. This brings in the related question of whether there should be a mechanism for ensuring that anyone moving into residential care receives some degree of information and/or advice. Perhaps most difficult of all, a solution will have to be found to the problem of informing clients who are dependent on carers but are not in contact with the health and social services.

Turning to the various formal sources of information which are available to people considering residential care, it was clear that social workers played a pivotal role in providing information. They were the most widely used source for all types of information. Social workers were regarded as the most useful source by clients who had had access to a number of sources. When people were asked who they would recommend to friends as sources, social workers and the social services department were again the most popular choice.

A large range of further formal sources of information were cited: general practitioners; community health practitioners; hospital workers; home helps; day centres and other community facilities; voluntary organisations including advice centres, home-finding agencies and carers associations. As stated earlier, the determining factor here tended to be which of the services the client happened to be in contact with, rather than any judgement that they would be the best people to talk to.

The degree of satisfaction with these sources varied greatly, to the extent that it is not feasible to attempt much in the way of comparisons. On the whole, though, it seems that general practitioners, district nurses, health visitors and other community health visitors were more informative than home helps and staff in community facilities. It is significant that the more useful sources are those which have a role to play in providing services and assessing clients' care requirements. This link between information provision and service provision was also evident in the fact that interviewees frequently answered questions about who gave them information with details of who arranged for them to receive support or attend facilities.

The limited number of clients who had approached voluntary organisations felt that they had been useful in providing information. However, our study supported other research which has established that specialist advice services are only consulted by a small proportion of the people who would be considered to be potential enquirers.

The homes themselves were named as sources by a number of clients. However, in terms of their role as an information source, homes must be considered from a different perspective than other sources. Clients who receive information from the homes will either have found out about them through their own initiative, or will have been given details by one of the other sources mentioned already. In this sense, the homes are a 'secondary' source of information. This is not to suggest that they are not useful in their own right - rather that they do not represent potential sources for more dependent people who are not receiving support from the health and social services.

What is the best way of providing information?

In addition to considering what information is required and who is best placed to provide it, we were also anxious to examine the question of how the information should be imparted. One of the central issues in this context was the use of printed and oral information.

On the whole, it was evident that printed information was unpopular. There were a number of reasons for this: it was difficult to understand; it did not apply to individuals' actual circumstances; it led clients to expect services that they could not get; it was not up to date; it still requires someone to discuss the problem with. Some of these problems could perhaps be solved or diminished by improving the leaflets and so on concerned. Indeed, there a number of clients clearly found information packs which they had received very useful. However, they also demonstrate inevitable deficiencies of the medium itself.

For these reasons, oral communication of information was generally felt to be the preferred method. This would provide an opportunity for clarification to be sought, and should ensure that the information provided was appropriate to the clients' needs. In addition, a number of studies have demonstrated that personal contact and discussion are of vital importance in ensuring that people act on information.

The important question of the relationship between giving information and advising or counselling is also relevant here. In regard to so traumatic a subject as residential care, it is artificial to draw too firm a distinction between these activities. The significance of people's attitudes towards residential care will be discussed in more detail later, but for the moment it is worth repeating that one of the reasons for providing information about residential care is to prepare the client and his or her family for the transition. This may partly involve providing reassurance about what life in the home will be like, along with advice about how to deal with the move. The more that this element of information provision is contemplated, the more preferable it becomes that the information is provided orally.

There are, on the other hand, certain drawbacks related to oral communication of information. Only a fraction of the information that is passed on will be remembered by the recipient, and that information which is retained will not necessarily be the most important or relevant. It is a time-consuming and labour-intensive method of imparting information, and one which requires a great deal of knowledge on the part of the provider. There is also considerable potential for inaccurate information to be passed on.

On one level then, our findings were very straightforward - printed and oral information both have advantages and disadvantages, and what is required is a combination of both. There is a widespread preference for oral information, but ideally this will be complemented by provision of leaflets or packs which can be referred back to. However, there are a number of implications of these findings which need to be considered.

Local authorities, other agencies and individual homes all produce a great deal of written information, mainly in the form of leaflets and brochures. However, it seems that little thought has been given to the question of exactly how the written information should be used. There is also the related question of which kinds of information are best suited to oral communication and which need to be written. One obvious criterion is that the quicker information goes out-of-date, the less suitable the written format. The distinction between locally produced information and nationally produced information is also relevant in this context. Most information is necessarily produced locally, but financial and legal information for example will apply nationally. It seems reasonable to suggest that if information is produced nationally, there will be a greater reliance on written communication of it. It is worth noting the idea that audio-visual materials might solve some of the problems discussed in relation to both oral and written information. However, this is certainly not a source which was widely used by the clients in our survey, nor was it mentioned in response to questions about possible improvements in information provision.

The benefits of using visits and trial stays to convey information were widely recognised, by clients and by professionals. Visits and short periods of residence will in themselves impart qualitative information about the homes, and they will also provide the opportunity for the communication of oral and written information. Indeed there are reasons to believe that visits and trial stays represent particularly conducive circumstances for conveying information. One reason is that they enable potential residents to meet current residents, and so give them access to an information source which they would not otherwise encounter and which may possess particular credibility. Visits or stays also provide the opportunity for information to be conveyed on less formal basis, in a situation where its relevance may be more apparent than would otherwise be the case.

There are two points about the place of visits and trial stays in the local authority allocation process which are relevant here. The first is that they tend to come at a fairly advanced stage in the process, and this has implications for the extent to which they can contribute to any choice between residential homes - by the time someone visits a home, it may be that turning down a place will mean returning to the 'bottom of the list'. The second point is that trial stays are generally a two-way assessment - they are designed to enable the home staff to assess the potential resident as well as providing the client with information.

The role of the key worker is also relevant in the context of how best to impart information. The significance of the key worker is that the client has a known individual contact point to approach for information, rather than relying on picking up information on a piecemeal basis from a number of sources.

Constraints on the use of information

The issues discussed so far have focussed on approaches to obtaining information. We also wanted to find out about constraints on the use of information which were imposed by clients' circumstances.

One of the most prominent themes to emerge from the survey was the extent of people's psychological and emotional resistance to the idea of residential care. Residential care is seen as something unpleasant - considering it is tantamount to accepting a dramatically reduced standard of life, to the point that it is viewed as 'a place to die'. For carers, considering residential care is equivalent to admitting defeat, and will often generate feelings of guilt at having failed to live up to one's responsibilities.

There are other elements of people's attitudes towards residential care which also have implications for their information seeking behaviour. One is the tendency to think of a place in a residential care home as a privilege or benefit, rather than as an entitlement. Along the same lines is the acceptance of residential care as 'one's lot in life'. This approach is apparent in the general absence of reference to residents' rights in discussions of clients' information wants. The perception that the client has no genuine power to influence the allocation process will also be significant in this context.

These attitudes will obviously place a considerable constraint on clients' information seeking. This has two principal implications for the provision of information. The first relates to the kind of information that is required. It will be necessary to provide information to counter the negative image of residential care. This is a deep-rooted conception, and to a certain degree is a function of generation. It will not be easy to dispel, and demands an innovative approach to information provision. Attempting to tackle the problem through established channels of communication will be unlikely to succeed, since the attitude which is at the core of the problem means that people are reluctant to use those channels.

The suggestions of the practitioners involved in the survey centred on two notions: the need for some form of public relations campaign; and the possibility of establishing closer links between residential homes and the community. The latter could involve holding open events at the home, and staff from the home going out to community facilities to give presentations (one of the other projects under the Caring in Homes Initiative has been established specifically to look into the issue of links between care homes and the community).

The second implication of the resistance to thinking about residential care is that information is not sought until the last possible moment. As a result, the communication of information will take place in great haste, and frequently at a time of crisis for the client and his or her carers. This will not reduce the need for information - it just means that the mechanism for providing information will have to work more quickly. An additional factor in this regard is the part played by health problems in precipitating the move into residential care. The decision will frequently have been made because the health of the client or of the carer deteriorates to such an extent that they can no longer cope.

The urgency with which information is required and the state of health of the client in turn obviously have implications for the provision of information. There will be less time to pursue particular queries, and it is likely that complex issues such as the financial and legal aspects of the move will not be dealt with in the depth they require. In terms of the method of provision it is likely that visits to the homes will be more difficult to arrange, and in cases of severe health problems information provision will be restricted by who is available to visit the client, and by the extent to which information is available in printed form.

This problem is not simply a matter of the amount of information that is made available. Ideally, different kinds of information should be communicated at different stages in the admission process. This will facilitate planning and will contribute towards the smooth running of the move into the residential home. It is particularly important that information is provided prior to the move, in order to create a more positive attitude towards the home. This will have a significant impact in providing for a successful transition. The more rushed the communication of information, the less scope there will be for structuring it along these lines.

Cultural factors also influence attitudes towards residential care. The Hindu tradition of acceptance amplifies the tendency to view residential care as one's lot in life. It was also evident that Afro-Caribbean clients would associate residential care particularly strongly with betrayal and failure.

Finally, in the context of constraints on information use, any consideration of the use of written information will need to take account of problems of illiteracy among clients and their carers.

Who is the information for?

In discussing the themes identified so far, there has generally been little distinction between the needs and behaviour of the potential residents, and the needs and behaviour of their carers. For the most part, it is reasonable to set this distinction aside, since carers will principally be acting on behalf of the clients, and will therefore have the same information needs. In terms of information seeking behaviour, the question of who is doing the seeking is largely irrelevant, since the important point is to appreciate the implications of the behaviour for the mechanisms of provision.

Nevertheless, the relationship between client and carer does raise some important issues. The heads of homes for elderly people tended to talk about providing information for the relatives and the carers rather than for the clients themselves. This picture is confirmed by the interviews with the elderly people themselves, which suggested that they expected their carers to take the initiative in obtaining information about residential care.

In the light of these findings, perhaps the most fundamental question is what the carers do with the information. Do they primarily need information in order to pass it on to the prospective resident; or is it rather the carers themselves who use the information to make the decision? The interviews with carers of people who are now in residential care made it abundantly clear that in their cases the decision was made by the carer rather than the client.

On this basis, it will be essential that carers have information about the requirements and preferences of the people they are caring for, in order to make their decision. Ideally this will be supplied by the clients themselves, but it will be necessary for practitioners involved in providing information to check that the carer is in a position to make the decision on behalf of the client. However, where carers are not related to clients they may be excluded from the decision-making process. This in turn will have implications for the information which carers should be given.

In some cases at least, the carer will need information in order to pass it on to the client. This may mean a greater reliance on written information than in other circumstances. It might also be beneficial for carers to be given advice as to how to pass the information on.

The interviews with heads of children's homes indicated that parents of young people represented an exception to most of what has been said about carers generally. Provision of information to parents was given a low priority in comparison to the importance of ensuring that the young person settles into the home. There was also a degree of uncertainty over the question of whose responsibility it was to provide parents with information.

The information 'system'

The primary focus of this survey has been the information needs and information seeking behaviour of clients and their carers. The themes that have been discussed concern what those needs are and how they can best be satisfied. However, it is also necessary to examine the information resources of the people who are involved in informing clients and their carers.

It was very clear from their interviews that the professionals relied largely on networks of personal contacts and on information accumulated through personal experience and initiative to meet their own information needs. This applies to information for their own use as well as information to pass on to clients. Other research has indicated that social workers tend to rely on personal stores of information, often kept in their heads. There was little evidence of formal structures or procedures to provide information. There are a number of disadvantages to this system of communication. It means that when someone leaves a particular position, they take with them a great deal of the information necessary to fulfil that role. It introduces a further element of chance into the already precarious position of clients who are seeking information through formal sources - they will be relying on having an experienced or well-connected social worker for example, rather than on an established formal information system. It seems that for various reasons these personal communication networks do not function so well between the health services and the social services. Finally, it is not a method of operating which lends itself to long-term planning - a series of telephone calls may be an appropriate way to set up an emergency admission, but it is not the most effective or efficient way of providing a client with detailed information.

These are serious problems in themselves, but they are also significant because of what they demonstrate about the prevailing attitude towards the provision of information. A great deal of uncertainty was evident from the interviews with the practitioners, including the heads of homes, over the question of responsibility for

information. There was no established approach: rather, collation, preparation and dissemination of information was undertaken out of personal inclination. This is not to say that established, formal communications networks do not exist. However, where they do exist it seems to be largely as a consequence of individual or local initiative. Again, this suggestion is supported by other studies which have discovered a lack of overall strategies within social services departments regarding the responsibility for information provision.

The central issue to emerge regarding the structure of a formal information system was the distinction between the need for information and the need for a designated referral point. It would clearly not be practical to provide detailed information about residential facilities to all the practitioners who have a role in providing information. There seem to be three levels of requirement. First, professionals who are most deeply involved in providing information, principally social workers, will need a great deal of up-to-date detailed information. Secondly, at the next level are practitioners who may need some general information to hand, but whose main requirement will be a resource that they can access for specific information as they need it. Thirdly, for some practitioners it will be enough to have details of a person or department which they can pass on to clients who need information.

The survey does not provide the basis for a definitive specification of which practitioners should be located at which level. There are, though, some general points to be made. Consideration must be given to the appropriate roles of the various practitioners. For example, there seems to be a lot of uncertainty about how much information home helps are and should be providing. However, this is not to imply a rigid characterisation of roles. It is apparent from the survey that the structure of the health and social services provide for a considerable degree of self-determination by practitioners, and this seems potentially beneficial to practitioners and their clients. The essential requirements are for a framework according to which responsibility can be allocated, and on which a system of information provision can be based.

A further general point is that the system will need to cater for all three categories of client outlined above. The fundamental questions here are how to provide for access by members of the public as well as practitioners, and how the system can be introduced to dependent people who are presently cut off from formal support services.

'Noises in the system'

The discussion so far has identified a number of factors which constrain clients' use of information about residential care. However, the survey also brought up some fundamental questions which threaten to undermine the premises that lie at the heart of much of the discussion of information about residential care.

Reference has already been made to the underlying assumption that information is provided in order to enable choice. One of the most urgent questions raised by the survey is that of the reality of choice in the context of residential care provision. There are two very straightforward circumstances in which choice is clearly not a reality: admission of young people into care; and the allocation of places to people

with mental illness or learning difficulties who for that reason are not capable of choice.

However, the issue is both more complex and more fundamental than is suggested by focusing on these particular cases. There are a number of related factors which restrict clients' ability to exercise choice over residential care placements. The first is that the simple model of choosing between possible placements (or between a residential placement and alternative care provision) overlooks the processes of assessment and care management. These processes are central to the allocation of care resources within social services departments, and clients' preferences represent only one of number of potential inputs into the allocation process.

In its guidance to the *National Health Service and Community Care Act, 1990*, the Department of Health places a clear responsibility upon social services departments to inform clients about the full range of their care services, and about assessment procedures. This is in order to enable users and carers to exercise genuine choice. However, the guidance goes on to note that the departments' aim in drawing up individual care plans for users should be '...to secure *the most cost-effective* package of services that meets the user's care needs, taking account of the user's and carers' own preferences... However, local authorities also have a responsibility to meet needs within the resources available and this will sometimes involve difficult decisions where it will be necessary to strike a balance between meeting the needs identified within available resources and meeting the care preferences of the individual.'¹

In other words, a client's scope for exercising choice will be constrained both by the assessment of his or her needs, and by the requirement to meet those needs in the most cost-effective manner. As a result, clients are likely to be presented frequently with a specific placement, rather than a choice between a range of alternatives.

A further obstacle to the exercise of choice is the possibility that practitioners' understanding of the assessment process may create a disincentive to provide information about the full range of placements and services which exist. They may feel that no good purpose is served by informing a client about services for which that particular client would not be eligible. Moreover, it is likely that experienced practitioners will have a good idea of the kind of placement or service which is most likely to be judged as appropriate - indeed, the practitioner will frequently have a role in making this judgement - and this may in turn influence both the amount and the nature of the information they provide about the placements or services concerned.

The issue of conflicts of practitioners' interests is also addressed in the guidance to the 1990 Act. Part of the rationale behind the division into 'service purchasers' and 'service providers' is to ensure a needs-based assessment and allocation process. This is to be achieved by divorcing responsibility for drawing up and implementing individual care plans from responsibility for managing the services. The care manager, who draws up and implements the care plan is there to represent the client's interests. However, the purpose of this is to ensure that the service provided

1. 'Community Care in the Next Decade and Beyond: Policy Guidance', HMSO, 1990 (our emphasis).

is determined by clients' needs, and not by what is available and/or convenient. In other words, the conflict of interests which threatens to restrict the exercise of choice - the conflict between providing full information and gearing information provision to likely allocation - is not the conflict which is addressed by the service purchaser/ service provider split. Since the care manager is responsible for deciding what service is to be provided, the incentive to gear their information provision accordingly will still exist.

These considerations have a significant bearing on the role of the social worker. The primacy of social workers as information sources has already been discussed. An equally clear element of the social workers' role is the part they play in the assessment and allocation process. It would clearly be artificial to suggest that these two roles can be considered as independent - the social workers responsibility to serve the client's best interests is part of an overall responsibility to ensure the most appropriate allocation of resources.

The fact that many clients and carers will be in no condition to make reasoned choices is also relevant in this regard. They are in contact with health and social services because they cannot cope and are desperate for assistance, not because they want information. There is also the possibility that clients will not feel in a position to ask for information about alternatives from a practitioner who also has this role in the allocation process.

None of this is to suggest that the provision of information is not necessary because of the lack of real choice. There will be circumstances in which potential residents will have genuine choices - either because of alternative vacancies or because they have sufficient support to wait for an alternative placement. In other words, choosing between homes is not the only form of choice - in some circumstances clients will have the option of choosing not to accept the placement.

Furthermore, provision of information benefits clients in enabling them to prepare for and cope with the move into residential care, and in adjusting to their new life once they have moved in. It is in everyone's interests to make the transition as smooth as possible, and to this end information provision should not just be built into the assessment and allocation process - it should also be an integral part of the procedures of the home.

There is also a particular category of clients for whom choice is a reality - those who are able to afford to move into private residential homes. This raises a series of problems. It is evident that public sector professionals do not feel confident about how to deal with information about private homes. They do not know how to react to approaches from private homes, and they do not know how to assess and utilise the information that private homes provide about themselves.

There are two distinct ideological objections which also hinder the communication of information about private homes. One is the fundamental objection to private provision of residential care. The other concerns social workers' conception of their role as providing support and assistance in tackling clients' problems. Where clients are in need of the support provided by residential care, provision of information is an essential element in tackling the problem. However, in the case of relatively

independent prospective residents, it is possible that social workers will not see provision of information as part of their responsibility.

Private homes also represent a problem in relation to the idea of a formal information system. It seems reasonable that any system will be developed as part of the health services or, as is perhaps more likely, the social services. This will obviously facilitate access to a broad range of information currently available in the social and health sectors. It is, however, unclear how sectors outside the statutory services will fit into this scheme. This consideration applies to voluntary organisations as well as private homes, both in their capacity as service providers and as information providers. The registration and inspection units will collect information about homes in all sectors, but this is specific information collected for a specific purpose, and will only meet part of the requirements of the envisaged information system. The system will also need to cater for assimilation of information about homes in other areas.

The requirement to provide objective information raises a number of interrelated issues. These include a variety of motives for providing biased information: the need to free a hospital bed; the desire to dispel anxiety about moving into a residential home; the desire to deal with problems informally to avoid escalation. This requirement can in fact result in restricted access to information by forcing local authorities to provide no more than lists of homes, in order to avoid expressing opinions or making assessments of homes. Unfortunately, the information which is most likely to be excluded by these considerations - qualitative or evaluative information - featured highly in potential clients' specifications of what they wanted to know. The issue of evaluative information about homes was also raised by some of the professionals - doctors in particular felt that directories were of limited use because they did not contain evaluations of the homes.

The registration and inspection units may also provide part of the solution to this problem. Much of the information that they will collect is likely to fall into the qualitative or evaluative category, and the 1990 Act does direct local authorities to make the units' reports publicly available. However, the Act also makes clear that local authorities should be aware of the legal implications of publication. It again seems reasonable to suppose that more qualitative information is the most likely to be excluded. All of which suggests that there may be a significant role in this context for voluntary or independent organisations who could provide authoritative information.