INTEGRATION OF HEALTH SERVICES

The Brighton and East Sussex Project

First Phase
Advisory Group Reports

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THE BRIGHTON AND EAST SUSSEX PROJECT

FIRST PHASE

ADVISORY GROUP REPORTS

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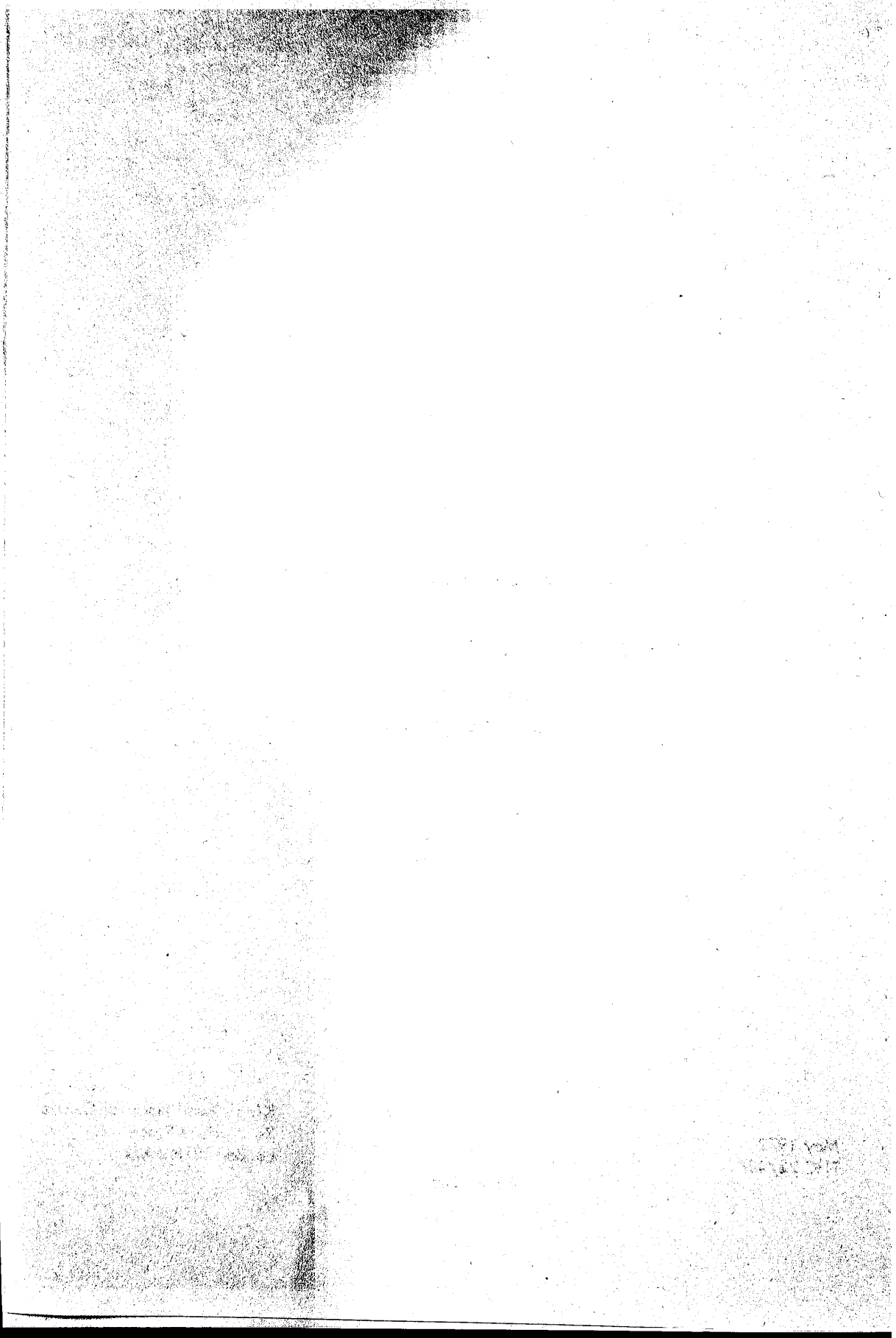

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INTEGRATION OF HEALTH SERVICES

The Brighton and East Sussex Project
Advisory Group Reports

Origins

The papers in this booklet consist of reports prepared by multidisciplinary advisory groups as part of a project concerned with the integration of health services. This project originated in an application to the King's Fund from the South East Metropolitan Regional Hospital Board for support for a study to see how the proposed unification of the NHS may be made to work at area level. The project was approved by the Fund's Management Committee in December 1970 and a sum of £13,000 was allocated towards the cost of the project over a period of two years. It was to be related to the Brighton and East Sussex area and to be conducted under the direction of Dr P J McEwan, Director of the Centre for Social Research at the University of Sussex.

Objectives

The main purpose of the study was defined as being to bring together those now responsible for the local health, general practitioner and hospital services in the area in order to identify the consequences of any possible unification. Initially, the emphasis was to be laid on:

a) The administrative re-organisation necessary to effect unification and the development of a district organisation if that is thought to be necessary.

b) The organisation necessary to ensure proper medical advice to any area health authority over the whole range of health services, the role of the Executive Committee and the application of the Salmon Report, together with the influence of the Community Physician.

Progress

The project started officially in January 1971, with the appointment of Dr John Powles as Research Fellow, based at the University of Sussex and working under the direction of Dr McEwan, and guided by a steering committee that now consists of the following members:

Dr K R Porter (Chairman)	Senior Administrative Medical Officer, South East Metropolitan Regional Hospital Board
Mr R W Alderton	Group Secretary, Brighton and Lewes Hospital Management Committee
Dr D Allen	Director of Social Services, East Sussex
Mr K Barnard	The Hospital Centre
Mr C Brady	Regional Officer for Health, Department of Health and Social Security (Observer)
Mr M C Hardie	The Hospital Centre
Mr H N Lamb	Secretary, South East Metropolitan Regional Hpl Board
Dr P J McEwan	University of Sussex
Dr J Powles	University of Sussex
Mr J Simmonds	University of Sussex
Dr J A G Watson	Medical Officer of Health, East Sussex

At an early meeting of the steering committee, it was agreed that nine Advisory Groups should be formed:

i) to consider the identification of current problems in providing services and needed improvements in the Brighton and East Sussex area

ii) to give detailed consideration to the cause of past problems

iii) to recommend solutions in the context of an integrated service

iv) to recommend areas of further study

The subjects covered by the nine Advisory groups are:

1 Preventive services and the promotion of health
2 Primary health care services
3 Centralised health care services
4 Birth control and maternity services
5 Child health services
6 Services for the elderly
7 Services for the mentally and physically handicapped
8 Psychiatric services
9 The consumer and the health service

The Advisory Groups produced their reports by early in 1972. These formed the basis for the second phase of the project, which involved the establishment of new Advisory Groups to discuss the recommend methods of implementing the proposals of the first phase Advisory Groups, and generally to relate the work done to the operational and administrative requirements of the new area authority and its constituent district. Four functional groups were convened as follows:

i) The area health authority - objectives, functions and management structure
ii) The district organisation - functions and management structure
iii) Consumers and the health service
iv) The professions and management

In order to co-ordinate the work of these groups and to resolve differences and deal with matters of common concern, a Joint Advisory Group has been formed at which all the functional groups are represented. The Joint Group also has links with a parallel linked study at the Centre for Social Research on the relationship between health and social services. In addition two workshops dealing with technical as distinct from policy considerations have been set up:

i) the organisation of information services
ii) the organisation of supportive services and estate management

It is expected that these second phase Advisory Groups will complete their work by the end of July 1972. In the following pages there are reproduced the reports of the nine first phase Advisory Groups. These reports were completed in February-March 1972 and passed to the second phase Advisory Groups for the next stage of the project.

At the end there is included a report by Dr John Powles on problems and opportunities in the future relations between health and local authority services as identified by the first phase Advisory Groups.

1

Advisory Group Report

on

PREVENTIVE SERVICES

and

THE PROMOTION OF HEALTH

MEMBERS OF ADVISORY GROUP

The group consisted of the following eight members acting in individual (and not official) capacities and met seven times between October 1971 and February 1972.

Dr D W Anniss	General Practitioner, Hove
Dr R Aspden	Chief Administrative Officer, Brighton County Borough Health Department
Miss G E Cloughley	Planning Assistant East Sussex County Planning Department
*Miss P Cross	Area Nursing Officer, East Sussex
Mr E Edlington	Chief Public Health Inspector, Eastbourne
Mrs B M Hampton	Health Education Officer, East Sussex Health and Education Departments
Dr W S Parker	Medical Officer of Health, Brighton
Dr K O A Vickery	Medical Officer of Health, Eastbourne
Dr J W Powles	Research Fellow to the Project, acted as chairman

* Joined the group after it has commenced its meetings

1 PRIORITIES AND OBJECTIVES

1 It was hoped when the National Health Service was established in 1948 that it would result in an increased overall emphasis being given to the prevention of illness. This hope has not been fulfilled. It will be a tragedy if, again in 1974, the opportunity of securing a higher priority for preventive medicine is lost.

2 In thinking of the prevention of disease it is important to consider not only specific preventive measures but also wider based activities aimed at the promotion of health, for example activities aimed at promoting healthy styles of living or at ameliorating environmental stresses. It is necessary to reach out to the community before they become patients. (It is for these reasons that the title of the group's report has been widened from 'preventive services' to 'proventive services and the promotion of health'. Where the term 'preventive services' is used in the remainder of the report it is meant in this wider sense).

3 The contemporary challenges to preventive services come from many sources. There is however an increasing public interest in and awareness of the new environmental stresses on the human organism. Areas demanding attention include:

(1) The environment

pollution of air, water and sea
noise and vibration
stress
problems generated by intensive agriculture (eg fertiliser nitrate in drinking water) and the keeping of animals and pets

(2) Accidents

At home and on the road

(3) Nutrition

obesity - especially in children
nutritional state of the elderly
dental caries
refined diet

(4) Communicable diseases

immunisation, control

(5) Leisure and tourism

sport injuries
advice to travellers, campers
education for retirement

(6) Living conditions

density and crowding
suitability for the handicapped and elderly

(7) Working conditions

physical environment at work
increasing need for re-training

(8) Family environment

may be such as to produce illness
may need help to cope with illness, eg with the elderly and mentally ill
maternal and child health

(9) School environment

including behavioural problems

(10) Early detection of diseases

4 The preventive services need to have connections with many other services, in particular with education, local authority environmental services, local authority planning departments and social service departments.

5 Within the health service the principal need will be to secure an emphasis on prevention in the primary care sector. This is particularly important as much of the current preventive activity in this sector is organised or stimulated by the local authority health departments and these departments are to be dissolved in the reorganisation of the NHS. Further, general practitioners are not generally prevention-oriented and may be reluctant to take on any new tasks that will increase their work-load.

6 There is a great danger that with the dissolution of the local government health departments, prevention-oriented health workers will become submerged in the much vaster number of clinically-oriented workers. For example, there are approximately 125 health visitors in Area 44 compared with some 1,000 hospital based SRNs and some 14 doctors with public health qualification compared with 350 GPs and 160 consultants. Thus, a preventive influence cannot be ensured by the number of prevention-oriented health workers but rather will depend upon the service being so organised as to 'structurally re-inforce' a strategy of prevention.

7 The future community physician will have a crucial role in providing a prevention-oriented medical 'input' into the planning and management processes in the new health service. At area level a strong health information system should be developed under the guidance of community physicians. Such a system will provide the basis formedical recommendations on the planning of future services that give due weight to prevention. The ideas and approach of preventive medicine ought to be widely and effectively communicated within the new health service.

8 The central component in the day-to-day management of the new health service will be the district management team. It is important that these teams should have a good deal of autonomy in coping with day-to-day management problems within the context of policies determined at area level. This applies particularly to the community physicians based at district level, for it is at this level that resources will need to be mobilised and co-ordinated towards the attainment of area policies. At district level the community physician will be able to familiarise himself with the staff, institutions and parellel organisations whose assistance needs to be mobilised. If management is to be conducted by a multi-disciplinary team, all members of such teams should be housed under the one roof so as to maximise consultation and the exchange of ideas.

9 The administrative functions currently performed at district level in support of preventive activities should not be underestimated. They include: administrative support for health visitors, the organisation of health education, the organisation of maternal and child health clinics, the organisation of cytological screening clinics, the organisation of immunisation clinics (including Yellow Fever in Brighton) and the supply of vaccines to GPs, the organisation of domiciliary family planning, the supply of welfare feeds, the registration and control of nursing homes and agencies, mortuary control and the provision of cremation certificates, the organisation of medical inspections under the Factory Acts, the provision of personal and immediately accessible information to the public on public health matters as well as general administrative functions such as personnel management. There is also a considerable quantity of administrative work currently performed in local government health departments in support of environmental health services (which will be transferred to the new district councils) and primary care services.

10 In view of the factors mentioned in 6 to 9 above, there should be a specific organisational focus at both area and district level from which the provision of preventive services would be co-ordinated. (There will probably need to be similar arrangements for other services, eg birth control and maternity services and psychiatric services).

11 If health visitors are brought under a unified nursing administration it is important that their preventive orientation be recognised and safeguarded.

12 There are two major elements of uncertainty with respect to future official policy:

i) The relationship between the area and district levels of administration (for this group's views see 8 and 9 above)

ii) The relationship between the different prospective members of the area and district management teams. In particular, what will be the respective roles of the community physician and the professional administrator within these teams?

13 The health education services could be organised either on a shared basis with the education department or entirely by the health authority. If they are organised within the health service then the need for effective penetration of the education service should be recognised. A health education liaison officer appointed by the education department could help in these circumstances. The future role of the health educationist needs to be more clearly defined.

2 ADMINISTRATION - AREA

1 A number of resources with relevance to prevention will be marshalled at area level. This includes computing facilities and hence the health information system will be organised at this level. The community physicians working on health information should not only review statistical information on the services being provided but should also preparebriefs for policy-makers on the likely costs and benefits of different possible health care measures (for example, screening and intensive cardiac care) within Area 44. They should have available to them the research resources of a university-associated regional unit of epidemiology or human ecology. There is also scope for further collaboration with the University of Sussex in research into health care organisation.

2 There should be a strong health education 'resource unit' at area level capable of making use of mass media and market research techniques. This unit should also prepare the more sophisticated materials suitable for use by health education field workers. It should also make use of every opportunity to 'teach the teachers' for example, by providing in-service training in health education for school teachers. In general the resources committes to health education ought to be greatly expanded. The opportunity for a much greater penetration of the primary care and hospital sectors that integration will bring should be taken up. There is also a need to co-ordinate health education programmes for special target groups - eg food handlers.

3 Continuing education for all health care workers should be co-ordinated at area level and have a bigger preventive component than in the past. Facilities for study leave to attend courses such as those currently provided by the Local Government Training Board should be available in the new health service.

3 THE DISTRICT LEVEL OF ADMINISTRATION AND THE ORGANISATION OF WORK

1 Functions of the district level of management with a relevance to prevention include: the co-ordination and deployment of relevant fieldworkers, the collection of health information data, the provision of medical advice to the environmental health services and health education.

2 An organisational focus for preventive services at district level is suggested in 1 10 above. A community physician could be appointed as 'co-ordinator of preventive services' at district level and progress in this field could be reviewed in regular multi-disciplinary meetings of community physicians, health visitors, health educationists, ancillary workers and administrators (all from 'headquarters staff'). There will also be a need to bring in relevant 'fieldworkers' eg GPs. Public health inspectors from the local authority district(s) that lie within the health district should attend these meetings.

3 Within each health district one community physician should be designated as medical consultant on environmental health to the local authority district or districts that lie principally within the health district. Adwquate deputising arrangements should exist to ensure that when he is away from the district there will still be another community physician available for prompt local consultation.

4 An important part of the duties of the community physician will be to establish close working relationships with doctors in the hospital and primary care sectors within the district. These are the sectors which have hitherto experienced the least preventive influence. The community physician's aims must therefore be to gain the confidence of his colleagues operating in these fields, to demonstrate that he has a useful contribution to make to the solution of their problems and to provide to area headquarters his assessment of health matters in the district.

2

Advisory Group Report

on

PRIMARY HEALTH CARE SERVICES

MEMBERS OF ADVISORY GROUP

The group consisted of the following seven members acting in individual (and not official) capacities and met seven times between October 1971 and February 1972.

Mrs E Beith	Chief Nursing Officer (Community), Brighton
Dr I M Brown	Consultant Geriatrician, Eastbourne
Dr N M Cole	General Practitioner, Hailsham
Dr M S Hall	General Practitioner, Forest Row
Miss N Mustard	Chief Nursing Officer (Hospital), Hastings
Mr T Ryder	Chief Administrative Officer, East Sussex County Health Department
Dr J A G Watson	Medical Officer of Health, East Sussex County Health Department
Dr J W Powles	Research Fellow for the Project, acted as chairman

1 PRIORITIES AND OBJECTIVES

1 Primary health care is concerned with the total health care of individuals in the community and is provided by a primary care team - see 3 1.

2 The objectives of a primary health care team are those of a comprehensive health care service but relate to persons registered with the general practitioner(s) in the team and resident in their own homes, community homes and community hospitals (as they are envisaged).

3 These major objectives are:

i) The promotion of health

ii) The prevention of illness and disability

iii) The provision of primary treatment and aftercare services

4 The promotion of health includes health education to influence individuals towards healthier patterns of living and the exertion of influence on the responsible authorities in order to improve the living and working environments of those for whom the primary care team are responsible.

5 The prevention of illness and disability includes specific preventive measures such as immunisation and the early detection of disease, for example, by screening procedures for "well babies", "well women", school children middle-aged men and the elderly. Screening includes appropriate follow-up procedures.

6 The provision of primary diagnostic treatment and aftercare services implies the provision of consultation facilities and treatment for all conditions within the team's competence and should be taken to include first aid and care for the terminally ill. The team should provide first aid for persons not registered with the practices in emergency situations.

7 With the dissolution of the local authority health departments it will be necessary to give all possible encouragement to the expansion of preventive medicine in the primary care sector. Essentially this means providing more resources to avoid creating an additional burden on primary health care workers. The resources involved are:

i) increased staff

ii) computer facilities to produce, for example, age/sex registers and "call systems" for immunisation and screening clinics from practice lists

iii) improved communication, transport and supplied networks

iv) improved vocational training and continuing educational arrangements for primary care workers

v) improved facilities and resources for health education

8 The optimum list size for a general practitioner has not yet been determined and requires further study.

9 First aid facilities should be encouraged in health centres and group practices. Minor trauma and medical emergencies comprises the vast bulk of hospital accident and emergency work and much of this could be coped with at primary care level. Sterile supplies ought to be made available for this work.

10 There is a case for community hospitals, not to substitute for DGH care but rather for domiciliary care when it is inappropriate, as in the following circumstances:

i) for patients whose home conditions are such as to necessitate residential care

ii) for those who no longer need the services of a DGH but are not yet ready to return home and for early discharge cases

iii) for terminal care

Patients in such hospitals would be under the care of the primary care team. The hospitals could well be associated with health centres.

11 Children, the elderly and the long-term disabled (eg, the mentally handicapped) who are in community residential care should receive their health care from the primary care team. Residents should have the option of choosing their own doctor but in large or special establishments it may be advisable for one GP to be designated to give general advice to the staff and care for those patients not able to exercise their option.

12 Recruitment to general practice depends upon its "image". There is evidence that vocational training is encouraging recruits and it should be further developed. Training schemes for nurses should include community nursing. Meetings for continuing education ought to have a greater emphasis on prevention and all primary care workers should be encouraged to attend such meetings.

13 There should be no financial dis-incentive to home care. Currently, for example, relatives caring for a terminally ill patient often face considerable extra expenditure. This is only partly recoverable in the "Attendance Allowance".

2 i) ADMINISTRATION - AREA

1 Many of the resources referred to in 1 2 above need to be marshalled at area level. In particular computer resources must be available as an aid to preventive medicine and research.

2 An effective health information system should be developed. The most useful information for general practitioners is information on the patients for whom they are responsible. The first item to be provided is an age-sex register from a computerised practice list. An outflow of useful information would, in turn, encourage an inflow of information.

3 Administrative boundaries should not be allowed to cause problems by interfering with the natural movement of patients. Where patients cross area boundaries for their hospital care it is important that the policies of the primary care and hospital sectors are compatible. This will clearly be of most importance in midwifery, geriatrics, psychiatry and paediatrics. The solution is to maintain effective liaison between the professionals responsible. Specialists should cross boundaries to maintain an involvement in community care throughout their catchment area.

4 General practitioners are likely to be apprehensive about being incorporated on a "divisional" basis into comprehensive professional advisory machinery. It is likely that GPs will feel their "independent contractor" status to be threatened unless they have a separate professional advisory body at area level. If dentists, pharmacists and opticians are to be included in a divisional structure then this would be best accomplished at area level.

5 Those functions of the Regional Medical Officer of the Department of Health and Social Security which are largely of a monitoring kind should continue to be performed by someone remote from area level.

2 ii) ADMINISTRATION - DISTRICT

6 An adequate communication network needs to cover both hospital and primary care sectors. Currently, the weakest link is the transmission of information outwards from the hospital especially on discharge. With a tendency to earlier discharge it is crucial that this be improved. Current practice often relies upon an overworked houseman. Therefore:

i) the consultant ought to take overall responsibility for ensuring that a discharge note is sent out before or at the time of discharge

ii) the doctor who actually prepares the discharge note ought to be given such help - in the form of dictating machines and secretarial assistance - as is necessary

iii) a full discharge summary should follow as soon as is practicable

7 Consideration ought to be given to the development of radio-telephone or radio-page facilities in primary care.

8 Hospital-based diagnostic services (pathology and X-ray) should be provided for the district, ie, for the catchment areas of the hospital and not just for the patients of the hospital. The principle of GP access to pathology and X-ray (including contrast media examinations) needs to be re-affirmed.

9 In providing X-ray facilities on a district basis it may be desirable to have one or two satellite units in the hinterland for non-specialised work. This would improve access for patients in rural areas. X-ray facilities at Victoria Hospital, Lewes and at Hellingly Hospital could be used in this way. There is also a case for highly mobile X-ray units for doing chest X-rays for GPs.

10 An effective district pathology service for the primary care sector will require:

i) The distribution of specimen collecting materials (eg, bottles, for blood samples, swabs, etc). This could be done by the district supplies service (see 2 11 below)

ii) The prompt despatch of specimens to the laboratory. A proper pathology specimen container would reduce the degree to which specimens are "mishandled"

iii) Prompt reporting of results

11 There is a need to develop an effective supplies and distribution mechanism on a district basis. The group agrees with the report of the Standing Medical Advisory Committee of the Central Health Services Council on "The Organisation of Group Practice":

'There is much to be said for the central provision of all supplies for all parts of the service, including such things as sterile dressings and laundry services. The supply service should cover the following items:

Syringes and needles
Sterile Dressing Packs
Instruments - including:

i) Full obstetric packs and sets of obstetric instruments
ii) Instruments for minor surgery and casualty work
iii) Sterile disposable instruments - catheters, speculae, prostoscopes, etc
iv) Laboratory equipment including culture media, swabs, slides, solutions, etc

v) Vaccines and prophylaxis materials
vi) Anaesthetic and resuscitation equipment, where necessary

There should be a central laundry service and provision for supply of paper towels or examination couch covers, paper over-covers, covering sheets, cubicle curtains, etc. One of the fruits of a unified health service administration might be the rationalisation of supplies.'

It should also be noted that the increasing use of disposables may greatly reduce the future demand on laundry and CSSD facilities.

12 Such a network could be developed on the basis of the existing hospital van services. Where GPs had not formed into groups or health centres, local depots could be designated as distribution and pick-up points. There is a need for further study and description of existing supplies networks.

13 There is a need for an effective supply and disposal service for patients where this is required. Nursing aids such as "Incopads", mackintoshes and hoists are especially useful in helping relatives to care for patients at home. ("Aids to living" are the responsibility of the social services department).

14 There will be a need for a single conspicuous point of access in each district for the public to make enquiries and complaints about the health service.

3 THE ORGANISATION OF WORK

1 The basic unit of primary health care is the primary care team working in practice units with persons registered with the general practitioners in the team. Such teams have been evolving over the past 10 years or so and a typical team serving 8,000 persons might consist of:

3 to 4 doctors
2 health visitors
a nursing team, eg, 1SRN, 1 SEN and 1 Nursing Auxiliary
reception and clerical staff

2 The presence of a midwife within the team will depend upon the future development of the maternity services. Even if a midwife is not part of the team she should be very closely associated with it.

3 The possibility of a psychiatric nurse being incorporated in the team merits further investigation as does relations between the team and the social services.

4 The team should function under the clinical direction of the general practitioner and will achieve its greatest potential when there is a mutual recognition of the personal attributes and professional skills that each member brings to the team.

5 There is scope for the development of an "associate team" covering a wider catchment area. This could include or have available to it:

i) Social workers (and home helps)

ii) Physiotherapists

iii) Psychologists

iv) Chiropodists

v) Occupational therapists

vi) Speech therapists

vii) Voluntary helpers

6 There may not be sufficient physiotherapists to provide a full domiciliary service. However, the employment of aides working under the supervision of physiotherapists would help, and group exercises could be organised at health centres. The additional costs would in part be offset by reduction in the costs of taking physiotherapy patients to hospital.

7 An area psychological service could be shared with the local authority.

8 Consultant work peripheral to a DGH is desirable but creates problems. The holding of out-patients sessions in health centres would require the geographic "sectorising" of the DGH catchment area and would reduce choice of consultants.

9 The importance of the role of the receptionist needs to be recognised and such staff should have special training.

10 Continuity and co-ordination of care within the primary team is best furthered by regular meetings of the team.

11 The most serious problems in continuity of care arise when the patient moves out of the primary care orbit. Communication of information about the patient back from the hospital sector is less than satisfactory. (see 2 6 above)

12 The discharges of long-stay patients differ in being planned and in these cases, there are no excuses for failing to notify the GP. The GP should be sent a transcript of the case-conference and his "observations" invited. If, when the patient is discharged, the follow-up is to be by the hospital staff, then the GP should be sent a copy of the brief.

13 Making patients records accessible to non-medical members of the team is implicit in the team approach. Some diluting of the confidentiality of doctor-patient interaction is thus inevitable.

14 The transfer of GP records when a patient registers with a new doctor can take too long.

15 Patients who fall ill away from home can pose special problems in continuity of care. If their illness is complex it may not be feasible to investigate it from the beginning again. It would be helpful if the health service operated a scheme similar to Medic-Alert.

16 Transport problems will increase with the grouping of general practitioners, the decline of public transport and the increase of fares. It will be more efficient to bring the patients to the doctor where possible. The best solution may be to extend the hospital car service and so to develop a "social" car service.

17 The following equipment should be available in a group practice or health centre setting: an easy-to-read electronic haemoglobinometer, an ECG and a spirometer (or peak flow meter). There were also cases to be made for a centrifuge and microscope. There should be ready access to a screening audiometry service. In general it was unlikely to be economic to locate expensive diagnostic facilities such as X-ray and more complex pathology services in health centres.

3

Advisory Group Report

on

CENTRALISED HEALTH CARE SERVICES

MEMBERS OF ADVISORY GROUP

The group consisted of the following nine members acting in individual (and not official) capacities and met seven times between October 1971 and February 1972.

Dr R Binning	Consultant Anaesthetist, Brighton
Mr I G Boon	Hospital Group Treasurer, Brighton
Mr C R Dyte	Hospital Group Secretary, Eastbourne
Mrs H M Hambledon	Chief Nursing Officer (Hospital), Brighton
Mrs K M Kelly	Assistant Matron, Eastbourne
Dr M P F Marshall	General Practitioner, Eastbourne
Miss J E Moss	Chief Nursing Officer (Community), East Sussex
Mr P F Plumley	Consultant Surgeon, Hastings
Mr A C Wright	Hospital Group Secretary, Hastings
Dr J W Powles	Research Fellow for the Project, acted as chairman

1 PRIORITIES AND OBJECTIVES

1 In thinking of the future organisation of the health services, it was unrealistic to presume that there would be a significant increase in the resources available. The key to improvement lies in making better use of the resources currently available.

2 The current means of assessing priorities offer considerable scope for improvement. The process could be further rationalised by improved health information system, by the development of experts able to "comprehend the whole" and able to assess the likely consequences and a re-allocation of resources and by the increased use of "cost-effectiveness" and related management techniques. Such quantitative techniques were particularly important when comparing services that provided a return in the short run and those where the benefit tended to occur in the future (ie, preventive measures).

3 Problems are raised by the regionalisation of specialties. This makes for better use of professional and other resources. The tendency to centralisation is added to by the needs of training where units have to be of a certain size if they are to be "recognised" for training purposes. Such tendencies reduce accessibility for the consumer and, whilst this would be acceptable for what were recognised as "super-specialties", it would be less acceptable for example in ophthalmology and paediatrics, (which involve the old and the young).

4 The administrative separation of social from medical services is a false one as most social problems have a medical component. Current relations between the two services are less than satisfactory in that doctors now find it more difficult to get social work assistance for their patients. Ways must be found of securing greater co-operation and co-ordination between the two services.

5 There are problems for doctors when they are placed (as they are increasingly) in a "service" relation, either to their patients or to the state. What, for example, is the legal situation of a doctor when there are complications following an operation - say for abortion or vasectomy - that was initiated by the patient and possibly encouraged by state policy? Is he "responsible" for such complications when it was not his opinion that the operation was medically indicated?

2 i ADMINISTRATION - AT AREA LEVEL

1 It is noted that performance in the hospital sector will be monitored from area level. An indication of this is given in the Department's draft accounting proposals.

Financial management will be at area level and, for example, "patient care services" will be divided by "cogwheel" divisions. This will make it possible, for the first time, to compare and assess the allocation of resources to the different medical specialties. It may thus aid more rational decision-making.

2 The proposed role of the community physician emphasises "medical intelligence". It is expected that he will be able to "comprehend the whole" of the health services in the area and to help in assessing needs in each of the divisions. There are two problems in this. Such a task will be intellectually demanding and there is not at present sufficient "academic strength" in public health. Secondly, relations between medical "headquarters staff" and consultants may become strained.

3 Area level decision-making will depend upon well-organised medical advisory machinery at area level. The development of this may draw interest away from medical management at district level - for at district level the medical advisory committee will be "advisory" to another (area) advisory committee where most of the important decisions will be taken.

4 The administrative integration of the health service makes possible the integration of the nursing services within it.

5 The increasing emphasis on community care was supported in a joint submission by a hospital nurse and a community nurse. The integration of nursing services should be so carried out as to safeguard the primary team.

6 The development of primary care nursing teams fully attached to general practices would not greatly increase pressure on nursing manpower resources and so would not constitute a serious threat to hospital staffing levels. This conclusion is supported by the following rough calculations: Suppose the following are taken as approximate yardstocks for provision of community nurses to a practice with 8,000 patients.

2 health visitors
1 state registered nurse
1 state enrolled nurse
1 part-time auxiliary nurse

Such a rate of provision would imply some 400 "field staff" (whole time equivalent) in Area 44. Current provision is around 340. An increase of 60 constitutes only a small fraction of current hospital nursing manpower, which is around 3,000. Also, there may be nurses currently unemployed who would come into community nursing, but who are not currently "available" to the hospital services.

7 There are likely to be other limitations on available nursing manpower, including "student" status and a 38 hour week.

8 The future of nursing is currently under consideration by the Briggs Committee. It is thought likely that they will recommend a common Basic Nurse training period of two years, with the opportunity for the addition of further specialty modules, eg, in intensive care, theatre, midwifery, health visiting, etc.

9 The presence of specialised nurses within the community could undermine the loyalty of the primary care team. The nursing representatives are, therefore, opposed to such specialised nurses with the possible exception of midwives. Although it will be argued by psychiatric and geriatric nurses that they have established special relationships with patients during the acute phases of their illnesses, they will face the problems in working in the community; (1) they will not be aware of what is going on in the primary care team (2) they can have no responsibilities towards other members of the patient's family.

10 With an increasing level of activity in the DGH there will be a need for a higher proportion of highly trained nursing staff. There is also a need for more supporting staff (SENs and nursing auxiliaries) in the community. Thus the "mix" of different kinds of nurses will change both within the DHY and within the community.

11 Boundary problems between area health authorities should not create undue difficulties in patient care providing flexible administrative arrangements are made.

2 ii ADMINISTRATION - AT DISTRICT LEVEL

12 "Fieldworkers" in the health service will find it much more difficult than administrators to relate to the area level of organisation. This makes it important to establish an identifiable unit of administration at district level. Parochial layalties might also be useful - for example, in recruitment to nursing.

13 There are several inconsistencies with respect to access to in-patient care. Waiting lists appear to be longer in Eastbourne, but it is not certain why this is so. This problem may be reduced with the construction of the new DGH. Re-distribution of waiting lists between DGHs will not be very practicable from the patient's point of view. Current practice in assessing priorities within waiting lists favours assertive patients and patients with assertive GPs.

14 The amount of notice that patients receive of their date of admission is frequently too short. The practice in the Hastings group is to book a firm date for those who want to book ahead. Others are normally given 7 - 9 days notice by mail. Those who are on the telephone and who are willing to come in on 24 hours notice are also noted down.

15 Waiting times for OPD appointments could be reduced by the methods used in Hastings. GPs are given information on waiting times for each specialist in a monthly newsletter. In approximately one third of referrals where no one specialist is designated, the patients are allocated to the shortest waiting lists.

16 Emergency admissions can be difficult when there is already great pressure on hospital beds. Where the number of separate hospitals is large - as in the Brighton district, then an emergency bed service can be operated. Elsewhere, other measures are needed. In Hastings, there are special medical and surgical admission wards. It is important that GPs should be able to contact one person who is in a position to give a prompt reply.

3 THE ORGANISATION OF WORK

1 The development of an adequate communications network between health care workers within and without hospitals is an urgent priority. This problem involves two main aspects - attitudes and mechanics.

2 Health care workers need to have the will to communicate. This can be helped by measures that encourage workers to develop a clearer idea of their own and other people's roles and responsibilities in an integrated health service. Multidisciplinary meetings and other face-to-face contacts will help. It has been claimed, for example, that hospital nurses and community nurses "do not even speak the same language" and the same could be said for other professional groups.

3 Communication outwards from hospitals to primary care workers would be much easier if primary care workers were concentrated into group practices and health centres.

4 Two possible measures for improving communication are:

i The leasing of "open" telephone lines between hospitals and health centres

ii The establishment of a telex service between hospitals and health centres.

5 It is essential that primary care workers are promptly informed when patients are discharged. The current practice of leaving an overworked houseman to complete a discharge note is not working adequately. Small portable dictating machines and clerical assistance should be available so that the doctor discharging the patient can at the very same time issue a short "dictated but not signed" discharge note. This is an urgent priority.

6 The problem of communication is central to the development of an effectively integrated health service. For this reason the early establishment of a pilot trial to improve communication links by the use of recently developed equipment is justified. This equipment need not be expensive when compared with the possible gains in efficiency. (Travel agents currently use telex apparatus to book theatre tickets). Such a trial could be run in Hastings between the different hospital units and several group practices.

7 The development of community hospitals would aid the early discharge of patients from the DGH. Such hospitals would be essentially nursing units and, in order to ensure continuity of care, would be staffed by the community nursing team with a skeleton attached nursing staff giving 24 hour cover. Former cottage hospitals would be used for this purpose and where appropriate, such units could also be located within the curtilage of a DGH.

8 The terminally ill are currently poorly cared for in a DGH setting. They also tend to "block" beds in a DGH. For these reasons their needs deserve special attention.

4

Advisory Group Report

on

BIRTH CONTROL AND MATERNITY SERVICES

MEMBERS OF ADVISORY GROUP

The group consisted of the following seven members acting in individual (and not official) capacities and met seven times between October 1971 and February 1972.

Mr B Eton	Consultant Obstetrician-gynaecologist, Hastings
Mrs N Gray	Family Planning Association, Brighton
Dr E J King	General Practitioner, Brighton
Miss M J Lilley	Midwifery Tutor, East Sussex
Mr H A H Melville	Consultant Obstetrician-gynaecologist, Brighton
*Dr C R Palmer	General Practitioner, Turners Hill
*Miss B D Thomas	Principal Nursing Officer (Maternity), Brighton
Dr J W Powles	Research Fellow for the Project, acted as chairman

* Joined the group after it had commenced its meetings

(Note: Throughout this report the word "district" refers to the proposed districts into which the area health authorities will be divided, ie to the catchment areas of the district general hospitals. It does not refer to the "community" aspects of the service as distinct from the hospital ones).

1 PRIORITIES AND OBJECTIVES

1 An "ideal" maternity service would be based in a maternity unit of a DGH but would be responsible for providing a service to the district community. All confinements would be in hospital and uncomplicated cases would be discharged early - perhaps after one full night in hospital. There would be only one group of midwives who would work both in and from the DGH maternity unit. They would be attached in teams to general practices - each team covering the practices in a sector of the hospital catchment area. These attached midwives would co-operate with the general practitioners in the provision of ante-natal and post-natal care. Those general practitioners willing and competent to conduct their own confinements would be entitled to do so in the hospital unit. Measures would be taken to ensure that general practitioners were informed of any change in the arrangements for the care of their patients.

2 The following qualifications apply to the above general model:

i It needs to be intepreted with flexibility if it is to apply to the varying conditions in different districts.

ii It would only be practicable for those GPs working within fifteen minutes travelling time from the maternity unit to do deliveries in the unit.

iii There will be a strong need to ensure that the service is community orientated.

iv For the foreseeable future some women will wish to have home confinements

3 As is implied by the above model, all full-term babies could be discharged from the maternity unit within 48 hours provided:

i all babies were carefully checked according to a standardised procedure, and by a doctor competent in this, before discharge.

ii there was good co-operation and communication between the hospital and community elements of the service.

4 "Early discharge" policies first arose because of a shortage of beds and then mothers began to ask for it. Hospital deliveries would be made more acceptable to the consumer by minimising the period for which she is away from home.

It should be noted however, that the mother's wishes are not the only factors determining suitability for early discharge. The medical condition of the mother and baby and their home conditions need to be taken into account.

5 An integrated maternity service was unlikely to be more expensive of skilled manpower (midwives) than the current arrangements, although transport costs will be considerably higher. A policy of early discharge will however stop the "hotel" element of hospital costs from rising as much as they would otherwise have done.

6 The concentration of deliveries into the DGH units will increase transport problems in the rural areas. In East Sussex in the past year there have been 6 or 7 deliveries in ambulances out of a total of 5,500 deliveries in the county. In most of these cases the mothers were being transferred from the remoter rural areas. (The maximum distance within the county from a DGH is around 15 miles). Mothers living in rural areas who are "at risk" should be admitted routinely before term. The procedure for artificial induction of labour was being improved continuously and it may have an increasing relevance for these patients.

7 An integrated maternity service should, where necessary, be provided across the new area boundaries so as to cover the full catchment area of the unit.

8 It is hoped that a fully integrated maternity service may become operational at Cuckfield Hospital (catchment area mainly outside of Area 44) in early 1973.

9 The number of deliveries that GPs would like to perform in DGH units may, in fact, be limited. At Royal Sussex County Hospital, provision has been made for 500 such deliveries per year, but the current rate of take-up is only around 200.

10 Ideally, a fully comprehensive family planning service, including sterilisation and abortion ought to be provided under the NHS. This will require additional staff and resources. Alternatively, the Family Planning Association could help to provide this service on a contractual basis.

11 It is difficult to assess how effective existing birth control measures are. There is no evidence that the number of unwanted pregnancies is declining. In England in 1970 live births exceeded deaths by 200,000. Money spent on an effective birth control service would produce proportionally greater savings elsewhere in the health and social services.

12 Most unwanted pregnancies are the result not of contraceptive failures but of the failure to use contraception. For this reason education in contraception should aim not only to inform but also to impart a definite attitude. This was that it was utterly irresponsible to have intercourse unprotected by contraception unless a pregnancy was desired.

13 Contraceptive education requires the co-operation of doctors, health educationalists, midwives, health visitors and those in the family planning services. There is a need for improved contraceptive education in schools. This should encourage a responsible attitude to interpersonal relations and should not be such as to encourage promiscuity. Contraceptive advice should be given to all mothers in the ante-natal and post-natal periods. Currently, in Brighton and Hastings maternity units all delivered mothers are given a letter or pamphlet outlining available contraceptive services before discharge from hospital.

14 A domiciliary service was necessary to help reach those most in need of contraceptive advice. Such services already exist in Hastings and Eastbourne, are about to be introduced in Brighton and in East Sussex health visitors are trained for this role.

15 The liberalisation of the abortion law has increased the work-load on hospital out-patients, beds and theatres and no additional nursing staff have been provided. This means that available NHS facilities have to be rationed and in Brighton it is the practice to select those who have a medical indication or who are poor and unlikely to be able to afford an abortion in the private sector. There is also a non-profit nursing home in Brighton (Wistons) which is attempting to hold down prices in the private sector. In Hastings it is possible to do most abortions within the NHS.

16 Policies on abortion vary between districts. There is a considerable reluctance to deal with abortions in some NHS hospitals and this places an additional burden on districts where abortions are more readily available on the NHS.

17 The development of the Karman-curette may enable abortions to be performed on out-patients for pregnancies of less than eight weeks. This could provide a basis for separate abortion clinics.

18 Doctors who have a conscientious objection to abortion should not be discriminated against when appointments are made to obstetric and gynaecology departments.

2 ADMINISTRATION - AREA

1 The maternity services will be operational at district level and only a limited number of functions specific to maternity services will need to be performed by area headquarters.

2 There is a need for information relevant to the provision of birth control and maternity services to be collated and made available to those responsible for reviewing the performance of the district services. This would be a role for the future community physician. The existing standard "Maternity Hospital Report" is cumbersome and not much used. The Royal College of Obstetricians and Gynaecologists is currently working with the DHSS to develop a suitable format for maternity data to be added to the new Hospital Activity Analysis returns.

3 Co-ordination functions to be performed at area level include:

i relations with ambulance services

ii relations with Family Planning Association

iii arrangements for further education and the secondment of students.

4 Budgeting should be on a divisional basis (ie, for the obstetrics and gynaecology division of the district) and allocations should relate to the need for the services provided rather than to past spending or staffing levels. Financial arrangements should be flexible so as to allow the transfer of funds between divisions in emergencies and for carrying funds over into the new financial year in special circumstances.

3 ADMINISTRATION AT DISTRICT LEVEL AND THE ORGANISATION OF WORK

1 In an integrated service midwives would be divided into teams. Each team (which could comprise around six midwives) would cover general practices in one sector of the hospital catchment area and would also be responsible for a portion of the hospital maternity division. Two members of each team could be attached to each group practice within the sector. Whether confined at home or in hospital the mother could, where possible, be attended by one of the midwives who had seen her during the ante-natal period.

2 All expectant mothers should be referred to out-patients for assessment and booking (where appropriate) as early as possible in the pregnancy. Ante-natal care should be shared between the general practitioner and the consultant and should include visits to the consultant clinic for re-assessment between 34 and 36 weeks and again at term (unless more frequent visits are indicated). In order to provide equal care for those in outlying areas a hospital team could conduct clinics in such areas. In Cuckfield such a team includes a consultant, houseman, nursing officer, midwives, clerk and technician and equipment and records are taken.

3 Routine testing for rubella antibody titre is now feasible and could be performed on all mothers. Those with low titres can then be given post-natal immunisation. At present immunisation is only officially encouraged for girls between their 12th and 13th birthdays. A much wider campaign should be conducted to include, for example, women on oral contraceptives.

4 Effective communication outwards from the hospital unit is vital. The GP and midwife (where the service is not yet integrated) should be informed immediately of any change in plans and also of imminent discharges. This problem is greatest at weekends and in the case of unplanned discharges - either initiated by the patients or by the hospital.

5 Following early discharge the midwife must visit as follows: immediately after mother and baby arrive home, then twice daily until three days after delivery, once daily until 10 days and then as necessary thereafter. (More frequent visits will be indicated in some cases).

6 The health visitor should normally assume care and supervision of the mother and baby after 14 days.

7 In order to safeguard the baby when there is a policy of early discharge, specialist paediatric assistance must be readily and continuously accessible. Paediatricians should be available for domiciliary visits when necessary.

8 An effective domiciliary pathology service could help in avoiding unnecessary admissions, for example when serum bilrubin needs to be monitored in neonates. Specimens could be collected by the GP or midwife.

9 Appropriate arrangements will be needed for the determining of medical policies in an integrated maternity service. It is important that general practitioners have adequate representation in the decision-making machinery.

10 The model of an integrated maternity service that has been described in this report is meant only to serve as a guide and not as a blue-print for the future. The changes proposed are in many cases considerable and the adjustment of staff to new patterns of work may take some time.

5

Advisory Group Report

on

CHILD HEALTH SERVICES

MEMBERS OF ADVISORY GROUP

The group consisted of the following seven members acting in individual (and not official) capacities and met seven times between November 1971 and January 1972.

Mrs. D.I. Dale	Superintendent Health Visitor, Eastbourne
Dr. G.W. Hatcher.	Consultant Paediatrician, Brighton
Dr. M.D.A. Heller	Consultant Child Psychiatrist, Brighton
Dr. E.P. Quibell	Consultant Paediatrician, Chailey Heritage, East Sussex
Dr. P.A. Shave	Deputy Medical Officer of Health, Brighton
Dr. D.M. Watney	General Practitioner, Crowborough, East Sussex
Dr. J.A.G. Watson	Medical Officer of Health, East Sussex acted as chairman

1. PRIORITIES AND OBJECTIVES

1. Whilst it is possible to find faults and gaps in the existing Child Health Services, particularly the long waiting lists at Child Guidance Clinics, they are, on the whole, satisfactory and successful. They have been built on the twin objectives of Prevention of disease and Provision of good treatment services.

2. The group would wish to see a continuing balance between Prevention and Treatment in both the physical and psychological areas in spite of the disappearance of the administrative authority with the prime responsibility for the preventive aspects.

3. The group would wish to emphasise the importance of the Health Visitor in achieving this balance. The Health Visitor's 'key role' in the Child Health Services is also evident in another aspect of this work to which the group would ascribe high priority - that of continuity of care.

4. Whilst continuity of care is important throughout the whole of the child age range, special emphasis should be given to the care of the heavily and/or multiply handicapped at school leaving age. As the group have commented (CHI 4 page 2, paragraph 3 e) a regional or national policy on the role of 'Special Paediatric Units' (e.g. Chailey Heritage) is required and the development of a coherent policy concerning the continuity of care for the heavily handicapped is dependent on this.

5. In the course of the group's discussions it became evident that the 4 - 5 year olds constitute the priority target group at the present time. A pre-school medical inspection involving, where possible, the child's general practitioner and his Health Visitor is recommended. This should include detailed developmental screening and other special screenings such as a 'Uricult' screen for bactiuria.

2. ADMINISTRATION

A. GENERAL COMMENTS

1. During the past 5 - 10 years there has been some trend towards the greater involvement of general practice in Child Health work i.e.

a) Child Health Centres

i) sessional work within the LHA Centres,

ii) the integration of Health Visitors into 'Family Practice',

iii) development of practice well baby clinics.

b) Increasing participation in vaccination and immunisation - particularly with the advent of the computer and the development of attachment which, in the county, has enabled general practitioners to do 90% + of this work.

c) School Medical Inspections

i) sessional work with the School Health Service,

ii) by incorporating them within the scope of family care.

2. This trend towards 'Total Family Care' in general practice is one that the Advisory Group would wish to see continue, with the following provisos -

i) Good and effective communication with the supportive 'specialist'services.

ii) A means of covering, in the interim, those practices where these developments are not taking place.

iii) An increase in Postgraduate education in Child Health for family doctors.

iv) Adequate monitoring of the work being done. In this the paediatricians and the computer services must play their part. Monitoring, in this context, does not mean inspection but ensuring that children are not lost sight of when the work is diffused amongst a large number or practices.

3. The group see the major administrative problem as the disappearance of the administrative organisation of the Local Authority School Health and Child Health services. The service will, therefore, have to divide between those which are absorbed into Family Practice and into the Specialist Services. The Administrative responsibilities will have to be shared by the District Departments of Child Health and the 'Community Physicians' Department' of the Area Authority (the group foresees difficulties in the way of paediatric departments accepting these responsibilities, especially in School Health).

B. DISTRICT LEVEL

4. The relationship with the Area Departments of Social Service, particularly in such matters as the Handicapped and children with unexplained injuries, is vital - this applies both to the general practice and specialist parts of the service.

5. In reorganisation, the regrouping of the staff of the Local Authority will be an important one. The District Departments of paediatrics will have to be strengthened by the inclusion of a proportion of these staffs, both medical and administrative.

6. As the group see the problems, it will be necessary for the existing paediatric services of the Hospital Authority to become more 'Community orientated'. The Consultant Paediatrician must develop a much greater involvement in the Community. This would best be achieved by centreing the service on an expanded:

Assessment/Out Patient Centre

7. To this would come children requiring normal out-patient facilities and detailed assessment following screening elsewhere.

8. This Child Health Department, with its connections with the Maternity Services would also have its own 'Risk Register' and follow up these children - either directly or through the general practitioner.

9. This Centre would look to a Children's Hospital Unit (60 beds or more, within, but independent of, a DGH) for in-patient resources.

10. There would be a peripatetic service based on the centre - using Clinics, Health Centres, Surgeries and home visits, to do some intermediate screening, follow-up work, and to cover gaps in the Family Practitioner services.

11. The group considered the concept of the 'Community Paediatrician'. They felt that all consultant paediatricians should be 'Community minded' and that the introduction of a specialist 'Community Paediatrician' would be divisive.

12. They recognised the particular problem of the existing Senior Medical Officers of the Local Authorities, who have particular skills in child development assessment and expertise in the whole field of community care in the pre-school and school age Child Health Services. There will be a clear need for the establishment of suitable posts for them in the District Department of child health. It would seem that this is one of the fields of medical practice in which a sub-consultant grade for permanent staff is required. A special responsibility of such staff would be the medical administrative element within the district department.

13. Clearly, there will be 'boundary problems' in Area 44, and the group would stress that no artificial administrative boundaries should interfere with 'patient flow' or continuity of care either in general practice or in specialist care.

14. The integration of the Local Authority Nursing Services (including Health Visitors) into general practice is doing much to encourage the trends identified at the beginning of this section of the report. This could be strengthened and encouraged still further by making available accommodation for Health Visitors within general practice premises, and the group would recommend that ways be found to do this.

15. A particular problem will be the provision for Child Psychiatric/Guidance Services. Here the group see the role of the specialist as providing a Child Psychiatric Service and supporting the work of "Family Clinics". The group consider it important that the Child Psychiatric Services and the family clinics should have some element of common staffing. It is particularly appropriate that they share the services of the Psychologist.

C. AREA LEVEL

16. The Child Health Services would look to the Area administration to provide:

i) The link with the Education and Social Service Authorities for policy purposes.

ii) Supportive information and computer services -

a) Two particular information aids would be of benefit to both the District Departments of Paediatrics and general practitioners:

1. Epidemiological information - most particularly in the form of an 'early warning system'.

2. Morbidity information, particularly on the numbers of handicapped children within the population for which they had responsibility for caring and the nature of the handicaps.

b) Provision of sex - age registers.

c) Call systems for immunisation procedures and screening purposes.

iii) Certain Area Services, administered centrally but operating in each district.

a) Audiology screening (recommendation d).

b) Speech therapy (recommendation i).

c) Psychology (recommendation j).

iv) Provision of special communication systems - Radio (See CHI 4, 3(d)).

v) Provision of Transport facilities -

a) Ambulances - with special equipment where required (e.g. incubators).

b) Hospital cars to convey patient to any Health Service premises when appropriate.

3. ORGANISATION OF WORK

1. (See pages 48 and 49).

2. The following matters are identified for further consideration

i) Area Specialists.

Paediatric Surgery.
Special 'Handicap' units.

ii) Child Dental Services.

School Dental Service.
Orthodontic Services.
Hospital dental services for children.
General dental services for children.

The full implications of bringing the School Dental Service within the scope of the National Health Service need special study.

iii) Education in Child Health.

Medical Staff - refresher courses.
- other in-service training.

Nursing staff including Health Visitors.

iv) In-Patient Child Psychiatric Services.

The proposed provisions in the West of the present county of East Sussex should be complemented by some provision in the Eastern end.

3. Staff Problems in Reorganisation

i) Whilst the majority of the staff in the Health Service will continue to work in the same place, certain child health staff will be considerably affected. The administrative and clerical staff of the Local Authority Child Health and School Health Sections may find the nature of their work altered considerably and will certainly be working in different premises.

ii) Health Visitors will find that their established 'administrative lines of communication' will be altered.

iii) The medical staff engaged in clinical work will require 'base accommodation' within the district departments and their geographical areas of work will be altered.

4. SPECIFIC RECOMMENDATIONS MADE BY THE GROUP IN THE COURSE OF THEIR DISCUSSIONS.

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1. The possibility of routine serological screening to detect children at risk from virus infections in early pregnancy be further explored.

2. The psychological needs of the very young unmarried mother should receive more attention.

3. There is an urgent need to develop postgraduate training and refresher courses for all persons engaged in the Child Health Services with particular reference to the emotional problems of childhood.

4. The school audiology screening service should be open to direct reference from General Practitioners.

5. The distinction between pupils at private and maintained schools should disappear when the School Health Service is incorporated within the National Health Service.

6. A 'Uricult' screening should be introduced at the $4\frac{1}{2}$ year old medical inspection and subsequently for a younger age group as well.

7. The $4\frac{1}{2}$ year medical (or school entry medical) should include screening for the less evident developmental defects - particularly neurological ones. A medical record card including a 'check list developmental screening' system should be devised.

8. The need for training in sick children's nursing should be reviewed in the light of the disappearance of the exclusive RSCH training.

9. The Local Authority speech therapy service should transfer to the Area Health Services with the School Health Services and its scope enlarged.

10. An Area Department of Psychology, embracing the present school and hospital psychological services, should be established. This single department should supply all the clinical and educational psychology resources required by the Local Authority (Education and Social Services) and the Health Authority.

11. General Practitioners should receive every encouragement (including financial help) to provide accommodation for their Health Visitors and Nurses within their practice premises.

1. Health Service Organisation, Personnel and Responsibilities in Relation to Child Health

ORGANISATION	PERSONNEL	RESPONSIBILITIES	ACTIVITIES (not necessarily a complete list)
Community Health Team	General Practitioners Nurses Health Visitors Practice admin. staff	Primary Health care of all children on the practice list	a) Preventive services: Prophylaxis Screening (including school medical inspections) b) Primary diagnostic, treatment and care services
	(Social Services: These teams need to relate to individual social workers).		
District Departments of Child Health	Consultant Paediatricians, Supporting medical, nursing, administrative (etc.) staff.	Specialist Child Health Services - chiefly for residents in the district, but not exclusively so.	a) Preventive services: i) New born (within maternity units). ii) Primary screening (chiefly as interim measure to fill gaps in primary care services); including school medical inspections. iii) Secondary screening. - peripatetic support to primary care services. - assessment centres. b) Diagnostic, treatment and care services: Outpatients, child guidance/child psychiatry, inpatients etc.
	(Social Services: At this level, there is need for communication with appropriate Area Department(s))		

Health Service Organisation, Personnel and Responsibilities in Relation to Child Health (continued)

ORGANISATION	PERSONNEL	RESPONSIBILITIES	ACTIVITIES (not necessarily a complete list)
Area Department of Community Physician	Community Physician. Supporting staff.	Special aspects of Child Health.	a) Promotion of Health: i) Influencing social policy) ii) Influencing public attitudes) Mainly through the advisory service to the Local Authority and by Health Education. b) Prevention of disease: i) Environmental hygiene (advisory service to Local Authority District Councils). ii) Medical Intelligence and Information services. c) Operational Services: Computer services. Speech therapy. Ambulance/transport. Audiology screening.

(Social Services:)
Education:) communication at this level is with the relevant County Council Departments).

6

Advisory Group Report

on

SERVICES FOR THE ELDERLY

MEMBERS OF ADVISORY GROUP

The group consisted of the following seven members acting in individual (and not official) capacities and met six times between 19 November 1971 and 11 February 1972.

Dr. E.W. Bedford-Turner	General Practitioner, Polegate
Dr. A.N.G. Clark,	Consultant Geriatrician, Brighton
Mr. H. Gaston	Hospital Secretary, Newhaven
Miss C. Hoad	Geriatric Health Visitor, Hove
Dr. R.E. Irvine	Consultant Geriatrician, Hastings
Mr. J.C. Matthews	Assistant Director, East Sussex Social Services
Dr. J.A.Whitehead	Psychiatrist, Hayward Heath
Mr. J.E. Simmonds	Reader in Social Administration, acted as chairman

INTRODUCTION

1. Changes of health and illness in elderly people must always be seen in relation to their over all experience of daily life and we believe that the daily life of many elderly people includes the experience of being in some sense second class citizens when they seek access to the final rewards and benefits of society. It is plausible to suppose that because the elderly - and other handicapped groups - have ceased to play the valued worker/consumer role they come to be less valued. So far as our discussions have gone it is clear to us that elderly people calling on the Health Service would probably experience some sense of being less well regarded than other groups of sick people. Our concern at the low status of the elderly sick has become one of our main preoccupations and it should be seen colouring all sections of our report.

2. A full understanding of the elderly sick requires a systematic consideration of the psychological, psychiatric and social context of any particular episode. The importance of the 'context' for the clinical diagnosis, treatment and/or care of the elderly calls for organisational structures and administrative procedures which actively encourage the sharing of resources, transmission of information and good working relationships between workers from various disciplines and specialities both in the Health Service and outside it. In particular we would want to see

I more effective sharing of skills as between workers in geriatrics and workers in psychiatry ; and

II much better co-operation and co-ordination between various levels of the Health Service, and the equivalent levels of the Social Services.

3. From the start of our deliberations we recognised that while the elderly patients' symptoms may be clear, the likely chain or pattern of causal factors require all those professionally involved to be alert to the significance of the social and cultural dimensions of the case as well as their more manifest medical and psychiatric features.

4. Responsibility for the efficient treatment and care of the elderly will be shared to a greater or lesser degree by the District Hospital Services, the Community Health Services, Family Practitioner Services, the Social Service Departments and the appropriate voluntary agencies. TO ENSURE THE PROPER AND COMPREHENSIVE DISCHARGE OF THIS JOINT RESPONSIBILITY, EFFECTIVE ADMINISTRATIVE PROCEDURES AND CLEAR CHANNELS OF COMMUNICATION MUST EXIST BETWEEN THE VARIOUS SERVICES AND THEIR AGENTS. The barrier to effective work presently include:

I ignorance of the provisions and resources (manpower, skills and equipment) held by others; lack of certainty about conditions under which these provisions and resources can be released; and the organisational and administrative structure entitled to authorise their release;

II disagreement between services as to the priority access to scarce resources;

III differing perceptions held by workers about:

a) the clinical picture

b) the pattern and ranking of actual or likely causal factors

c) the appropriate treatment or intervention plan

d) lack of interest and/or lack of knowledge about the special needs of the elderly

IV patients who do not fall into an area of responsibility of one department in a clear and neat way and may need help from two or more departments at the same time.

5. One recurring contextual factor for the elderly sick, handicapped or infirm is the presence of poverty and a second is accommodation.

I Poverty. Poverty among the elderly needs to be assessed relative to the standards of living of the remainder of society and not in simple baseline terms. Furthermore, the private financial resources of an elderly patient may be a wasting asset and this possibility must be recognised in any long term treatment or intervention plan. (See paper The Notes on Discussion regarding Supplementary Benefits and Welfare Allowances, East Sussex County Council Social Services Department 10 November 1971).

II Accommodation. In general terms the exposed positions of the elderly in relation to the housing shortage can all too easily contribute to sickness in the elderly and frequently limits and undermines the effectiveness of treatment. We recommend that the new organisation at Centre, Regional and Area levels of operation should devise administrative machinery to ensure that the special housing needs of the elderly are kept squarely before those authorities who have responsibility for housing policy and housing provision.

6. Demographic Factors. The peculiar 'pull' the 'seaside strip' exerts on the retired already imposes a very heavy strain on all workers concerned with the needs of the elderly. It seems very probable that the provision of effective care for the steeply increasing number of those 65+ will constitute the greatest challenge for the new health organisation in this Area. We assume that it will not be possible to plan the number of elderly immigrants the Area can comfortably carry. It is probable therefore that authorities and agencies providing the health and social welfare services will eventually need to seek special support at a national level as do other social, economic and industrial 'problem areas' of the United Kingdom.

7. The Concept of Prevention and the Concept of Cure cannot have the same comprehensive meaning in geriatrics as they do when applied elsewhere. It should be stressed that cure of acute illness in old people is rewarding and possible, and another function is to attempt to assess residual disabilities which are permanent and incurable so that the patient may live as full a life as these disabilities permit. It is in this particular type of case where the co-operation of two or more departments is important. In most cases, therefore, amelioration is a more realistic aim than cure and an intention to reduce the rate of decline is more appropriate than prevention. It is certainly very important that there should be a greater understanding on everyone's part of the special problems of retirement and old age and of the range of services available to the elderly. We therefore recommend that the new authority should take responsibility for an imaginative public educational policy which

may bring about a better understanding of the problems and potentials of old age. We would also like to see an increase in the practice of encouraging and enabling the healthy and active elderly to assist through voluntary organisations and other means, those who are incapacitated by greater age or by marked infirmity.

8. Screening, Checking and Monitoring.

1. So far as our timetable has allowed we have paid a good deal of attention to the idea of regular clinical examination and assessment of the elderly. We understand that research and the accounts of various innovations suggest the need for further evaluation before this Area should give priority to a fully comprehensive screening service.

2. We have no such doubts about the practice of routinely checking the health of 65+ patients at the General Practitioner level. We heard a full account of how a regular and routine health check can be operated with marked success by G.P. attached Health Visitors and we commend this scheme.

3. We also see the need to establish what might be called a 'monitoring attitude' among the wide variety of workers who are in touch with the elderly. By a 'monitoring attitude' we mean a preparedness by these workers to be a) particularly sensitive to the dimensions of need we mention in 3. above; b) sufficiently alert to notice changes; and c) appropriately knowledgeable to predict the more likely consequences of unchecked adverse change.

Handling Information

4. Present experience suggests that the Geriatric Health Visitor or the Health Visitor attached to General Practice is particularly well suited to both receive and redirect information about individual and group needs of the elderly and we recommend that consideration should be given to making these arrangements more formal.

9. Education and Staff Training. An improvement and a widening of skills among those who work with the elderly will be necessary for the quality of service to keep pace with the increased demand. Continued education should be one of the important duties undertaken by the Area Health Authority in association with Social Service Departments, who already have administration machinery for in-service training and staff development.

10. Changing the Professional Culture. It is to be hoped that a wider and more systematic dissemination of knowledge about the needs of the elderly among workers in the Health Service and the Social Services will eventually lead to a much desired shift in the professional culture of doctors, nurses and social workers. Our experience very strongly suggests that work with the elderly in each of these professional groups is poorly esteemed and this affects the number as well as the quality of recruits to this specialisation. There is also in our view good grounds for believing that the relatively low status of geriatric care is reflected in the low standard of hospital accommodation for the geriatric sick and the scarceness of auxiliary services. The low status of the elderly sick is reflected not only in the lack of capital resources but the appearance of wards and other hospital facilities used exclusively or mainly by geriatric patients. We believe that the level of maintenance and furnishing in long stay wards should be at least equal to the more prestigious standard of short stay, specialised or general wards. Geriatric patient care should have an increased allocation from revenue expenditure.

11. Administrative Relations with the Social Services.

1. As the Consultative Document makes clear in paragraph 8, 'an effective mechanism is essential for the mutually agreed planning of an investment in the health and releated local authority services'. The need for joint planning and co-ordination of activities is particularly vital in the care of the elderly, and we accordingly strongly recommend that cross representation of members on Health committees and Social Service committees be standard practice at all levels of operation. We also strongly recommend that there should be a statutory requirement that both authorities should exchange planning documents. We wish to underline our strong conviction that generalised declaration of intent will not ensure the quality of co-operation required for the proper care of the elderly. We therefore urge that there should be formal and specific requirements to co-ordinate policies and activities; only in this way can 'effective mechanisms' operate.

12. The Middle Band.

1. The suggestion (i) that by 1992 on present trends 73.5% of all beds currently available for men and 93.7% of non-maternity beds currently available for women could be filled by old age pensioners, underlines the prominence we have given in our discussion to the concept of the 'middle band' employed by Brocklehurst, Budd, Clark and Irvine(ii).

2. The 'middle band' is conceived as the area where there is the greatest operational, policy and administrative overlap as between the hospital services and the social welfare services. Policy decisions about hospital provision, day care and the various types of residential and day facility provided by the Social Services Departments will clearly need to be very closely co-ordinated at District and Area level, and at Regional level also. Without joint planning it is difficult to see how the hospital services can avoid being overwhelmed. So far as we could judge, co-ordinated planning does not at present exist at the level of seriousness required. We urge that a start should be made to remedy this defect. There are many issues which need to be solved in co-operation particularly those to do with the availability of paramedical resources, occupational therapists and the level of care to be offered in the variety of establishments provided by the National Health Service and by Social Service Departments. So far as full patient care is concerned it is important that there should be an easy two-way flow through geriatric, 'middle band' and welfare(iii), and an imaginative and innovatory attitude to the provision of a wide variety of local day and residential facilities.

(i) Old Age Health. Klein R. & Ashley J. New Society 6.1.72.

(ii) The Development of Services for the Elderly and Elderly Confused in the South East Metropolitan Hospital Region, Brocklehurst, Budd, Clark and Irvine.

(iii) Refer to Para.383 of The Development of Services for the Elderly and Elderly Confused by Brocklehurst et al.

13. District Hospitals. At the District level we would place considerable emphasis on the need to link the Family Practitioner Service, and particularly the General Practitioner, with the district hospital. We have experience of General Practitioners working as clinical assistants and we consider this is a particularly useful and effective way of improving the professional expertise of General Practitioners in the field of geriatric medicine. Consideration should also be given to district hospitals accepting responsibility for long stay patients to avoid the problem which flow from isolation of the long stay geriatric patient.

14. Organisation of Work. We have already emphasised the central importance of close co-operation between all those who service the elderly and we believe that every encouragement should be given to innovations and experiments designed to give operational effect to this view. The range of services increasingly available through the Social Services Department need to be publicised in a form which ensures that fellow workers and potential beneficiaries are fully aware of the services available and the means of securing them. We have considered the possibility that existing services might be overloaded as the public become more aware of their entitlement but in our view the health service (and the Social Service Departments also) should adopt an adventurous outgoing style. It may be that this more public offering of service will hasten the introduction of rational and public decision-making about the allocation of scarce resources. We believe this would be an excellent development.

15. General Practice.

1. While recognising that many, if not most, of the resources and services we have discussed are heavily pressed and overloaded, we believe that particular attention should be paid to the role of the General Practitioner and the Family Practitioner Services.

2. In the long run the best hope for change lies with changes in medical training particularly as it relates to General Practice where we hope that increased attention will be given to the psychological and the social aspects of medicine. In the meantime we would like the new authorities to find ways of encouraging General Practitioners to develop and continue an interest in the care of the elderly. The attachment of a Health Visitor can, we believe, add considerably to the resources of many practices and we would like to see further development and some evaluation of this scheme. We have been told that the recruitment of Health Visitors is difficult and we recognise that the number of Health Visitors available will be influenced by the drop of nurses in training. We therefore recommend that some consideration be given to recruiting auxiliary Health Visitors to perform a task similar to that being performed by theRed Cross auxiliaries in hospitals. We believe that auxiliary Health Visitors could, under appropriate supervision, perform many useful services within a practice.

3. With the reduction and curtailment of rural and urban 'bus services', consideration should be given to the extension of the ambulance or hospital car service to enable patients to visit surgeries.

16. Psychiatric Services. We cannot stress too strongly the need for the closest possible link between geriatric and psychiatric services. We have touched on the problem in our Introduction and our view is well expressed in the paper The Development of Psycho-geriatric Services, Dr. A.N.G. Clark and Dr. J.A.Whitehead, from which the following is an extract:

Summary and Recommendations

i The provision of Joint Assessment Unit facilities in Brighton and Mid-Sussex, at Brighton General Hospital and St. Francis Hospital, the former to take precedence over the latter.

ii Day Hospital facilities to be provided in relation to both these Units.

iii The appointment of a Senior Registrar/Registrar in Psycho-geriatrics directly linked with a teaching Hospital appointment. Extension of the SHO post at Bevendean Hospital could also provide cover in the Brighton Unit. The existing medical staff in the Psychiatric and Geriatric Units at the Brighton General Hospital would participate in the new Unit and provide medical cover. A further appointment of possibly a second Registrar or SHO may be needed depending on the growth and volume of clinical work produced.

iv The formation of a Liaison Committee to discuss problems and devise solutions. An important function of this Committee would be to ensure that the administration of the various departments involved was such that unrestricted direct co-operation is possible between the various field workers involved with the problems of old people.

v The overall direction of this Department to be in the hands of Dr. J.A. Whitehead.

vi The increased provision of community care for the mentally disabled old person by the Hospital and Local Authorities, such as Day Hospital facilities, community care by Hospital Nurses, Local Authority Day Centres, purpose-built EMI Homes, special housing for the elderly, Home-Helps, night sitters, meals-on-wheels, home occupational therapy and physiotherapy, laundry service, etc.

17.

1. As workers involved in various ways with services in the elderly we are particularly conscious of the scarceness of resources compared with volume of actual and likely need. We are also very aware that too many gaps exist between service agencies and between workers. While efficient administrative and organisational practices are centrally important, the day to day effectiveness of new policies and procedures must in the end depend upon quality of care experiences by the consumer. We would like the elderly person in particular

to feel that the workers they meet have a comprehensive understanding of the total range of services available and of the roles and functions of their colleagues.

2. At the field level we therefore urge that the leadership of the Health Services and the Social Services should strongly support any well formulated innovation designed to bring about a greater sharing of skills and experience between workers.

18. At the next stage of the Project we urge that particular attention should be paid to document 5 below on Home Help Services and Laundry Services.

List of papers considered by the Project Team

1. Report of a Working Party on the Development of Services for the Elderly and Elderly Confused in the South-East Metropolitan Hospital Region. Professor J.C. Brocklehurst, Dr.W.E.R. Budd, Dr. A.N.G. Clark, Dr. R.E. Irvine.

2. The Development and Future of Psychiatric Services for the Elderly in Brighton, Hove and Mid-Sussex. Dr. J.A. Whitehead.

3. The Development of Psycho-geriatric Services. Dr. A.N.G. Clark and Dr. J.A. Whitehead.

4. Report of the Director of Social Services, East Sussex County Council, on Non-Residential Services within the Community for the Elderly, including the Elderly Mentally Infirm. Dated 19 July 1971.

5. Report of the Director of Social Services, East Sussex County Council, on Non-Residential Services for the Elderly in the Community - Home Help and Laundry Services. Dated 17 December 1971.

6. Report of the Director of Social Services, East Sussex County Council, on Non-Residential Services for the Elderly in the Community - Meals Services. Dated 25 October 1971.

7. Report of the Director of Social Services, East Sussex County Council, on Non-Residential Services for the Elderly in the Community - The Transport Needs of the Elderly. Dated 17 January 1972.

8. East Sussex County Council Social Services Department, Draft Note on Discussions regarding Supplementary Benefits and other Welfare Allowances on 10 November 1971.

9. Old-Age Health. Klein R. & Ashley J. New Society 6.1.72.

10. Report on Transport Services in General Practice. Hilary Lance. Journal of Royal College of General Practitioners. October 1971.

11. Forms. East Sussex County Council 'Care of Aged Persons - Health Visiting Record'; 'Health Screening of Old People (65)'.

7

Advisory Group Report

on

SERVICES FOR THE MENTALLY
AND PHYSICALLY HANDICAPPED

MEMBERS OF ADVISORY GROUP

The group consisted of the following seven members acting in individual (and not official) capacities and met seven times between November 1971 and February 1972.

Mrs. B.J. Cushnie	District Nurse, Hastings
Dr. E.M. Forster	Deputising for Dr. J.M.E.F. Dunn, Consultant Psychiatrist (Mental Handicap) Hailsham H M C
Mr. K.E. Godley	Organiser, East Sussex Association for the Disabled
Mr. A. Hoad	Deputy Head, Mental Health Section, Brighton Social Services Department
Mr. H.J. Lyne	National Society of Mentally Handicapped Children
Mr. T.F. Mears	Hospital Secretary, Chailey Heritage
Dr. R.G. Brims Young	Deputy Medical Officer of Health, East Sussex
Dr.P.J.M. McEwan	Director of the Centre for Social Research, University of Sussex, acted as chairman.

TERMS OF REFERENCE

1. The group considered all kinds of physical and mental handicap including blindness and deafness, but excluding those specific forms of handicap that have been dealt with by other groups concerned with old age and mental illness.

MAJOR AREAS OF CURRENT DIFFICULTY

2. Conflicts of Responsibility

1. At the present time, there is no single authority responsible for ensuring that all available help is, in fact, being obtained.

2. The co-ordination of all relevant services, diagnostic, therapeutic and preventive should be an essential part of any comprehensive health service. The group, therefore, consider that responsibility for liaison between the medical services themselves and also between the medical and social services should be one of the responsibilities of the community health physician.

3. Communications

1. There have been frequent failures of communication and co-ordination in the provision of services to the handicapped. It is necessary to gather and collate information especially with respect to the physically handicapped and the young chronic sick (the East Sussex authorities know of approximately 3300 physically handicapped and young chronic sick, but this figure is estimated to be only 60% of the total).

2. There has also been a deficiency of information flowing outwards from the providers of services to the handicapped. There should be more widespread dissemination of information about the needs of the handicapped and the services available to all health care workers, especially those in primary care. This information should be distributed through the agency of a health education service (see paragraph 9 below).

3. An Intelligence and Evaluation Service - There should be a constant monitoring of all existing services, a continuous assessment system built into the revised plans, which would be the responsibility of the community health physician answerable to the area health authority.

4. Staffing

1. The number of consulting psychiatrists working in the field of mental subnormality is quite inadequate.

2. There is a need for a more adequate psychological service for both the mentally and physically handicapped and also for the families concerned, especially young mothers. It was considered that this service could best be improved by -

a) an increase in the number of trained psychologists, and
b) by improved communications between these services and other units in the health care system, e.g. hospitals, general practice.

3. Salaries - Area Health authorities should adopt the most favourable scales of pay in all cases where at present there are discrepancies between the scales paid by the various authorities.

5. Hospital Services

1. Before further plans are either made or implemented regarding any new hospitals that may be concerned with handicapped members of the population, it is essential that the numbers of such people be accurately ascertained.

2. Before any hospitals catering for mentally and/or physically handicapped are closed, or their catchment area altered, a detailed review should be undertaken of the numbers of patients and the areas of population served, bearing in mind the increasing difficulties of rural transport and the number of beds that would be required for specialist assessment purposes (recommended in paragraph 7 (2)).

3. Problems are posed by the difficulties of obtaining advice and treatment for mentally handicapped patients with superimposed mental illness.

SERVICES FOR THE PHYSICALLY AND MENTALLY HANDICAPPED

6. Prevention

1. A comprehensive preventive service should encompass the following four main areas -

a) To prevent conception in women likely to bear children with hereditary disabilities. This involves the provision of genetic counselling with related diagnostic services and comprehensive family planning advice, including termination and sterilisation. (It was noted that the Child Health Services group considered that genetic counselling services provided from two London hospitals is satisfactory. This group, including representatives in a position to know the situation on a County rather than local basis, is convinced that, whilst the service provided by those London hospitals is of a high standard, it is neither sufficiently known, nor sufficiently accessible). It should be possible to have, for example, a monthly clinic in Brighton. It is the case that only a small proportion of parents with a first child suffering from Downs syndrome have received counselling, although all should do so. We would also point out that there is a clear financial implication in this proposal since the money spent in improvements to the genetic counselling service would be more than offset by subsequent savings.

b) To protect the foetus from damage by dangerous maternal influences during pregnancy. This should include such measures as immunisation of adolescent girls against rubella; prevention of excessive smoking and alcohol consumption during pregnancy; prevention of other drug abuses during pregnancy.

c) To protect the child from injury during birth.

d) To detect biochemical abnormalities likely to damage the child. This would include, for example, screening for phenylketonuria.

2. A vital part of all prevention is health education and this means educating the medical profession as well as the lay public. With this in mind, we believe that refresher courses for general practitioners should include problems commonly associated with physical and mental handicap and up to date information about all the services that are available.

7. Diagnostic

1. Every newly born infant should be thoroughly examined during the first week of life, irrespective of whether born in hospital or at home.

2. The careful observation of the child's development during infancy; when any abnormality is suspected, a full investigation should be available in a comprehensive assessment unit with reference to the relevant specialist department. There should, therefore, be established, as a matter of urgency, centres for the continuous and comprehensive assessment of all disabilities at all ages and such centres should include facilities for inpatient observation. These centres would be concerned not only with forms of disability for which specialist assessment procedures already exist but also for such categories as adult sub-normals whose assessment at the moment leaves much to be desired.

8. Care

1. The group found it useful to distinguish between care that should be provided within the hospital and care appropriate outside the hospital.

2. Inside the Hospital
- Specialist treatment relevant to the need, including skilled nursing, should be sufficiently available and readily accessible to all in need.
- The provision of social and educational services available inside the hospital under the supervision of the medical authorities should be readily available to all in need.
- There should be effective liaison between the hospital and the family doctor.

3. Outside the Hospital
- The services of the family doctor, working as a member of a health team, should be readily available, including domiciliary services, eg physiotherapy - there being an express need for such services to patients having suffered strokes and similar conditions.
- There should be effective liaison between the medical team and the social and educational services, including the school health service.

- The group advocates a streamlined supply service for all permanent aids for all handicaps. This service should be related administratively to the comprehensive assessment centres (recommended in 7(2) above) although supplies need not necessarily be supplied through these centres.

VOLUNTARY ORGANISATIONS

9. 1. At the field level, liaison between voluntary organisations and statutory authorities has not been good. Hospital information officers should be more closely informed of voluntary organisations and the health services should consider appointing information officers similar to those already appointed by the social services.

2. The new area health authorities might consider the appointment of a staff member whose primary responsibility would be the liaison and integration of all voluntary organisations within the area.

8

Advisory Group Report

on

PSYCHIATRIC SERVICES

MEMBERS OF ADVISORY GROUP

The group consisted of the following six members acting in individual (and not official) capacities and met six times between November 1971 and February 1972.

Mr J Barry	Principal Nursing Officer, St Francis HMC, Haywards Heath
* Mr A A G Mitchell	Group Secretary-Treasurer, Hailsham HMC
Dr D G Pendlebury	Consultant Psychiatrist, Hailsham HMC
Dr H Savery	General Practitioner, Brighton
Mr P Symonds	Area Director (Haywards Heath), East Sussex Social Services Department
Dr R W Wheeler	Consultant Psychiatrist, St Francis HMC
Dr J W Powles	Research Fellow for the Project, acted as chairman

* Joined the group after it had commenced its meetings

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1 PRIORITIES AND OBJECTIVES

1 The following is desirable as a general model for the future provision of psychiatric services provided certain qualifying factors are acknowledged: in-patient provision for the mentally ill should be substantially reduced and the beds re-located out of the large psychiatric hospitals into district general hospital psychiatric units and, in parallel with this, community care ought to be greatly expanded

2 The major factors which need to be acknowledged as qualifying this general model are:

i Some categories of patients requiring in-patient care for mental illness have special needs which cannot be met by a standard DGH psychiatric unit. Examples of such groups are children and adolescents, psychopaths and deteriorated psychotic and psychogeriatric patients.

ii If the mentally ill are to be well cared for in the community adequate resources must be made available for the task.

iii There will be major problems both for existing patients and for staff in the run-down of the major psychiatric hospitals.

3 With respect to the special needs of children and adolescents the report of the South East Metropolitan Regional Hospital Board's Working Party on "The development of psychiatric services for children and adolescents" is noted. The report supports an increased emphasis on community care and recommends the provision of special in-patient units for children and adolescents.

4 The special needs of those who are a danger to society or to themselves are currently not well catered for. Such patients need to be cared for in a secure unit and it is probably not feasible to locate such a unit within the curtilage of a DGH. Some such unit is however needed to bridge the gap between Special Hospitals (such as Broadmoor) and the community and the recommendation that a Regional Security Unit should be developed at Maidstone in Kent is noted (South East Metropolitan Regional Hospital Board, "The development of adult psychiatric services", para 181). The number of such patients is not known but a recent study at Hellingly attempted to estimate the total number of such persons within the hospitals catchment area.

5 The elderly confused pose special problems. They should be seen as part of a broader category - "The old with a need for residential care". In this context the elderly could be seen as needing a lot of care from a lot of people and it is unusual for their problems to be exclusively psychiatric. It is difficult to know what the criteria for hospitalisation are - for example, the development of incontinence seems in practice to be a factor in initiating hospitalisation. These patients need a system of graduated community care where the relatives can help

in caring for the patient where appropriate. Often support is needed at night. As is the case for other categories of mentally disturbed persons there is a need for an increased commitment of resources towards caring for them in the community. Day hospitals, day centres and domiciliary and supporting services have an important role to play in such care.

6 Institutional care for psychogeriatric patients falls under three heads:

(1) Assessment units
(2) Short-stay care
(3) Long-stay care

7 It is official policy to develop psychogeriatric assessment units and this is supported. However, if such units are to function efficiently, adequate arrangements must exist to enable the rapid transfer of patients from such units to appropriate longer-term accommodation.

8 Facilities for short-stay psychogeriatric care are particularly helpful in keeping a larger number of these patients in the community by being available to supplement domiciliary care when necessary. A valuable example of this is the provision of "holiday relief" for relatives.

9 The recent regional working party report had this to say on long-term psychogeriatric care, (South East Metropolitan Regional Hospital Board, "The development of adult psychiatric services, Appendix 1, Psychogeriatric care):

> "Patients with organic dementia comprise a high proportion of all those in long stay care in geriatric and mental hospitals and in local authority residential homes. The long term aim must be to run down and close the large remote mental hospitals and to provide long stay care for these patients in small units near their own homes."

The advisory group agrees with this view.

10 The further development of community care for the mentally ill is critically dependent upon adequate resources being committed to this end. These resources can be thought of under four heads:

i development of therapeutic teams

ii increased assistance to the primary care sector

iii development of social care and residential support

iv development of day care facilities

11 The development of therapeutic teams is supported. They should comprise psychiatrists, psychiatric nurses and psychiatric social workers. However, it is possible that hospital-based psychiatric social workers will be transferred to Social Service Departments. Whatever happens arrangements must be made for some social workers to be attached to the therapeutic teams. (The Hailsham Hospital Management Committss is experimenting with the joint appointment of a social worker with the Hastings Social Services Department and there are numerous other examples of such co-operation throughout the country).

12 The primary care team needs increased assistance in coping with psychiatric problems. They need ready access to therapeutic teams including social work assistance. Currently the task of coping with these problems falls largely on the health visitors but few of them are trained or willing to take on this role. Some general practitioners feel in particular that social work assistance ought to be more readily available than it currently is.

13 The general trend of mental care from the hospital sector to the community implies a transfer of costs from the exchequer-funded NHS to the rate-funded local authority services. The extent of this trend will be determined by the ability and desire of the local authorities to expand their role in caring for the mentally ill. The community care of the mentally ill depends not just on social services but also for example, on the availability of suitable housing. A severe shortage of housing for the elderly makes a nonsense of "community care".

14 There is a serious risk that, during the transition phase to psychiatric units in the DGH, existing psychiatric hospitals will become "dumping grounds" for these patients considered less attractive by health care workers. This could have a serious effect on staff morale and for this reason the staffing of the psychiatric service for each health district should be considered as a whole. The same staff ought to cover both the DGH unit and the traditional hospital, where necessary being rotated between the two units. There are also dangers for patients if they are to be left in a declining facility with low staff morale and with resources inferior to those available in the DGH unit.

15 There are at least three major areas of uncertainty in the future provision of psychiatric services which require clarification:

i What is to be the relation between the (psychiatric) therapeutic team working in the community and the existing primary care team?

ii What is to be the relation between the (psychiatric) therapeutic team, the primary care team and the social services department?

iii What is to be the relation between the roles of the psychiatric nurse working in the community, the health visitor and the social worker?
(This question needs to be considered both in respect to their work situation and to their separate professional career structures).

16 It is probable that the new local government district boundaries will not closely correspond to the boundaries of the hospital catchment areas. It is however officially intended to base the new health district boundaries on the hospital catchment areas. As the social services department is likely to be organised on the basis of local government district boundaries it would be desirable if, as far as possible, the health district boundaries take into account local government boundaries. For instance, a health district could include two or more local government districts.

17 The new proposals for the psychiatric services would involve a shift of resource-commitment from hospital beds to skilled manpower. This would provide a more valuable service to the community. The financial situation of the psychiatric units within DGH's may, however, be precarious. Hospital money tends to flow towards complex technology and psychiatry may continue to be a poor relation. Against this it should be noted that both the region and the Department were now favourably disposed towards the psychiatric services.

2 ADMINISTRATION - AREA

1 There will be a need for a joint consultative committee at area level of those responsible for psychiatric services and those responsible for psychiatric services and those responsible for social services. This would be especially necessary in order to co-ordinate policy formulation and the planning of capital expenditure for the mentally ill.

2 The continuing education of all workers in the psychiatric services should be co-ordinated at area level. The development of community care requires a re-orientation of the interests and capabilities of many health care workers and this will need official encouragement. Some emphasis should be given to team-based training.

3 An area medical intelligence unit could serve three functions for the psychiatric services:

i The collating and editing of data which is currently collected both locally and nationally and the relating of this data to the functional units of the new service.

ii The carrying out ad hoc investigations into different aspects of the psychiatric services in Area 44.

iii The monitoring of current research activities that are relevant to the provision of psychiatric services of Area 44.

In gathering information it is essential to safeguard the confidentiality of medical records.

3 ADMINISTRATION AT DISTRICT LEVEL AND THE ORGANISATION OF WORK

1 A joint consultative committee of those responsible for the psychiatric and social services at (health) district level will be necessary in order to co-ordinate the provision of services to the mentally ill.

2 The catchment area of the psychiatric in-patient facilities at district level should be "sectorised" geographically with one therapeutic team being responsible (in co-operation with the social services department as necessary) for both the hospital and community care for all patients in that sector. Such sectors might have populations of 50 - 80,000 and it is hoped they will relate to the geographic units into which the social services will be divided. There will also be a problem relating therapeutic team areas to GP catchment areas, day hospitals, hostels, etc.

3 With "sectorisation" there will be opportunities for increased interaction between psychiatric service workers and primary care workers. If primary care is centralised into group practices and health centres then it may be possible to arrange joint meetings to discuss patients. This would reduce the number being referred to out-patients. Currently it is very difficult for general practitioners to find time to discuss patients with consultants.

4 Lines of communication between primary care workers and members of the therapeutic team will need to be developed. It is likely that the health visitors will have a central role to play in this. There is considerable room for improvement in the existing communication practice between in-patient units and primary care workers. Ward clerks and dictating machines might help but there is also a problem of attitudes. Health care workers need to have the will to communicate and this depends upon an appreciation of the other workers' roles and expertises. This can be helped by increased face-to-face meetings at post-graduate centres, etc.

5 The general practitioner and the other members of the primary care team will continue to carry the day to day responsibility for the major portion of psychiatric morbidity in the community. Ways and means must be found to help them in this task.

9

Advisory Group Report

on

THE CONSUMER AND THE HEALTH SERVICE

MEMBERS OF ADVISORY GROUP

The group consisted of the following 11 members acting in individual capacities (and not as representatives of their nominating organisations) and met six times between November 1971 and February 1972 (The nominating organisation is shown in brackets)

Mr P D Baker	(Rye and Bexhill Conservative Association)
Miss A M Barman	Hastings (Patients Association)
Mrs B Jefferis	Lewes (Old People's Welfare)
Miss S Lewis	Isfield, near Uckfield (Red Cross)
Mr C H Mobbs	(Eastbourne Constituency Liberal Association)
Mrs A Peacock	(Brighton Women's Royal Voluntary Service)
Mr W Trend	(Kemp Town Constituency Labour Party)
Mrs Tate	(East Sussex Federation of Women's Institutes)
Mrs R Wallace	(Home Help Organiser, Hastings Social Services Department)
Mrs F E Ward	(Brighton and Hove District Association for Mental Health)
Reverend W P Webb	Buxted (British Legion)

CONSUMER AS PATIENT

General Practice

The concept of group practices was strongly supported and it is proposed that a social worker, preferably a medical social worker, should be attached to each Health Centre.

The group also recommends that, where possible, part-time geriatricians might be attached to certain group practices where their services would be most useful, a service that might incorporate help from retired general practitioners with particular interest in problems of the Elderly.

It was felt that, in some way, the general practitioner should see himself more as a member of a team and less of an individual operating in isolation, more as a first violin and less as a prima donna.

It was thought useful if more extensive refreshre courses could be offered to general practitioners, with reasonable incentives for attendance. These might deal with such matters as family studies, sociology and medicine, and certain selected aspects of psychiatry (the group noted that such a course is already operating with considerable success at this University).

There was a need for closer liaison between general practitioners and industry, particularly personnel officers and industrial padres. There was much of relevance that a responsible and experienced personnel officer could report to an employee's general practitioner and there were times when those concerned with personnel problems in industry could pursue their work more effectively if they were given more information from the medical profession. This need not involve breaking any professional confidences. Since general practitioners were unlikely to take the initiative individually, it was suggested that some form of machinery might be set up to ensure that at least the opportunity for closer liaison was available.

In rural areas, the development of health centres means that patients who used to attend a surgery in their own village now have to travel distances which are impossible to cover on foot, and where no public transport is available. It is recommended that a car be attached to health centres to collect patients who could not get to the surgery by ano other means. (In areas where this has been tried, the doctors have found that the number of requests for home visits has been considerably reduced).

It was proposed that first aid facilities should be always available in health centres and where there is no dispensary in the village, a dispensary should also be provided.

Deficiencies in the present system of lodging complaints regarding medical attention was criticised and the concept of a health ombudsman was warmly supported. The group took note of the fact that there were too many cases of victimisation in that patients making complaints of their general practitioner were then no longer persona grata with him and were forced to make alternative arrangements, which, in rural areas particularly, could be difficult.

In addition to structural alterations which may be implicit both in some of the recommendations of this group and also those made by others, Health Centres might be encouraged to develop the team concept whereby regular meetings would be held involving health visitors, home help organisers, district nurses and general practitioners.

Hospital Services

It was agreed that the small cottage hospital provided a valuable and irreplaceable service for patients hospitalisised with comparatively minor complaints. Such hospitals provided continuity between the general practitioner and the patient, avoided unnecessary clutter ing of major jospitals with minor cases, were usually more convenient for the patients and, not least important, provided the general practitioner with the opportunity for participating in hospital care on an active basis.

Strong criticism was made of the appointment system in many hospitals. There are three bases for criticism:

i The long delays of hours within the hospital waiting to see a consultant or to receive attention and of weeks waiting at home for the call to enter hospital, which might come at very short notice.

ii Too often, after a lengthy delay in a waiting room, the patient is eventually seen not by the consultant or senior registrar that has been expected but by a more junior doctor.

iii The absence of co-ordinated information between the hospital and the general practitioner. Cases were reported of individuals waiting long periods before entering hospital and without even their own doctors having been informed of the diagnosis. (The group detected an unfortunate attitude among many members of the medical profession in treating the patient as an isolated individual without regard to his membership of the family or community).

There should be more flexibility in visiting hours, particularly as centralisation may mean long journeys for visitors. Evenings can be particularly difficult for some people working in industry and for mothers with young children in country districts.

The siting of new hospitals should take into account ease of access for patients as well as for medical and para medical staff, bearing in mind the public transport situation.

The Elderly

The Home Help Organiser who is responsible for the day to day care of the elderly should be brought into all consultations concerning domiciliary care. She needs to be well informed regarding the patient's physical and mental capabilities. Without this knowledge, she cannot allocate help or train staff adequately. The Home Help Organiser also runs the incontinent laundry service. More information should be published regarding the facilities available to enable the Organiser to effectively plan the use of this service. A bathing attendant service is operating in a few areas, also run by the Home Help Organiser. This service should be extended. It is a free service and economises on the utilisation of highly qualified nursing staff. If there are any signs of deterioration in health, cases can be quickly referred to the District Nurse. These three divisions of the Home Help Service complement each other. The advice and support of the proposed nursing team should be available to the Home Help Organiser.

There should be a distinction between the elderly and the elderly confused and these groups of patients should not be mixed in hospital.

More co-ordination was needed of services for the elderly and this might perhaps be a responsibility of the community health physician.

Home Help organisers might be invited to attend conferences from time to time at Psychiatric hospitals, when the specific problems of the elderly and confused are being considered. This would help them in their work and might even introduce additional insights for the medical staff.

The suggestion was made that nursing wings might be attached to Homes for the Aged. It was recognised that, at the moment, Homes for the Aged did not fall within the administrative ambit of the health service, but in spite of this difficulty, it was considered sufficiently important to require this administrative obstacle to be overcome. Subsidised semi-private accommodation for the elderly should be made available on a large scale in those areas where there was special need, eg, the South Coast. This development might be related to the previous proposal.

Maternity Services

There is at present insufficient post natal care. The proposed revisions were approved provided assurances can be given in advance that the necessary skilled personnel, particularly midwives, are available.

It was further resolved that all aspects of the family planning services should be incorporated into the health service.

Transport

With the increased centralisation of services, the question of accessibility, particularly within rural areas, would undoubtedly become more critical.

It was proposed that there should be an extension of the hospital car service (i) to enable patients to attend their general practitioners in areas where public transport is inadequate, (ii) for the purpose of collecting and delivering prescriptions and (iii) for transporting patients to and from hospital when no ambulance was readily available. This and similar services might require voluntary help on a larger scale than hitherto and someone within the health service should be made specifically responsible for co-operation between various voluntary organisations and for planning the strategic use of their over all resources.

Communications

One of the most important matters regarding the health service as it at present exists is the problem of communication, both between patients and the medical profession and - perhaps more easily improved between those professions engaged in the provision of health care, eg, between hospitals and general practitioners. Are general practitioners always aware of the arrangements for emergency beds? There is evidence that this is not always the case, yet upon them may depend whether a patient gets admitted or dies unnecessarily.

Mentally and Physically Handicapped

Greater attention should be given in informing the parents or guardians of handicapped patients of the true nature of the condition and the treatment and care that should be given. Too often, handicapped patients return home and those providing care are given no guidance as to what they should do nor indeed what may be wrong.

CONSUMER AS CUSTOMER

The notion of the health ombudsman was warmly supported. It was agreed that, at the national strategic level, consumer interests are becoming less and less considered. The only effective way of changing this trend would be to incorporate within the structure of the Department of Health and Social Service, Consumer representation having access to all the information available to expert committees within the Department.

With regard to the proposed Community Health Councils, some doubt was expressed about their useful function, but it was agreed that, if the notion was to be really effective in giving the public efficient representation, then the following revised proposals of the National Association for Mental Health would need to be put into operation.

There is much to be said for divorcing the several functions of management which have hitherto been carried by Hospital Management Committees. We welcome the idea that Community Health Councils might in future assist management in the task

of overseeing and improving the well-being of patients and staff. It has become very clear that the business side of management work has too often engrossed the whole attention of managers; as a result they have been able to spend too little time in familiarising themselves with actual conditions on the wards.

We believe that the proposed Community Health Council should be given a far more detailed role than has yet been outlined. We do not believe that volunteers will come forward to serve unless a meaningful role is spelled out for them as members given an opportunity to promote and pursue consumer interests at management level. In particular, we believe that they will be unable fully to fulfil their role unless they have the right to be heard at area board level by one of their members, elected by themselves to the board.

Members elected to the area boards within a region should elect from among themselves a representative to sit on the regional health authority.

The Consumer Council representatives on regional health authorities should elect one of their members to participate at department level as part of the consumer representation recommended in the first para of this section.

So far as the appointment of members is concerned, we suggest that they should be nominated by the largest local voluntary organisations active in health affairs within the district. Invitations to nominate representatives should be sent by the secretary of the area board. The chairman of each council should be elected by the members of the council themselves.

Community Councils should be serviced by paid officers of their own provided from centrally allocated funds.

Before a new member joins a council, he should undergo training in order to familiarise himself with problems of hospitals and gain some understanding of the patients he is to serve, particularly those in hospitals for the psychiatrically ill and the mentally handicapped.

We suggest that the duties of the Community Health Councillors should include their accessibility to patients and families and friends of patients visiting them in hospital, and to members of staff for the discussion of ward problems. We believe that, if Community Councils were required to be available and be seen to be available within the hospital, the recognition of patient and staff problems at management level would be very greatly improved. We stress, however, that this could only be so if the voice of the Community Health Council were subsequently heard on both the area boards and regional authorities.

OTHER RECOMMENDATION

The marking of medicines is a particular problems among the confused and elderly, some of whom might have several different medicines left over from past occasions. This could be dangerous and the group thought that the question should be referred both to the College of General Practitioners and also to the pharmaceutical industry.

RELATIONS BETWEEN HEALTH & LOCAL AUTHORITY SERVICES

The report in the following pages has been prepared by Dr John Powles to indicate some of the problems and opportunities in the future relations between health and local authorities as identified by the first phase advisory groups. These groups were concerned with the provision of medical services to different patient need groups. As their primary focus was not on the future inter-relation between health and social services the following is not meant to be a comprehensive list of problems in this area. There were in fact only 7 representatives of the statutory and voluntary social services out of a total of 76 participants in the advisory groups. This report should therefore be seen as a (necessarily limited) "brief" from the health services project on future relations between health and social and other local authority services. The report is divided into four sections:

1 Objectives, priorities and principles for the provision of services

2 Administration at area level

3 Administration at district level

4 Subjects for further investigation and clarification.

1 OBJECTIVES, PRIORITIES AND PRINCIPLES FOR THE PROVISION OF SERVICES

1 A policy of community care implies the provision of adequate resources to support the sick, disabled and disadvantaged in the community. It also increases the need for effective co-ordination between the provision of medical and local authority services.

2 The local authority services for which co-ordination with health services is especially important are:

i Environmental health services

ii Social services

iii Education

iv Housing

v Planning

3 To ensure the proper and comprehensive discharge of the joint responsibilities of these services, effective administrative procedures and clear channels of communication must exist between the various services and their agents.

4 A generalised statement of intent will not ensure the quality of co-operation required, therefore there ought to be formal and specific requirements to co-ordinate policies and activities. It should be obligatory for these services to exchange planning documents.

5 The community physician will have a central role to play in the co-ordination of health and other services.

6 Effective integration of services depends upon a mutual recognition between provider groups of their respective roles and contributions. This mutual understanding needs to be developed. Further education programmes and discussion meetings which are "problem" rather than "discipline" orientated can help in this. For example, joint meetings could be held to explore the needs of the elderly.

7 General practitioners should be encouraged to regard themselves as members of a team. Social workers should be attached to health centres.

8 To avoid wasteful duplication, shared services should be developed where appropriate:

ii Basic demographic, social, land-use, transport and communication data should be produced as a "data base" by the county planning department to be used by the health service, social services, education services, etc.

ii A single area psychological service should be developed to serve the health, social and education services.

iii A health education service could be established jointly by the health and education authorities.

9 There should be no financial dis-incentive for patients or relatives to home care.

POINTS OF RELEVANCE TO SPECIFIC MEDICAL SERVICES

10 Preventive Services

i Preventive services need close links with environmental health services, education, planning, housing and social services.

ii For the purpose of health education, effective penetration of the educational system is essential. If the health education service is not a joint one with the education authority (as is suggested in 8 iii above) then a health education liaison officer should be appointed by the education authority in order to ensure effective co-operation between teachers and health educationists.

iii With an increasing awareness of environmental influences on health it is important to ensure an adequate "health input" into the wider social planning processes.

11 Birth Control and Maternity Services

There should be effective links between the birth control and maternity service and social services in order to ensure:

i ease of referral to birth control services by social workers

ii ready social work assistance to abortion patients and to mothers and babies with social problems (especially unmarried mothers)

12 Services for the Physically and Mentally Handicapped

Both health and social services are heavily involved in institutional and other care for this group. Hence a careful co-ordination of capital and service planning is essential. Special attention should be paid to the needs of the handicapped when they reach school leaving age. There will be a need for close links between disability assessment centres, if developed and social services. Co-ordinated help should be given to families which include a member having a physical or mental handicap. There is a potential role for a community physician in co-ordinating and monitoring the provision of services to this group.

13 Services for the Elderly

The probability of an increasing proportion of hospital beds being taken up by old age pensioners highlights the need to develop the "middle band" of provision. This is conceived as the area of greatest operational, policy and administrative overlap between the hospital sector and the social services. Policy decisions about hospital provision, day care and various types of residential and day facility provided by the social services will clearly need to be very closely co-ordinated at district and area level and at regional level also. Without joint planning it is difficult to see how the hospital services can avoid being overwhelmed. So far as can be judged, co-ordinated planning does not at present exist at the level of seriousness required.

14 Psychiatric Services

The proposed radical expansion of community care for the mentally ill will require the careful co-ordination of health and social services. If (psychiatric) therapeutic teams are to cover the needs of the mentally ill within specified areas (as is recommended in the Department of Health and Social Security White Paper "Hospital services for the mentally ill", December 1971) then they will need to co-operate closely with the social services. A social worker should be attached to each team. There are a number of uncertainties in the future provision of services to the mentally ill and these are mentioned in 4 2 and 4 3 below.

2 ADMINISTRATION AT AREA LEVEL

1 The area health information service should compile and maintain a register of all handicapped persons in the area.

2 There should be an integrated supply service for all permanent aids for all handicaps. This service should be related to handicap assessment centres.

3 There should be co-ordination of transport facilities - especially for the physically handicapped.

4 The area health education unit should make use of every opportunity to "teach to teachers". In particular it should provide in-service training in health education for school teachers.

3 ADMINISTRATION AT DISTRICT LEVEL

1 Local authority districts and health districts will not be co-terminus. This is because the health districts will be based on district general hospital catchment areas which do not necessarily bear any close relation to local authority boundaries. This will make co-ordination of health and local authority services at district level more difficult to achieve. The following measures could help:

i Where a hospital catchment area boundary runs relatively close to the new local authority district boundary, the local authority boundary could be taken as the health district boundary.

ii For the purpose of co-ordinating services, those local authority districts that lie wholly or principally within a health district could be considered in aggregate and the services provided within their boundaries could then be co-ordinated with those of the health district. For example, if the area Social Services Department divides its work up geographically into (local authority) district offices then the offices of those (local authority) districts that lie principally within a health district could combine for the purpose of co-ordination with health services.

iii From the viewpoint of the health services it would be more satisfactory than (ii) above if the Area Social Services Departmenr were to divide itself internally on the basis of health district boundaries. The argument for this is that the health service is the most important service with which the social services interact. On the other hand, of the services to be provided by the future district local authorities only housing is of major importance to the social services.

2 If improved communication networks are to be established within the health districts, in particular between the district general hospitals and primary care teams, then arrangements for effective links with social service departments should be included.

3 If a single point of access is to be provided within each health district for enquiries and complaints from the public, it may be desirable for this to cover both health and social services.

4 AREAS FOR FURTHER INVESTIGATION AND CLARIFICATION

(In list form)

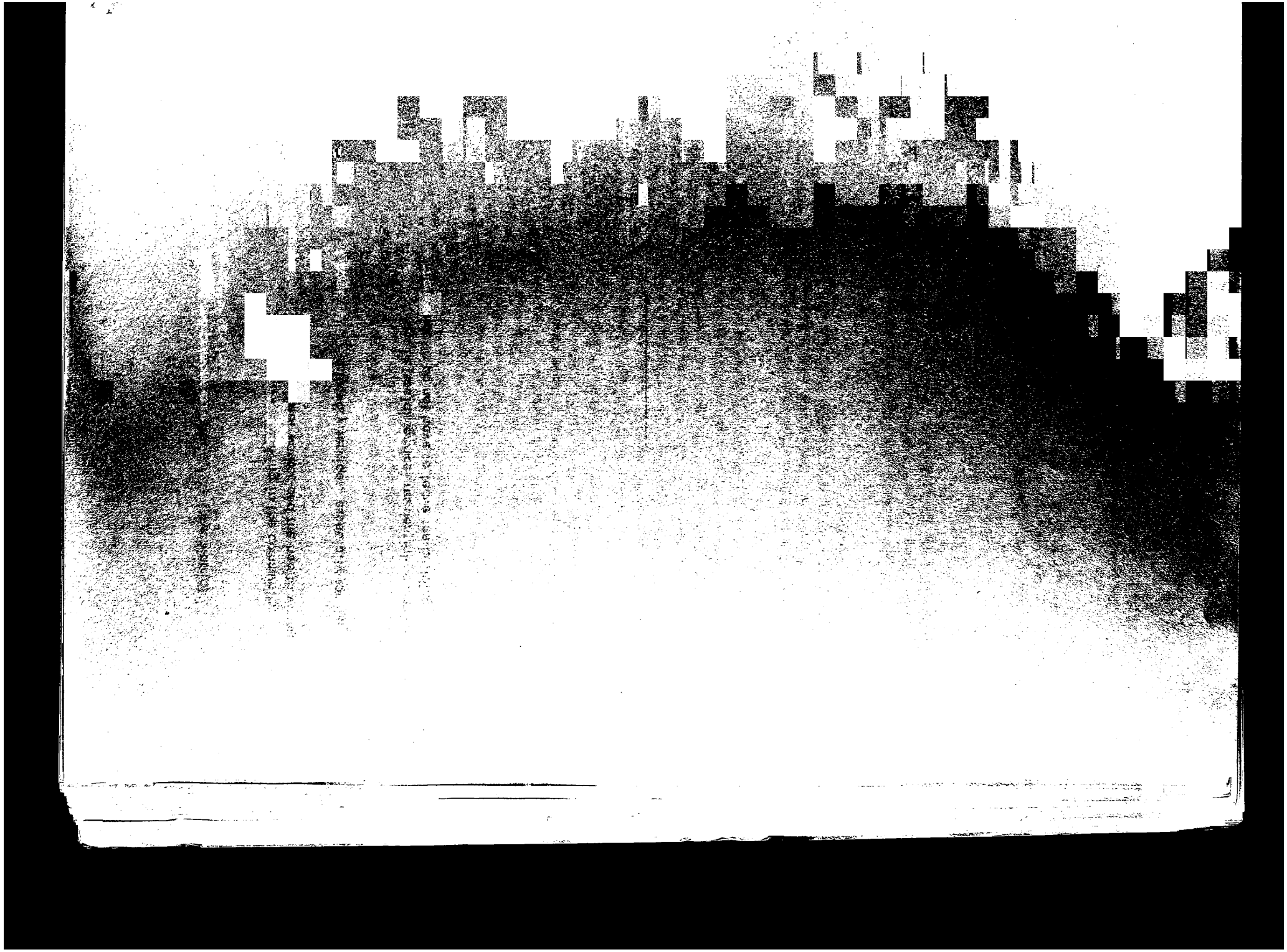
1 The problem of non-correspondence of local authority and health district boundaries (see 3 1 above).

2 The relationship between the primary care team, the (psychiatric) therapeutic team and the social services.

3 The relative roles of the psychiatric nurse working in the community (as a member of a therapeutic team), the social worker and the health visitor.

4 The organisation of home help and laundry services, especially for the aged and handicapped.

5 The possibility of nursing wings in (social service) residential accommodation for the elderly so that residents do not have to leave the building when ill.



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