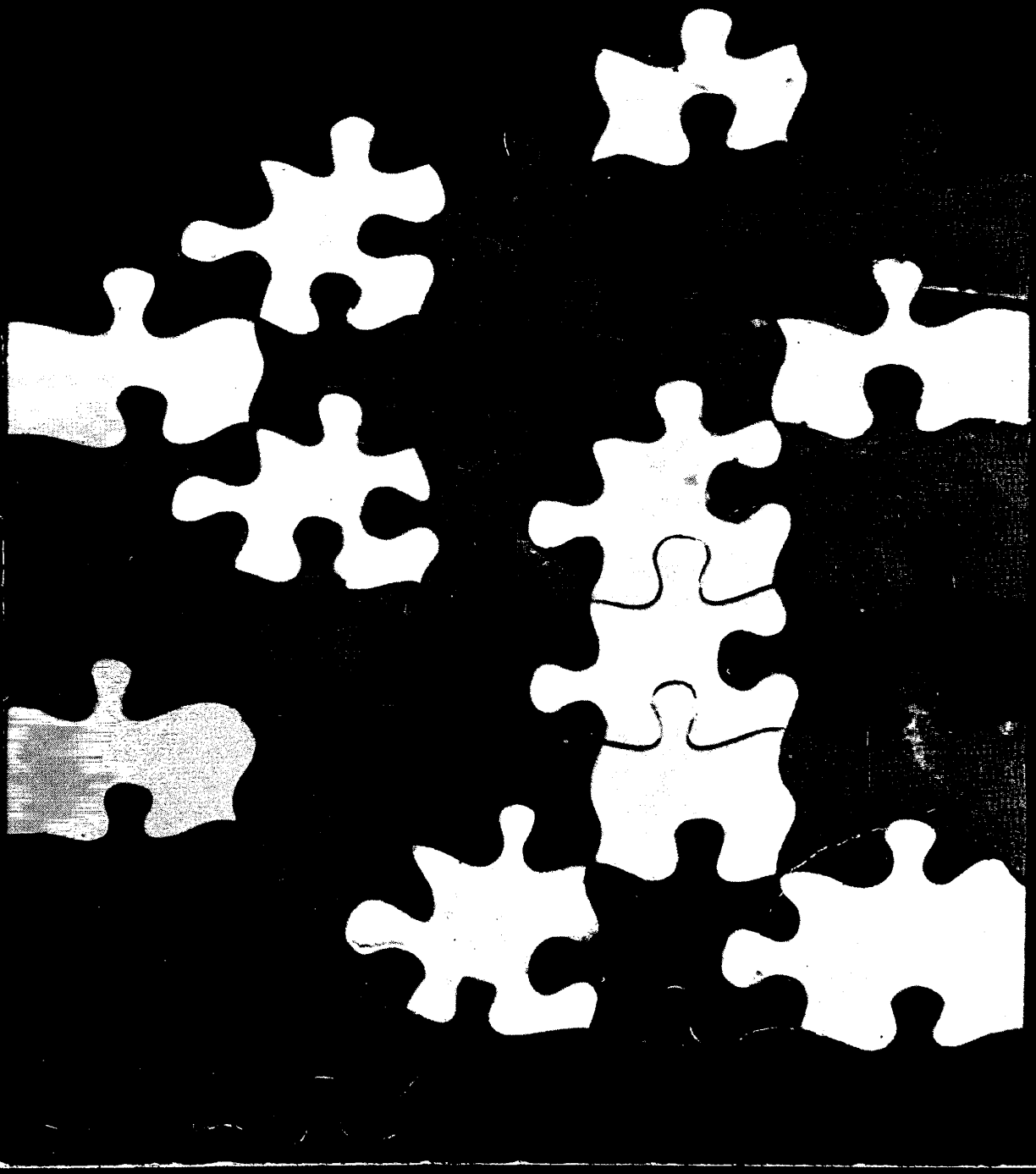
A King's Fund Report

Working Together

A study of coordination and cooperation between general practitioner, public health and hospital services



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Chairman's Foreword

The National Health Service is one of the big forward movements in our social history. It has resulted in a much better distribution of specialist skills and has taken the financial sting out of illness. After 19 years it is clear that the foundations are sound but that there is still much readjustment to be achieved within the general plan. It might be thought that the task of reorganisation should have been completed, but in the earlier years housing, schools and industry had the first priorities and it is only in the last five years that the health service and the universities have begun to get a better share of the national resources.

Historically it was perhaps inevitable that the main divisions of the health service – hospitals, public health and general practice – should have developed independently. The task of complete integration at the beginning would have been too great; but for many this remains an ultimate objective. Meanwhile, it has become increasingly clear that somehow much better cooperation must be achieved if we are to make the best use of our limited resources. In due course further legislation may be needed to bridge some of our present boundaries; in the meantime, however, it is up to each of us to see what steps can be taken to work together more closely with others who are also trying to help patients or the community. It is in the power of every single person working within the National Health Service to make some personal contribution. There are many ways. All of us can take some steps to facilitate the work of others; some can coordinate similar work, some can define problems and work at their solution. Systematic studies will be needed for a long time as there are many answers we do not yet know.

Public health, general practice, occupational health and hospital

service : each has its own special contribution to make. There must be more pooling of resources and opening up of better lines of communication. The public health service can make a big contribution towards helping the reorganisation of general practice and mobilising ancillary help. Hospitals can make their diagnostic facilities available to general practitioners. They can also provide a meeting ground for social and professional contact – one looks forward to the day when all members of the health services will meet easily and freely in academic medical centres within our main hospitals.

This study brings together many examples of possible cooperation and we hope it may stimulate others to do the same. It is confined to a consideration of England and Wales, and is the result of a collection of information made since April 1966. It is by no means an exhaustive investigation of the whole field of cooperation. Some of the projects described have already been discussed and evaluated in other publications; others still need to be critically examined before their full value can be assessed. The examples quoted are, therefore, only illustrations and the object of the report is to demonstrate that it is not necessary to wait for new legislation before embarking on attempts to coordinate health services.

F Avery Jones
January 1968

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Introduction

The tripartite structure of the health service has its disadvantages.
Kenneth Robinson, Minister of Health.

The pattern of divided medical services in England and Wales which took its present shape in 1948 owes its character largely to historical circumstances, now more or less irrelevant. There is, however, an increasing realisation of the need for coordination of the activities of these different branches of the health service, accelerated by the publication of three Ministry reports with their subsequent revisions.[1] The Minister has himself expressed pleasure at seeing 'more and more evidence . . . of integrated planning of health services as a whole'.[2] It should be remembered that the intention of the 1946 Act was 'to promote the establishment of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness'.[3]

To provide a truly comprehensive service designed to meet all the needs of every type of patient in the most efficient way calls for both cooperation and coordination of the highest order.

The concern over this problem felt in many quarters led the King's Fund, at the suggestion of Dr Avery Jones, chairman of its Hospital Development Committee at the time, to finance a study of the practical ways in which cooperation might be achieved between the branches of the health service. The purpose of the survey was to produce a report with the aim of encouraging widespread discussion and adoption of good ideas and practices in the field of cooperation and coordination in the service.

In April 1966, Dr M R McDonald, MB, BS, DPH, assistant principal medical officer in the health department of the London Borough of Ealing, was seconded to help with the study. After reviewing the current literature on the subject, she made a series of visits to authorities and individuals in different parts of the country, to discuss and record developments in the field of coordination.

Circular letters were sent to all senior administrative medical officers of regional hospital boards, and later to all local authorities and executive councils in England and Wales, see Appendix A, requesting details of what were considered to be good examples of cooperation in each area.

A survey of the relevant material was carried out by Miss M Dorothy Hinks, FHA, FRSH, research officer at the King's Fund Hospital Centre, who wrote this report.

In addition to the comments from regional hospital boards, replies were received from 138 local health authorities, 79 per cent of the total. Replies received from executive councils covered 62.6 per cent of the local authority areas. Table 1 contains a detailed analysis of their replies, which shows that 89.6 per cent of the local health authority areas in England and Wales were covered by replies from either one or both groups of respondents. Reprints of published articles relevant to the subject of the survey were received from 17 local authorities, see Appendix B, and 33 supplied additional material in the shape of annual reports, minutes of meetings, handbooks and special reports. Five authorities supplied material under both categories.

Setting the Scene

To attempt any reasonably accurate assessment of the findings of this survey, it is necessary first to consider limiting circumstances.

The first difficulty is geographical. The difficulties of the different boundaries between the various types of administrative health areas can cause much confusion. Very rarely do the boundaries of the local health authority, the executive council and the hospital management committee coincide, and relationships can be further complicated by the administrative divisions of regional hospital boards. Again, the recent reorganisation of the Greater London area has resulted in the formation of new local health

authorities which have as yet had comparatively little time to settle down. In this area too a single executive council can cover as many as thirteen boroughs. The MOH of the Isle of Wight County Council wrote: 'We find that having the same identical areas for health and welfare authority, the hospital group and the local medical committee is a great help'.

The second difficulty is to be found in the individual interpretations of the request for information made by the King's Fund, see Appendix A. It became quite clear that there were widely varying views on what constituted 'good examples' of coordination and cooperation. While some replies listed every example in existence in that particular area, others obviously took many of these for granted and thus referred only to practices which could be considered to be of outstanding interest. It has been quite impossible, therefore, to produce any statistical evidence of the frequency of certain good practices throughout the country. It is thought, however, that this omission does not invalidate the report which seeks to describe briefly the many ideas and suggestions that have been collected.

One must also take into account the widely different circumstances that exist in the various local authority areas, from the large rural areas with scattered population to overcrowded cities. The influence of such conditions as availability of staff, transport problems, types of population and industry and, not least, the personalities of the individuals involved, has an important effect upon the organisation and running of the health services. As one MOH commented, 'conditions in a large county vary so widely that quoting what goes on in one place where everything combines to produce a happy and harmonious system, may well be confronted by a less happy state of affairs in what at first sight might appear to be parallel circumstances elsewhere'.

Thirdly, it is necessary to differentiate between the true meaning of the words *coordination* and *cooperation*. The latter can be described quite simply as *working together*. The Shorter Oxford English Dictionary defines coordination as 'a harmonious combination of agents or functions towards the production of a result'. The basic difference was emphasised by one executive council's reply which commented: 'It is appreciated, however, that while cooperation may occur between people as individuals, coordination means close deliberations upon policy . . .'

Bird's Eye View

Given goodwill, administrative difficulties caused by tripartite control can be overcome – without goodwill, no legislation could effect a coordinated service. Letter from a Medical Officer of Health.

It was noted that the response from medical officers of health exceeded that of executive councils (79 per cent as against 62.6 per cent) and it was also clear that relationships between the two varied markedly from area to area. 'The very fact that the Clerk to the Executive Council sent me a copy of his letter to you epitomises the excellent relationships which exist', wrote one MOH. Elsewhere, it was interesting to observe the different opinions on what constituted good examples of cooperation apparently held by both sides in the same area. At the other end of the scale one respondent complained that his authority's attempts to infiltrate cooperation and coordination into all aspects of their service was hindered by 'longstanding prejudice and misunderstanding of their purpose'.

However, the emphasis laid by so many on the importance of personal and informal contact and goodwill left no doubt that good human relationships form the basis of good cooperative practices. The clerk of one executive council wrote, 'very little has been done by way of cooperation on a formal basis, but an enormous amount is done informally . . . the informality of the methods employed are in themselves a guarantee of speed, effectiveness, goodwill and a real desire to cooperate'. Informal liaison at officer level was considered to be one of the most fruitful sources of cooperation but, as another writer observed, this could be only 'as good as the senior officers are prepared to make it'.

'An unqualified success' is the verdict from the SE London and Kent area on the first appointment to be made of a Planning and Medical Liaison Officer for the county with the idea of securing better liaison between the local authority and the professions. A similar appointment is reported from the West Riding of Yorkshire.

The organisation of committees of various types was one of the most frequently mentioned methods of cooperation. Many replies included references to liaison committees for maternity,

geriatric and mental health services, to which can also be added ambulance services, exfoliative cytology and care of the mentally subnormal.

One county health authority considered that their chairmen's committee, which could meet at any time and consisted of the chairmen of the local health authority, the hospital management committee and the executive council, was a valuable tool in the prevention of possible misunderstandings within the service. Both the MOH and the executive council of the East Riding of Yorkshire report enthusiastically on the value of their Standing General Practitioner/Health Authority Liaison Committee. In Middlesex, area liaison committees with a purely medical membership based on hospital management committees are said to have proved their worth.

In the city of Bristol a joint committee on hospital and local authority services has close contact with both the regional board and the teaching hospital. The recently formed Joint Working Party of the Metropolitan Joint Consultative Committees consists of the four senior administrative medical officers, four representatives of the undergraduate teaching hospitals, a representative each of the postgraduate teaching hospitals, the University of London, the London Boroughs Association, the Inner London Executive Council and Local Medical Committee.

Although it seems clear that such liaison committees have a useful part to play, particularly in areas where geographical conditions make it easy for them to meet, the prime importance of personal and informal contact was stressed by many respondents. One executive council struck a warning note by its comment that, although such committees looked well on paper, their effectiveness could be sometimes open to doubt, particularly when they tended to become moribund.

Cross-representation on various committees was mentioned even more frequently than liaison committees. In particular, medical officers of health are represented on a wide variety of committees concerned with the health and welfare of the population. A study of this subject and of the functions of such committees would make a valuable addition to present knowledge.

1 NATIONAL HEALTH SERVICE. A hospital building programme for England and Wales. Presented to Parliament by the Minister of Health. Cmnd. 1604. HMSO 1962.
and NATIONAL HEALTH SERVICE. The hospital building programme. A revision of the hospital plan for England and Wales. Presented to Parliament by the Minister of Health. Cmnd. 3000. HMSO 1966.
MINISTRY OF HEALTH. Health and welfare: the development of community care. Plans for the health and welfare services of local authorities in England and Wales. Cmnd. 1973. HMSO 1963.
MINISTRY OF HEALTH. CENTRAL HEALTH SERVICES COUNCIL. STANDING MEDICAL ADVISORY COMMITTEE. The field of work of the family doctor. Report of the sub-committee (the Gillie report). HMSO 1963.

2 The Minister on administration of the NHS. The Lancet vol II no 7470. 29 October 1960. pp 957-959.

3 PARLIAMENT. National Health Service Act. HMSO 1946.

1 General Practice and the Local Health Authority

The fact that some 90 per cent of all medical episodes are estimated to be handled from start to finish by the family doctors of this country[4] demonstrates the importance of the general practitioner in the National Health Service. It is vital that, as the linch-pin of the service, he should enjoy the closest possible contact with the preventive and curative functions of both the hospital and local health authority health services.

According to the Ministry of Health[5] 'care in the community provided through the health and welfare service supports and is supported by the medical care given by the general practitioner'.

Attachments

The development of group practices has greatly facilitated attachments of para-medical staff to general practitioners. Support of the general practitioner by the services of local authority para-medical staff was frequently mentioned during the survey, and the attachment of health visitors to group practices occurred more often than any other suggested means of cooperation. Even so, opinions and practices varied widely. Reports of almost 100 per cent attachment in some areas contrast strongly with the situation in other parts of the country. In complete attachment the nurse is regarded as a full member of the general practice team, working from the surgery and joining in all case conferences. Improved communications and continuity of care for the patient are the main advantages of this method of working.

The city of Oxford attained complete attachment for all health visitors, district nurses and midwives over two years ago. The success of this scheme is thought to have led to an increasing interest by

general practitioners in preventive work, with the result that more than one third of the authority's child welfare clinics are now taken by GPs. In Berkshire, the same scheme has been in operation for one year and the local health authority is completely convinced of the benefit of such a practice.

The situation in some areas, however, is far less advanced, with often only one or two health visitors or nurses involved in pilot schemes. Apathy or even opposition to the idea has been reported by some authorities. 'There is an open invitation for the attachment of health visitors', reports one MOH, 'but only two practices have as yet taken up this invitation.' Yet another reports the complete failure of attempts to start any attachment schemes.

Reports from a number of areas seem to indicate that geographical conditions can play a major part in the success or otherwise of direct attachments.

In Leeds[6] it was found that the size and population density of the area combined with the scattered nature of the average practice made the attachment of health visitors to a practice, or a group of practices, neither feasible nor desirable, but the Leeds Medical Officer of Health is sympathetically considering proposals for attachment. On the other hand, a study of patients in Salford[7] reports little or no difficulty in this direction.

Experiments in Hampshire[8] seem to indicate that attachments in a fairly rural area can be both practicable and highly successful. In all new premises which doctors in this area have built for themselves during the last ten years, accommodation has been specially provided for attached staff. Some authorities report that full attachment in very rural areas is a physical impossibility, but it has been found in Berkshire that attachment schemes have proved successful in both rural areas and medium sized towns.

Although it has been shown that attachments are administratively possible in both town and country areas, the criteria of success of such schemes in terms of benefit to patients have yet to be clearly defined.

In areas where official attachments are considered to be either impracticable or undesirable, more informal liaison arrangements are often to be found, with health visitors calling frequently on general

practitioners during surgery hours. This has been found to work very successfully in Portsmouth.[9]

The attachment of health visitors to GP well-baby clinics, antenatal, child welfare and immunisation clinics in doctors' surgeries is reported from several areas. It is also interesting to note the extension of attachments to cross-county boundary visiting, which has been reported by several authorities.

The organisation of nursing teams to assist groups of family doctors has proved to be a satisfactory alternative to attachments in some rural areas. In East Sussex, nursing teams consisting of health visitor, district nurse, midwife and ancilliary help, numbering in all the equivalent of about 21 whole-time nurses, have been attached to an approximately equal number of family doctors. In Lindsey (County of Lincoln) the composition of the nursing team may vary with the volume and nature of the work of the district. Each team has a leader who is a state registered nurse or midwife, and includes at least one midwife, two SRNs or one SRN, and one state enrolled nurse, in addition to bathing attendants who undertake work not needing the skill of more highly qualified people. Each team also has an automatic telephone answering machine from which messages are cleared several times a day. Two experienced health visitors have recently been sent by the Hertfordshire public health authority to undergo district nurse training with a view to returning to work as group advisers to teams of nurses attached to group practices.

District nurse attachments received fewer references than attachments of health visitors, but comments on staff shortage applied equally to both groups. Problems connected with attachments, already discussed in connection with HVs, are found to be very similar in the case of the district nurse.

A recent experiment in Bristol[10] provided some interesting results. Although distances travelled by the attached nurse were double the average for the unattached nurses, it was found that apart from greater job satisfaction and improved communications, there was a marked increase in the number of visits an hour employed, as well as more effective hours being worked by the nurse. It was also discovered that, before the attachment, the two doctors concerned were under the impression that there was a shortage of district nurses and, therefore, frequently curtailed their requests

for nursing services. This belief was also held by many doctors in the city, and the fact that this erroneous belief is widespread is supported by the findings of the recent survey produced by the Queen's Institute of District Nursing.[11]

In the mainly rural county of Cumberland, attachment and liaison schemes met with considerable opposition, but now, with by far the greater number of staff integrated into the plan, the MOH reports that no nurse or general practitioner in the county would wish to return to the old system. 'The end is thus in sight', says the report, 'for the "village nurse" '.

Frequent references to midwifery attachments also occurred in the replies received by the King's Fund, and the comments of one authority merit further thought. It was pointed out that with the gradual decrease of home midwifery, it will be necessary for midwives to practise their skills over a larger geographical area for their proficiency to be maintained. 'It appears', says the report from this authority, 'that the midwife of the future will deliver fewer mothers, but will become the expert, in conjunction with the general practitioner obstetrician, in ante-natal and post-natal care and in the early neo-natal developmental progress of the child.'

The work of the local authority midwife will be considered in greater detail in a later section.

To meet the need for constant communication facilities, Cumberland health authority have started to instal radio transmitter receivers in the cars of their district midwives. From Manchester and Wolverhampton come reports of the provision of high-frequency pocket radio telephones for midwives. The King's Fund has recently given a grant to the Hythe Medical Centre, see page 22, for the establishment of a radio communication system to keep not only midwives and district nurses in contact with the centre, but also the general practitioners.

A general study of attachments of local authority staff to general practices is being undertaken by the Social Medicine Unit of the Department of Medicine of Guy's Hospital Medical School.[12]

Health Centres and Group Practices

The first allusions to health centres were made fifty years ago by

Beatrice Webb and others and the idea was clarified by the Dawson Report[13] which pointed out the dangers of isolation in the practice of medicine. The National Health Service Act of 1946 laid on every local health authority in England and Wales the duty of providing, equipping and maintaining health centres, but by the end of 1966 only 33 centres were actually in existence. A few attempts had been made prior to 1948, outstanding among which was the Pioneer Health Centre at Peckham.

It cannot be denied that not only have many general practitioners been loth to consider moving to health centres, fearing loss of independence and increased expenditure, but central and local authorities have been equally slow in providing the necessary facilities. The situation is now rapidly changing.

'Up until recent weeks there has been no demand or interest on the part of the GPs for health centres;' wrote the MOH of a county borough, 'over the last ten years I have failed to "sell" health centres to GPs, but I am now hopeful.' From the opposite side of the country another MOH reports that more than a third of the general practitioners in his area have approached him in regard to the possibility of bringing their practices into health centres. The latest revision of the Ten-Year Plan envisages nearly 300 centres by 1976. Information obtained during the current survey shows clearly, however, that there is still considerable reluctance and misunderstanding to be overcome in certain areas.

At present there is a multiplicity of different schemes for the provision of health centres, but there is an urgent need for some systematic evaluation. Further guidance from the Ministry of Health was issued in Circular 7/67 (HM(67)22).

i Section 21 Centres These are centres provided by the local health authorities under Section 21 of the 1946 Act. Accommodation is rented by the authority to general practitioners through executive councils.

Bristol has been the pioneer of this type of health centre. At the St George Centre, opened in 1964, in addition to an appointment system and ante-natal and well-baby clinics undertaken by the general practitioners, this centre also has age and sex registers and a retirement clinic run by a public health doctor on behalf of the GPs. Although Bristol has no official attachment scheme, health

visitors, district nurses and local authority workers are based at both the St George and the William Budd Centre (opened in 1952), and work closely with the GPs. A third centre was opened in November 1967.

The Alderman Jack Cohen Centre, opened in Sunderland in 1956, provides maternity and child welfare, dental and pharmaceutical services, in addition to five suites for general practitioners. School clinics for the treatment of minor ailments, chiropody service for old age pensioners and a cytology service are also included.

The West Riding of Yorkshire claims to be the first authority to provide a purpose-built centre in a well-established town. The Cleckheaton Health Centre near Dewsbury, opened in October 1964, provides accommodation not only for all eight doctors practising in the town, but it also houses the divisional medical officer and his staff, the public health inspectors for the borough of Spenborough and the registrar of births and deaths. Similar cooperation is planned in Gloucester where a health centre now being constructed will eventually accommodate not only six general practitioners and the necessary ancillary staff, but the top floor of the building will house the local authority dental centre. A health centre now being built in Thornbury, Gloucestershire, will include accommodation for home help organisers, mental welfare officers and health visitors. The Nechells Green Centre in Birmingham was incorporated into a newly built block of flats.

Doubts as to the practicability of health centres in rural areas have been cleared by the success of the Faringdon Health Centre in Berkshire which is situated in an old cottage hospital closed in 1945. Devon County Council, with the approval of the executive council, has embarked on an ambitious scheme to provide a total of 35 health centres in small towns and semi-rural areas. At Okehampton and Lynton, the centres are situated in hospital grounds; the Buckfastleigh Centre also houses the registrar of births, marriages and deaths. The Ilfracombe Centre will in addition be an education welfare officers' base and at Sidmouth, the BRCS and WRVS and the Council for Social Service will be given accommodation.

The Hythe Health Centre is interesting for several reasons. Apart from a group practice at Huntley in Aberdeenshire, this centre is unique in so far as the doctors concerned have had experience of both health centres and group practices. The centre is structurally

attached to a 27-bed GP hospital and provides accommodation for three distinct types of service – general practice, local health and education services, and consultant out-patient and treatment sessions from hospitals in Southampton. Physiotherapy, rehabilitation and syringe services are carried out in the hospital wing. The salary of the administrative officer responsible for the day-to-day running of the centre is paid partly by Hampshire County Council and partly by the Wessex Regional Hospital Board. The subsidised rent of £500 per annum per practice is partly offset by the fact that the family doctors in the centre undertake, without fee, a number of local authority clinics, such as well-baby and immunisation sessions. They are also responsible for the school medical service for which payment is made on a sessional basis.

An alternative approach to a health centre type of building has been reported from Berkshire. Here the general practitioners and the local health authority have each purchased half of a site. The doctors intend to erect a group surgery to serve their somewhat far-flung rural practice and the local authority plans to erect a 'mini-clinic' alongside. The whole will be designed with a common entrance and certain common facilities.

The Harlow Centres, although not strictly Section 21 centres, should be mentioned here. They were the first to be provided in a new town; financed originally by the Nuffield Provincial Hospitals Trust, they are managed by Harlow Development Corporation. The services of the Essex County Council nursing staff are available from these centres to the general practitioners who, in their turn, staff the council's maternity and child welfare services.

ii Diagnostic Centres At present there are two diagnostic health centres in England.

The diagnostic centre opened in 1954 at Corby was initiated by the Nuffield Provincial Hospitals Trust with added financial assistance from a local steel firm. The nearest out-patient facilities for this rapidly developing new town were 8 and 25 miles away respectively at Kettering and Northampton, and the centre was established to meet this need and to give local GPs access to diagnostic facilities. The response from general practitioners is reported to have been disappointing, although, as a hospital out-patient department, the centre was a success. It is now maintained and staffed by the Kettering and District HMC.

The South East London General Practitioner Centre, opened in 1961, is housed in part of the former Peckham Pioneer Health Centre and is open to any GP in the area. Here the main emphasis is on the use of the centre as an accessible and convenient place for diagnosis rather than on the practitioner's actual presence. A health visitor is attached to the centre and joint meetings of family doctors and consultants are held regularly.

It has been suggested[14] that this type of centre could well provide a suitable compromise between the present type of local authority health centre and the general practitioner's surgery. A hint of the shape of things to come may well be seen in the fact that plans for the new Charing Cross teaching hospital in Fulham include a general practitioner unit on these lines, which it is intended to staff with nurses from the hospital.

From Lancashire comes news of plans for a comprehensive diagnostic and therapeutic centre with beds, proposed by the regional board, for the use of general practitioners and local health authority services. Yet another experiment which is an example of cooperation between local authority, general practice and hospital, is the Nuffield Health Centre at Witney. The population of this area is expected to double within the next 14 years, but the nearest hospitals are 12–14 miles away in Oxford. This purpose-built centre, which is the property of the Nuffield Provincial Hospitals Trust, meets the urgent needs of all three sections of the health service. The local authority required better premises for their clinics and the Oxford Regional Hospital Board felt the need for a diagnostic centre and for the improvement of local clinics and out-patient sessions. The partnership of six family doctors in the town also urgently required better accommodation to meet the needs of the growing population.

iii GP Teaching Unit Centres The Medical Planning Commission of the BMA recommended that health centres should be used for the teaching of students, but so far only two attempts have been made to implement this recommendation. One centre is in Edinburgh and the other, Darbishire House, which was financed by funds from the Rockefeller Foundation and the Nuffield Trust is now the property of the University of Manchester. There is a possibility of a similar centre in Wales. Cardiff City Council is proposing to build a Section 21 centre in a new estate at Llanederyn, and the Welsh National School of Medicine is at present exploring the possibility of using the centre as one of its 'clinical facilities' for teaching

and research. Plans are also in hand for the accommodation of medical students from University College Hospital Medical School in the new Kentish Town Health Centre which the London Borough of Camden proposes to establish shortly with financial assistance from the Kings Fund.

iv Group Practice In 1959 Eckstein commented that 'both health centres and group practices on a large scale are conspicuous mainly for their non-existence'.[15] Although there are only about 30 health centres in England and Wales, there has been considerable change in the attitude to group practice. By October 1966 only 26 per cent of principals (that is, 4,759 out of 19,822) were working single-handed (the figure in 1952 was 47 per cent) 44 per cent (8,902) were working in partnerships of three to six*, leaving 30 per cent (6,166) working in partnerships of only two practitioners. The system of interest-free loans to encourage general practitioners to improve their premises following the Danckwerts recommendation in 1952 has much to do with this change.

Some very interesting examples of group practice premises have been reported in various professional journals, but no further mention will be made of them here as they fall outside the brief of this investigation.

Dual Appointments

A number of authorities report the appointment of general practitioners as sessional medical officers in local authority maternity, child welfare and school health services. In Oxfordshire, general practitioners have acted as infant welfare clinic doctors and school medical officers since the inception of the National Health Service. A serious shortage of full-time medical officers in 1961 in Middlesbrough resulted in an invitation being issued to all general practitioners in the area to join in the work of the school health service. Each practitioner was allocated five schools of three different types and during 1964 and 1965 the family doctors carried out more than 90 per cent of the routine medical inspections. Appointments of general practitioners to run family planning and cervical cytology screening clinics are increasing, and from Enfield comes news of a smokers' clinic staffed by general practitioners on a sessional basis.

*Detailed figures are: 4,761 in partnerships of 3; 2,556 in partnerships of 4; 895 in partnerships of 5; 690 in partnerships of 6.

The Borough of Oldham reports that sessional appointments have been offered to all GPs. Greenwich reports that as far as possible all sessional work not undertaken by permanent assistant medical officers is done by local family doctors and all cervical screening clinics are manned by general practitioners The Health Committee of the County Borough of Dudley has recently agreed to full-time members of the health department staff acting as locums for general practitioners, provided that this does not interfere with their public health duties.

In addition to the sessional appointments of general practitioners to public health clinics, there is an increasing use of local authority premises by family doctors for their surgeries. Several authorities report such arrangements on a rental basis, but a number of others state that general practitioners are offered the free use of clinic premises for ante-natal and post-natal work, well-baby clinics and vaccination and immunisation clinics.

4 MINISTRY OF HEALTH. CENTRAL HEALTH SERVICES COUNCIL. STANDING MEDICAL ADVISORY COMMITTEE. The field of work of the family doctor. Report of the sub-committee (the Gillie report). HMSO 1963.

5 MINISTRY OF HEALTH. Health and welfare: the development of community care. Plans for the health and welfare services of local authorities in England and Wales. Cmnd. 1973. HMSO 1963.

6 AKESTER J.M. *and* McPHAIL A.N. Health visiting and general practice. The Lancet vol II no 7356. 22 August 1964. pp 405-408.

7 VAUGHAN D. M. Dispersion of patients in urban general practice. The Medical Officer vol CXVII no 25. 23 June 1967. p 337.

8 SWIFT G. *and* MacDOUGALL I. A. The family doctor and the family nurse. British Medical Journal vol I no 5399. 27 June 1964. pp 1697-1699.

9 HALL T. Experiment in co-operation. The Lancet vol I no 7399. 19 June 1965. pp 1325-1327.

10 FLETCHER W. B. A district nurse/g.p. attachment. The Medical Officer vol CXVII no 13. 31 March 1967. p 167.

11 HOCKEY L. Feeling the pulse. A study of district nursing in six areas. Queen's Institute of District Nursing 1966.

12 ANDERSON J. A. D. *and* DRAPER P. A. The attachment of local authority staff to general practices. The Medical Officer vol CXVII no 9. 3 March 1967. pp 111-114.

13 CONSULTATIVE COUNCIL ON MEDICAL AND ALLIED SERVICES. Interim report on the future provision of medical and allied services (the Dawson report). HMSO 1920.

14 Health centres and group practices. Articles collected from the British Medical Journal, with an introduction by Lord Cohen of Birkenhead. British Medical Association 1966.

15 ECKSTEIN H. The English Health Service. Harvard University Press 1959.

2 The General Practitioner and Hospitals

The admission of a patient to hospital often represents only a brief episode in the long-term care of an individual by his general practitioner. It is, therefore, particularly important that the general practitioner should be kept fully in the picture and the lines of communication between doctor and hospital kept as open as possible by telephone, postal and personal contact. The Robophone Secretary telephone answering and recording machine installed in the Aberdeen Royal Infirmary for the dictating of letters requesting out-patient consultations and for letters to the hospital staff has proved to be a successful innovation.[16] Few hospitals have made such special efforts to facilitate contact by general practitioners. Notification of admissions and indication of convenient times to contact consultants would seem to be appreciated. The subject of communications between general practitioners and hospital medical staff has already been studied[17], see Appendix C for recommendations.

Diagnostic Services

'In common with most other areas,' wrote the clerk to one executive council, 'general medical practitioners in this area have no difficulties with regard to direct access to diagnostic facilities provided by the hospital service.' Numerous hospital laboratories have had an 'open door' policy for local general practitioners for many years. A survey of a random sample of GPs made in 1963[18] showed that 92 per cent had access to chest x-rays and 98 per cent were making use of the facility. In the field of laboratory investigations, 98 per cent of the sample had access to a full blood count and 94 per cent of these were using the service. Various other reports, however, have stressed the very wide variations in the demand for such services from general practitioners[19, 20] but are unanimous in their view that such facilities are rarely, if ever, abused. A recent statistical survey of replies from

local medical committees to a questionnaire circulated by the Medical Practitioners' Union[21] seems to indicate a desire on the part of general practitioners for greater access to ECG and physiotherapy departments.

Admission of Patients

Emergency admissions, particularly of elderly patients, are not always easy to obtain. Bed bureaux to facilitate such admissions have been set up in various parts of the country. The best known is probably the Emergency Bed Service, started by the King's Fund in 1938 for the benefit of patients in the London Metropolitan area, which now handles between 60,000 and 70,000 cases each year. In its latest annual report the Fund points out the need for mutual understanding of the work of this service and would like to encourage visits to the EBS by groups of medical students and newly qualified doctors and nurses.

An outstanding example of cooperation between hospitals and general practitioners is found in the Admissions and Doctors Inquiry Service, started in October 1962 at Whittington Hospital, London, which has reduced to a minimum the delays and frustrations often experienced in trying to get patients admitted to hospital. This scheme is based on the principle of the non-selective admission of GP cases dependent upon the vacant bed-state. Quick access to the admissions office is possible by way of a 'clear-way' telephone extension and cases are admitted by the clerical staff without the prior approval of a house officer. It is estimated that only about 5 per cent of the cases offered by family doctors have to be referred to the RMO, usually on account of difficulties in bed accommodation. Two of the staff of the admissions office are experienced social workers who, with the GPs' permission, may visit cases requiring admission. By this means, the number of admissions of elderly people for social reasons is kept to a minimum, and the geriatric waiting list is kept continually under review.

GP as Member of Hospital Staff

It is estimated that between a quarter and a third of all general practitioners already hold some sessional hospital appointments.[22] As a result of the greater increase in population now expected, the Ministry anticipates that the original scheme of a network of district general hospitals to serve the needs of the country will have to

be augmented by the combined use of some of the smaller hospitals originally intended for closure. 'There will be scope', says the report, 'for further experiments in the use of small hospitals for patients who no longer require the full facilities of the district general hospital and can be cared for by their own family doctors.'

An experiment carried out at High Wycombe[23, 24] to assess the potential of general practitioner hospital appointments has demonstrated that the appointment of GPs as hospital registrars can be both practicable and profitable. Three appointments were made for a period of three years and the GPs appointed were attached to the department of medicine under the authority of a consultant. The patients benefited from the continuity offered; the hospital gained from the assistance of mature practitioners at intermediate level and from the improved supervision of house officers; while the GPs themselves found the hospital atmosphere a stimulating change from the isolation of general practice. Furthermore, the experiment resulted in a greater understanding of each other's role and problems on the part of all concerned.

Many general practitioners, however, see their role not as integral members of the hospital staff, but rather as users of hospital facilities to treat their own patients. Apart from the maternity units (to be discussed later on page 35) GP beds are available mainly in what were hitherto cottage hospitals. In 1965, only 11,455 of the 468,295 available beds in England and Wales were under GP control and of these 4,428 were for maternity cases.

An experimental unit of 12 beds opened at East Birmingham Hospital in 1964 is now well established. The general practitioners staffing the unit are entirely responsible for the management and supervision of patients admitted, and consultant advice is always readily available. This unit has been so successful that the executive council has asked the regional board to make provision for the establishment of similar wards at two other large hospitals in the Birmingham area.

16 MANN C. J. H. An experiment in communication between GPs and hospital staff. Nuffield Provincial Hospitals Trust. Problems and progress in medical care. Essays on current research, second series. OUP 1966. pp 235-248.

17 SHAW M. Report on communications and relationships between general practitioners and hospital medical staff. King Edward's Hospital Fund for London 1963.

18 CARTWRIGHT A. *and* MARSHALL R. General practice in 1963: its conditions, contents and satisfactions. Medical Care vol 3 no 2. May 1965. pp 69-87.

19 SIGNY A. G. Pathology and the GP. Medical World vol 105 no 5. May 1967. pp 7-13.

20 FRY J., DILLANE J. B., GLENDINNING A. C. *and* KEALE J. Diagnostic facilities for GPs: a closer look. Medical World vol 101 no 1. July 1964.' pp 23-31.

21 Medical World Newsletter vol 18 no 18. 24 November 1967.

22 NATIONAL HEALTH SERVICE. The hospital building programme. A revision of the hospital plan for England and Wales. Cmnd. 3000. HMSO 1966.

23 KEABLE-ELLIOTT R. A., TUDOR J. *and* WILLIAMS J. T. N. The general practitioner as medical registrar. The Lancet vol II no 7367. 7 November 1964. p 1005.

24 ODDIE J. A. General practitioners and hospital staffing. The Lancet vol II no 7319. 7 December 1963. pp 1219-1220.

3 Hospitals and the Local Health Authority

Close cooperation between hospitals and local health authorities can be attained in various ways, particularly by means of joint appointments, staff liaison arrangements and the joint use of premises.

Joint appointments work in both directions: not only are hospital consultants offered sessional appointments by the local health authority, but medical officers of health and their assistants are to be found working in hospitals and out-patient clinics. The City of Westminster has an interchange of medical staff with local authority medical officers holding clinical assistantships in the local HMC and, in some areas, MOsH and their deputies still have clinical responsibility for infectious diseases hospitals. At Central Middlesex Hospital, an MOH holds an honorary consultant appointment.

Many authorities offer sessional appointments to hospital consultants, particularly in the field of diseases of the chest, mental illness and geriatrics. Consultant sessions are also offered by the local authorities in such specialties as orthopaedics, anaesthetics, ophthalmology, audiology and ENT.

Other categories of staff are also employed in a dual capacity in some areas. In Barrow-in-Furness, for example, an audiology technician has been appointed jointly by the council and the hospital management committee to undertake screening surveys in all local schools.

In Blackburn, local authority speech therapists and orthoptists carry out sessions in the hospitals on reimbursement, and from Carlisle comes a report of a local authority physiotherapist helping out at a

hospital suffering from staff shortages. The joint appointment of an additional social worker between the hospital management committee and the local health authority in the London Borough of Merton helps with the work in the general field of diseases of the chest. The Board of Governors of King's College Hospital have recently advertised a joint appointment of medical social worker/ social welfare worker to take charge of the geriatric social work services at St Francis' Hospital. It is intended to develop a joint hospital and community care scheme for old people in that part of Southwark which is included in the hospital's catchment area.

At the Belgrave Hospital, London, an audiology unit has been set up with the local authority providing equipment, social workers and auditory trained staff who work in premises belonging to King's College Hospital which also provides the necessary medical staff. From several sources comes news of local authority medical officers attending the clinics and ward rounds of hospital consultants. Birkenhead reports an 'ever open' door for local authority medical staff to follow up schoolchildren in hospital and to attend ward rounds. The services of medical consultants are enlisted by Hertfordshire County Council to assist in planning the development of the health services of the county.

Health visitors are probably the most widely used members of staff in liaison arrangements between the public health and hospital services. From all quarters come reports of health visitors working in liaison, not only with general practitioners and ante-natal clinics, but also in connection with out-patient clinics for paediatrics, diseases of the chest, geriatrics, venereal diseases, diabetes and premature babies.

In Harrow, health visitors attend lectures in paediatrics given to nursing and medical students, attend 'at risk' clinics and join in ward teaching rounds. In Westminster, health visitors help to staff child welfare clinics in hospital premises.

The attachment of a liaison health visitor to each of the Sheffield hospitals is described as a 'long-standing arrangement'. Similar arrangements hold good in most of the Manchester hospitals but the amount of liaison depends upon the type of hospital. In the Cumberland area, nursing officers are welcomed in hospital wards, particularly geriatric wards, and from Oxford comes the news that

plans are in hand for liaison meetings between the chief nursing officers of all the local health authorities in the region and of the regional hospital board.

Agreement between the Northamptonshire County Council and the Oxford Regional Hospital Board for the establishment of a Department of Social and Preventive Medicine to be run by the County Council Health Department in the new Kettering General Hospital, offers a unique experiment in cooperation. Other interesting examples of cooperation between hospital and local authority have also been collected. Public health inspectors in the Royal Borough of Kensington and Chelsea make regular inspections of hospital kitchens in their area. Mothers living in the London Boroughs of Hammersmith and Hackney who have to keep hospital out-patient appointments are allowed to leave their children in borough crèches free of charge for that occasion. In Islington and Hackney, the local hospitals' telephone switchboards cover all the borough night and week-end emergency calls for services connected with infectious diseases, mental health, midwifery and home nursing.

4 Community Services

A traveller from the cradle to the grave
Through the dim night of this immortal day.
P B Shelley: *Prometheus Unbound.*

Adequate community services should meet the needs of the population at all stages of life. Maternity services, child health and care of the elderly will be considered.

Mother and Child

The Cranbrook report on maternity services includes a summary of recommendations for adequate liaison arrangements, see Appendix D. Probably the best examples of cooperation between the three branches of the health service in connection with maternity services, are the provision of general practitioner maternity beds in general hospitals and hospital deliveries of their patients by domiciliary midwives. It is estimated that GP units now deal with 10,000 deliveries a year.[25] Forty-six general practitioner beds are provided in the new Coventry Maternity Hospital at Walsgrave. One general practitioner is designated as coordinator and allotted sessions to compensate for the time spent on such administrative duties.

A short-stay delivery unit has been established at St David's Hospital, Cardiff, for the use of local general practitioners and domiciliary midwives. The hospital provides a sister and a staff of nursing auxiliaries, but the domiciliary midwife must remain with the patient throughout labour. Patients are normally transferred back to their homes after 24 hours. Any patient whose condition necessitates a longer period in hospital is transferred to the care of the consultant obstetric unit at the hospital. Crawley Hospital has a 48-hour delivery unit for general practitioners. The hospital

provides pathological facilities and hotel service and there is no supervision of the domiciliary midwives by the hospital midwives. In two GP hospitals in Surrey, domiciliary midwives undertake the confinements of those patients who have been under their care ante-natally and who have been admitted for confinement only and early discharge. The consequent continuity of midwifery supervision is held to be of great value.

A pilot scheme is reported from Cumberland where midwives have been given dual appointments to local authority and hospital services for work in GP obstetric units, and the participation of hospital midwives in local authority ante-natal, mothercraft and relaxation classes run by health visitors, is reported from Berkshire.

From Northamptonshire come reports of diminishing numbers of home confinements: in four hospitals in the county, district midwives now attend their own patients who are discharged home 24 hours after delivery.

Tomorrow's Citizens

Child health care covers a wide field from the premature baby to the school leaver and involves the welfare and education services of the local authority in addition to the health department. From Carlisle comes a report of the joint purchase by hospital and public health authorities of a special incubator for the transport of premature babies. The hospital supplies an experienced nurse to accompany the baby in the ambulance.

Joint appointments for specialist children's work are reported from various parts of the country. The children's department of Guy's Hospital includes a senior local authority medical officer with a special knowledge of the services available to handicapped children, and the consultant paediatrician at Whipps Cross Hospital has a joint appointment with the London Borough of Waltham Forest.

A joint circular from the Department of Education and Science (9/66) and the Ministry of Health (HM(66)24) stressed the need for the coordination of services for physically and mentally handicapped children and young people. The detection of handicaps is undertaken by child welfare clinics and hospital paediatricians and general practitioners. In 1965, the Borough of Hounslow started an Observation Register by which both children born with a

congenital defect and those considered to be 'at risk' are notified to the health department at the same time as the notification of birth. Access to hospital records is available to local health authority medical officers so that full information is available to the health department when the children are followed up on a developmental basis in the normal child welfare clinics. This experimental scheme, though still in its infancy, should prove to be of great benefit to the individual child and an improvement on the previous 'at risk' register.

In the London Borough of Bromley, the local authority is cooperating with the hospital management committee in the introduction of a new system of infant case records to include all infants born at home or in hospital in the area, which will be in such a form that they can, with little further work, be analysed by computer.

Audiology clinics for assessment of hearing of deaf and partially deaf children demonstrate good cooperation between the two authorities, since the team consists of ENT surgeon, paediatrician, school medical officer, educational psychologist, teacher of the deaf and speech therapist. In Carlisle, the teacher of the deaf is available to visit the hospitals and to see patients at the school clinic.

Evening of Life

In addition to the combined services of the general practitioner, hospital and local health authority, the full care of the elderly requires the additional help of local authority welfare services and voluntary agencies. A memorandum from the Ministry of Health (HM(65)77) asked for liaison between all bodies concerned and this has hastened the setting up of more geriatric liaison committees. Attempts are also being made to rationalise geriatric catchment areas.

A survey in 1962–3[26] pointed out that 30 per cent of people over the age of 65 years had not seen their general practitioner for over a year. An attempt to provide preventive services for this 'high risk' group has been made in the London Borough of Redbridge where GPs are to operate a screening clinic for their patients over the age of 65.

Some examples of good cooperative practices in connection with the care of the elderly have been collected in this survey. From the London Borough of Islington come two examples. Under Section 28 of the NHS Act, two council geriatric clinics are held; the session

at one being held by the consultant geriatrician from the hospital in the area with the largest geriatric unit and the other being under the charge of a senior medical officer of the department. A weekly geriatric preventive session, quite separate from normal surgeries, has also been organised at a large group practice in the borough. Elderly persons on the practice list are invited to attend this session on a rota basis. In conjunction with medical screening done by a member of the group practice team, concurrent educational sessions are also held, arranged by the full-time health visitor attached to the practice. The Geriatric Day Centre at St Matthew's Hospital, Hackney, is unusual since, apart from its availability for hospital patients, elderly residents in the borough, not necessarily ex-hospital patients, may also attend. Geriatric advice clinics are being established as a joint venture in Devonshire, some being run by general practitioners from their own premises and others in health centres. Mention of a geriatric well-person clinic comes from Gloucester.

In the town of Rye, members of an old people's club meet at their own request in clinic premises belonging to the East Sussex Council. In these favourable circumstances it has been customary for the health visitor to attend and, in an informal atmosphere, she is able to observe the 60 or 70 members and advise where necessary. As has already been mentioned, the attachment of health visitors to hospital geriatric clinics and consultants is widely practised, but one authority reports the home visiting of geriatric patients by the consultant accompanied by the superintendent nursing officer of the health authority to select those patients needing hospital care.

Croydon Council reimburses 5/11 of the salary of a consultant geriatrician who supervises the general medical aspects of the old people's homes in the borough. Regular conferences in geriatric units, for members of the hospital team and representatives of health visiting and home nursing services with the consultant geriatrician, are held in various areas. From the London Borough of Tower Hamlets comes a report of similar conferences organised by the home help section of the local authority services to which all the health, welfare and social agencies involved are invited so that full assessment and mobilisation of resources can be brought to bear for the benefit of the socially isolated old person.

Local authority geriatric clinics are of interest because of the different types of service which may be provided under the same title. For example, in West Sussex, clinics are being held by local

authority medical staff to give advice on management. These are run on the same lines as infant welfare clinics. As already mentioned, the clinics in the London Borough of Redbridge, although organised by the local health authority, will be staffed by general practitioners who will provide a clinical examination and screening service. The London Borough of Ealing has a day treatment centre which undertakes assessment and rehabilitation with facilities for physiotherapy and occupational therapy. The London Borough of Richmond runs a clinic for preventive medicine which arranges clinical assessment for the replacement of dietary-hormonal deficiencies.

Difficulties have arisen from the overlap between geriatric and psychiatric disease. A survey in 1962[27] found that 24 per cent of the patients in the mental hospital were misplaced and 34 per cent in the geriatric unit. The establishment of psycho-geriatric units in general hospitals under the joint care of geriatrician and psychiatrist is one answer to the problem. Others are the joint appointments of consultant geriatricians to hospitals and public health authorities, and increased coordination by means of more frequent meetings of all hospital and public health staff concerned with the total care of the elderly.

In the psycho-geriatric unit at Severalls Hospital, Colchester, social workers are employed in both hospital and community; nursing staff are likewise encouraged to do the same, and regular joint conferences of professional workers are held.

25 British Medical Journal vol III no 5560. 29 July 1967. p 301.

26 TOWNSEND P. *and* WEDDERBURN D. The aged in the welfare state: the interim report of a survey of persons aged 65 and over in Britain, 1962 and 1963. G. Bell and Sons Ltd. 1965. Occasional papers on social administration no 14.

27 KIDD C. B. Misplacement of the elderly in hospital. British Medical Journal vol II no 5318. 8 December 1962. pp 1491-1495.

5 Mental Health Services

The change of emphasis in the mental health services from institutional to community care has given rise to an even greater need for close coordination between hospitals and local authority services. The County Borough of Nottingham reports that there is almost complete integration between hospital and local authority health services in the field of mental health. In Oldham, the psychiatric service is reported to be completely unified, with the hospital providing the psychiatrists and the local authority the psychologists and social workers.

In Salford, the development of a community mental health service began in 1954 and now includes the provision of a day centre, therapeutic social clubs, hostels, regular case conferences for professional workers and joint appointments of psychiatric social workers. A local authority medical officer is also employed part time in the local hospital management committee.

Methods of attaining the desired coordination include those familiar in other sections of the health services, such as joint appointments, joint use of premises and staff liaison arrangements.

Honorary appointments of medical officers in the mental health division of the local authority as assistant physicians in psychiatric hospitals are matched by the sessional appointments of consultant psychiatrists to local authority clinics. Arrangements in the London Borough of Tower Hamlets include the combined use of the same child psychiatrist in the toddlers' clinic, local school health service, school for maladjusted children and in the local teaching hospital academic unit of psychiatry. The London Borough of Newham has developed a family psychiatry service which can help all the members of a family.

Adequate social work cover is particularly important in the mental health field and here combined arrangements seem to be particularly well advanced. Joint appointments of PSWs are reported from several large mental hospitals, and many areas report the regular attendance of local authority social workers at out-patient clinics, ward meetings and case conferences, and admission and discharge conferences in hospitals. It is reported that social work for three day hospitals in Wandsworth is undertaken by local authority social workers. In Coventry, interchange of PSWs is undertaken when necessary; from this area, too, comes a report of the attachment of a local authority PSW to a group practice in the Tile Hill Health Centre.

In Wiltshire, the areas of the mental welfare officers are being rearranged to conform with the areas of the hospital psychiatric teams, and from East Sussex comes a report that local authority mental health welfare officers are being steadily formed into teams to be led by the consultant psychiatrists. 'I forsee', says this report, 'a time when the immediate direction of the mental welfare officers, in so far as their work among the mentally ill is concerned, will be increasingly directed by the consultants.' For the last 15 years, all mental welfare and psychiatric social work of the Stoke-on-Trent Public Health Department and the local hospitals has been carried out by the mental health staff of the borough council. This is not a joint appointment since the hospital makes no payment for the services received but, when working in either hospital or out-patient department, the social workers come directly under the control of the hospital consultants concerned.

Complete integration has been attained in both Northamptonshire and the County Borough of Northampton where, by agreement with the St Crispin HMC, a team of social workers serves the needs of both the hospital and the public health authorities. These workers are on the establishment of the County MOH, and a suitable proportion of the total salary bill is met by the hospital authority. Identical arrangements are also reported from Croydon. The amalgamation of social workers to form a joint staff has also been approved in principle by the Reading Borough Council and the management committee of the local psychiatric hospital.

Although psychiatric social clubs fall into the sphere of responsibility of the local authority, increased cooperation can be seen in this field. Accommodation for such work is provided in

hospital premises in Burnley; in Carlisle, a joint social club is organised which both hospital and community psychiatric patients are able to join.

Cooperation has been taken a step further in Leeds where the acute psychiatric unit, built in 1963 at St James' Hospital, contains a wing specially allocated to the local authority with accommodation for all the mental health welfare officers who deal with mental illness. Joint-user arrangements are also reported between the department of social and preventive medicine at the University of Manchester and the Salford health department.

Two more recent developments in the mental health field are the provision of psychiatric units in general hospitals and the opening of mental health centres. Psychiatric units in general hospitals are now being developed as a national policy and offer yet another opportunity for cooperation. For example, in the unit opened in the Central Middlesex Hospital the staff includes a mental nurse from the local health authority.

Mental health centres were proposed in 1959 by a joint committee of the Society of Medical Officers of Health and the Royal Medico-Psychological Association. Such centres bring the hospital, local health authority and general practitioner services together to provide diagnostic and therapeutic services, occupational therapy, sheltered workshops and social clubs. Centres are usually built by the local authority but may also be provided jointly by the LHA and the regional board as at Plymouth, or by the RHB alone, as at Southampton.

The fourth local authority mental health centre planned to be opened in 1968/9 in Bournemouth is to be built in the grounds of the psychiatric day hospital with some facilities used in common between local authority and regional board.

Planning in the Birmingham area includes a postgraduate Institute of Psychiatry where the new John Connolly Hospital will be the heart of a complex system of psychiatric units, which will eventually form part of a new district general hospital being developed on the same site. This provides closer liaison between the local health authority and the general practitioners, some of whom will be members of the hospital staff.

6 Preventive Medicine and Occupational Health

A greater awareness of the importance of early detection of potentially dangerous conditions at a latent or pre-symptomatic stage is gradually emerging. A national plan of screening for carcinoma of the cervix is now under way, and the Ministry of Health have issued circulars calling on local authorities to cooperate with local executive councils and hospital boards to combine in the planning of cervical cytology programmes.

Several interesting developments on these lines have been noted in the current survey. Preventive medicine for older people has already been mentioned on page 37. As far back as 1958, the Corporation of London financed a well-woman clinic at St. Bartholomew's Hospital, primarily for the diagnosis of cancer by cervical smears. The corporation also contributes to the running costs of a mammography unit for the early diagnosis of breast cancer.

A new project for the early detection of disease is being organised by the department of social medicine at St Thomas' Hospital Medical School, in collaboration with the South East Metropolitan Regional Hospital Board and the health department of the London Borough of Bromley.[28] This will be carried out under the joint supervision of general practitioners, the local health authority and the hospital service.

An experiment with health-check weeks was started in Rotherham in 1962, where attempts were first made to introduce diabetic diagnosis at the same time as the mass x-rays took place. Each year, the list of available tests has been increased until in the autumn of 1966 there were eleven. It is reported[29] that in nine days 5,763 people took an average of five of these tests. Close cooperation between hospitals, general practitioners and local authority nursing staff is

essential to the success of the domiciliary cytology service in Derby which is said to be the first of its kind. It is reported that almost two-thirds of the citizens of Bedford were investigated in a diabetic survey undertaken by a team from Guy's Hospital with the cooperation of the local authority and general practitioners in an attempt to screen the entire population over the age of 21 years.

Various investigations into the incidence of diabetes mellitus[30, 31] suggest that the detection, treatment and control of this disease offer wide scope for cooperation between all the branches of the health service as well as the education and youth employment services.

The difficulty of supervising the health of the roving population has been tackled in an imaginative way by the City of Westminster health department. 'In order to secure the maximum response when the Mass X-ray Unit visited a men's common lodging house,' says this report, 'prizes were awarded for lucky numbers on record cards.' This was felt to be a good example of cooperation between hospital, chest clinic, local welfare and public health departments and the mass x-ray unit.

A computer was first used as an aid in preventive medicine in 1962 by West Sussex and since then other areas, including Coventry and Somerset, have introduced similar arrangements. Electronic data processing services are provided for clinics and general practitioners in order to facilitate vaccination and immunisation arrangements. All appointments and documentation are handled automatically, doctors are relieved of clerical work, and payment for their services by the executive council is simplified. As a result, higher levels of immunity have been attained. According to a survey undertaken in 1966 by the Local and Public Authorities Computer Panel and the Society of Medical Officers of Health, 42 major local health authorities in Great Britain intend to adopt this scheme with or without modification. A computer-assisted population screening programme for cervical cytology became operational in West Sussex in July 1967.

The Citizen at Work

It is in the interest of the national economy that everything possible should be done to promote and maintain optimum health and welfare of industrial workers. Many large firms have established medical departments which undoubtedly take a considerable load off

both the general practitioners and hospitals. It is obviously desirable that there should be close liaison between the factory medical officer and the various practitioners who serve the staff, and relationships on the whole are reported to be excellent. The fact that their patients can have dressings and treatments whilst at work, is appreciated by the general practitioners, some of whom are glad to make use of the physiotherapy and x-ray facilities of the factory medical service. Similarly, close relationships are frequently to be found between the industrial medical officer and the local hospital which sometimes offers clinical assistantships or part-time duties in the casualty department.

In recent years, a few of the smaller firms have begun to provide similar facilities for their employees by means of group medical schemes. There are at present six such groups in the British Isles, and one has the part-time consultant at the Central Middlesex Hospital as its medical director, who is in charge of the Occupational Health Unit there. This arrangement results in a very close and effective cooperation between the hospital and many of the local factories.

Occupational health is also becoming integrated into the public health world through the appointment of medical officers specifically to care for the health of local government employees in relation to their occupation.

In some areas the student health service is also linked with an occupational health department: this is so, for example, at the Universities of Newcastle and Manchester. The recent attachment of a health visitor to the Student Health Service of Southampton University has proved to be such a valuable method of liaison that arrangements for further extensions of this type of attachment to the local college of education are being made.

28 A joint presymptomatic screening project. The Medical Officer vol CXVII no 14. 6 October 1967. p 169.

29 Health check weeks. House of Commons. Official report. Parliamentary debates. (Hansard) vol 748 no 211. 15 June 1967. cols 733-742.

30 REID J. J. A. Some public health aspects of diabetes mellitus. Public Health vol LXXVII no 3. March 1963. pp 145-157.

31 BEARDMORE M. *and* REID J. J. A. Diabetic children. British Medical Journal vol II no 5526. 3 December 1966. pp 1383-1384.

7 Training

Undergraduate Medical Training

A sound knowledge of the interaction of medical services is an essential part of student training and various methods of attaining this have been reported. The observation of normal families by medical students at the Royal Free Hospital[32] was considered to be a success, in spite of certain difficulties connected with the amount of time involved. Students at St Thomas' Hospital Medical School are attached to families in which a new baby is expected, visiting at about the 34th week of pregnancy, attending the delivery if possible and doing a follow-up visit later. Information comes from the South East London General Practitioner Centre of a scheme of training for medical students involving attachment both to general practitioners and to local health authority staff.

General practitioners are appointed to the staff of the University of Newcastle upon Tyne as tutors in family medicine and combine with public health lecturers to give a coordinated course on family and community medicine.[33]

Postgraduate Medical Training

i Medical Centres Although facilities for postgraduate training have been available in many hospitals for a number of years, the Christ Church (Oxford) Conference in 1961 led to an explosion in the development of postgraduate facilities and centres. Exact figures are not available but it is known that there are well over 200 people in the country holding positions as area organisers or tutors. Many centres are housed in temporary or converted accommodation, but by the end of 1966 it was estimated that there were about 60 purpose-built centres. Financial assistance for many of these has been obtained

from a number of sources, including the Nuffield Provincial Hospitals Trust and the King's Fund. Besides lecture room accommodation, library and research facilities are valuable sections of the work of such centres. Official encouragement has recently been given in a memorandum on the subject from the Ministry of Health (HM(67)33).

A report made to the Nuffield Provincial Hospital Trust in 1965[34] stated that 'the catalytic effect of a building which is labelled "Postgraduate Medical Centre" cannot be over emphasised, and efforts should be made so that everyone in the health services, not least lay committees, should be made aware of their importance to the whole scheme of medical care'. Latest thoughts on this subject are epitomised in a further report.[35]

'There is an obvious incidental improvement in personal coordination and liaison arising from the development of postgraduate medical centres,' wrote one MOH. 'While these are obviously primarily for clinical meetings, by acting as a focal point for doctors in all three parts (together with dentists in this area) they can lead to understanding which may be harder to obtain by an exchange of letters.'

The Academic Centre at Whittington Hospital, London, financed largely by a grant from the King's Fund, was built with the express purpose of providing training facilities for all persons engaged in hospital or allied work. Consequently, its facilities are freely used not only by the nursing staff of the hospital but by such organisations as the British Red Cross Society.

ii Other methods Reports have been received from several areas concerning the participation of local health authorities in the postgraduate training of general practitioners.

A two-year training scheme has been started in the Wessex region with the help of the Nuffield Trust. Appointments are made jointly between the regional board and the executive council. The first year is spent in a general hospital and the second in general practice. It is intended that in this way trainees shall obtain good experience in the specialties which are of particular importance in general practice, in industrial and preventive medicine, rural practice and the work of the local authority health services and voluntary organisations. In Surrey, short instruction courses are held approximately every six months in conjunction with the local medical

committee for trainee medical practitioners newly come to the county. Courses in the health department of the Enfield authority are offered to GP trainees and DPH and DCH students. In-service training for general practitioners is arranged in several areas, while from other authorities come reports of introductory courses of two to three days to enable general practitioners to obtain insight into the services available and the methods of work of their respective public health authorities. Psychiatric training in day nurseries is offered by the London Borough of Lambeth to postgraduate medical students.

Training for Non-medical Staff

Facilities for both health visitors and local authority nursing staff to attend courses in local hospitals are reported frequently. District nurses in Cumberland have a regular week's refresher course in a hospital surgical department in order to keep up to date with the latest surgical procedures. From the same area comes a report of residential refresher courses for mixed groups of hospital and public health personnel, both administrators and field workers. A recent similar course was held for ward sisters and district nurses on the subject of *Continuing Patient Care.* The new Kettering and District General Hospital offers training facilities for district nurses and refresher courses for local authority midwives.

All nursing staff in the employ of the Derby public health department attend weekly lectures over a period of six months at the local mental hospital. These lectures are given to the final year of nurses and are a résumé of all their clinical lectures. Health and welfare staff in the London Borough of Barnet attend study courses in the geriatric unit of Edgware General Hospital. Similarly, medical officers and health visitors employed in Lambeth are given in-service training at St Thomas' Baby Hostel.

The Middlesex Executive Council report that their staff attend residential courses organised by the regional hospital board, and in Bournemouth, trainee hospital administrators are offered a three-day attachment to the public health department in order to gain an insight into the services available.

32 HORDER J., LOVELL E. A. *and others*. A study of normal families. The Lancet vol I no 7223. 3 February 1962. pp 263-265.

33 WALKER J. H. *and* BARNES H. G. Teaching of family and community medicine. British Medical Journal vol II no 5461. 4 September 1965. pp 557-564.

34 NUFFIELD PROVINCIAL HOSPITALS TRUST. Assessment of postgraduate medical education. British Medical Journal vol II no 5461. 4 September 1965. pp 557-564.

35 REVANS J. *and* McLACHLAN G. Postgraduate medical education: retrospect and prospect. Nuffield Provincial Hospitals Trust 1967.

8 Other Spheres of Coordination

Communications

'It is all very well for pious declarations to be passed at meetings, but unless these sentiments are passed down to ward sisters and district nurses, and are accepted by workers in this field, these meetings have no value.' This trenchant comment from a medical officer of health, highlights the need for good communications in any attempt to improve coordination and cooperation.

The importance of personal relationships has already been discussed at length elsewhere, see pages 14 and 15. Face-to-face contact where it is possible is, of course, ideal but this is restricted normally to the smallest geographical areas. Its place must necessarily be taken most frequently by written communications. In spite of the inevitable retort that 'nobody ever reads anything', this aspect is worthy of serious consideration.

A number of publications were received from public health authorities in the course of the survey, including annual reports. It is not intended to discuss the latter as they are, in any case, a statutory obligation for medical officers of health but they can, of course, be used as a means of increased cooperation. Two items of particular interest are the newsletters or bulletins and information handbooks published by some authorities.

The Health of Camden, a weekly bulletin from the MOH, was designed primarily to keep in touch with general practitioners working in the borough, but its distribution has now been widened to include other interested persons. The quarterly information bulletin, *Health Notes*, published by the public health department of the West Riding of Yorkshire, though intended for general practitioners, is worthy

of a wider public. The occasional supplements on specific subjects of interest are particularly noteworthy; so too, are the progress reports included in the bulletins. These keep readers in the picture on the progress of the policy of cooperation officially adopted by the county council three years ago. The quarterly information bulletin published by the Cambridgeshire and Isle of Ely health authority, though originally intended to serve as a house journal for the many disciplines employed in the health department, has now widened its scope to include local hospitals, general practitioners, schools and voluntary organisations.

Examples of information handbooks have been received which give very full details of all possible services available, not only from the three branches of the health service, but also from the welfare and other related services of the local authority, such as housing and libraries. In some cases, these handbooks also contain information concerning services available from the Ministry of Social Security and the Ministry of Labour, as well as numerous voluntary bodies. It was noticed, however, that although the contents of these information handbooks were very broadly the same, some of the guides were intended solely for the use of professional and voluntary workers in the field of health and welfare.

Others, equally detailed, were used for wider distribution to the general public. The largest guide, amounting to over 200 pages, published by the Derbyshire County Council, came into this category. Most of the handbooks were issued by the health department of the borough or county but two, both written specifically for the general public, were produced by the local joint liaison committee, consisting of representatives of the local health authority, the executive council and the hospital management committee.

The circulation of newsletters giving factual information concerning such items as clinic times and length of waiting lists is one method by which hospitals can maintain contact with general practitioners.

An experiment planned by the Central Middlesex Hospital is intended to extend the normal monthly broadsheet into a newsletter. This, it is hoped, will provide details of any developments in the hospitals in the group which may affect the services available to both the local authorities and general practitioners.

A number of respondents to the enquiry referred to 'post office'

facilities offered by executive councils to local health authorities, regional boards and hospital management committees whereby relevant literature from all or any of these bodies can be quickly and easily circulated to general practitioners.

Meetings

Examples of various types of meetings organised for the purpose of improving communications have been collected. Annual conferences are arranged by the West Cumberland HMC for its members, hospital consultants, medical officers of health and general practitioners. Elsewhere, occasional liaison meetings between the three branches of the health service are convened.

From Gloucestershire comes a report of regular weekly morning coffee meetings, lasting for about an hour, which are arranged in various parts of the county. These largely social occasions which include brief ten-minute talks on different subjects by outside speakers, enable local doctors, ministers, nurses, social welfare and other officers concerned with the care of the community, to meet informally and discuss points of mutual interest. An experiment is at present being tried in Lindsey (County of Lincoln) where coffee evenings enable nursing staff from both the hospital and the public health services to gain an insight into each other's methods and problems. District nurses who participate in the training of the student nurses from the United Manchester Hospitals are always invited to attend sisters' study days.

Medical dining clubs, sometimes in connection with postgraduate medical centres, were mentioned in several replies and from Dorset is reported a scheme of regular informal lunches for the County MOH, local group secretaries and the Clerk of the Executive Council.

Research

Research into medical care can involve a number of different organisations as the following examples will demonstrate. A three-year enquiry into the need for social and medical services in the London Borough of Camden is being undertaken jointly by the Social Studies Research Unit of Bedford College, University College Medical School and the Borough of Camden. The Wessex RHB, in association with the local health authorities and the University of Southampton, is undertaking a study on the prevalence of subnormality in the

Wessex region. Several studies are being undertaken by the Department of Clinical Epidemiology of St Thomas' Hospital Medical School. A survey is being made of the health and welfare of people living in certain electoral wards in the London Borough of Lambeth, in conjunction with the local health department and general practitioners. Three projects being undertaken in association with the health department of Kent County Council include an evaluation of respiratory diseases in school children, the health and survival of old people in relation to care received, and the relationship of mental retardation to birth and pre-natal history.

Of considerable interest in this field is the research panel which was established four years ago by the health department of the Hertfordshire County Council to coordinate all research activities. This panel consists of all interested medical, nursing and social work staff of the department, together with a full-time statistician and is strengthened by the inclusion of a university reader in public health, an industrial psychologist from a college of technology, an interested general practitioner and a emeritus professor. The Nuffield Centre for Combined Research at Stoke Mandeville, opened in 1964, was the first centre of its kind in which research is undertaken by hospital specialists, general practitioners and public health medical officers. The building is also used as a centre for postgraduate medical education.

Various Ways and Means

Attempts to improve ambulance services and eliminate the lengthy waiting time for patients which seems to be a common complaint, have been made in several areas. In Essex, joint appointments of transport officers have been made at the larger hospitals to assist in providing effective as well as economic ambulance facilities. Elsewhere, as for example, in Surrey, these appointments have been made by hospital management committees. In Bolton, the local authority provides a full-time ambulance liaison officer at one of the hospitals in the town. A study of ambulance transport is being made by the Wessex Regional Hospital Board in conjunction with the Hampshire County Council and the Portsmouth City Council, using the services of a medically qualified research worker. An operational research unit based in the University of Reading is also undertaking a study of ambulance service requirements in the Reading hospitals.

The important problem of accident prevention is being tackled in the London Borough of Islington where arrangements have been made for hospital casualty departments to report home accidents to the public health department for follow-up with a view to later evaluation.

An interesting example in the field of welfare comes from Cheshire where food for the meals-on-wheels service run by the WRVS is supplied from the hospital kitchens of the Central Wirral Hospital Management Committee. Payment for the meals comes largely from the local authority, although the recipients pay a small sum towards the cost.

9 Conclusion

In the past, fragmentation of services and lack of communication have been two of the greatest obstacles to the provision of an adequate and efficient health service. There is now an increasing realisation of the urgent need for both cooperation and coordination between the various departments. It should be realised, however, that this need was not something created overnight by the introduction of the National Health Service. It had existed long before 1948, for problems of cooperation and communication are inevitable in any large-scale organisation.

Looking Ahead

The planning of new towns and overspill areas has provided unusual opportunities for further cooperation and coordination between all sections of the health and welfare services.

From the County Borough of Northampton comes a report of meetings of professional representatives and officers from all three sections of the health and welfare services, to coordinate the planning of the services which will be required in the proposed expansion of the area, so that coordinated advice can be given to the Development Corporation, 'a feature', says the report, 'which has been sadly lacking in new towns so far'.

Plans for the establishment of an integrated health service for Daventry to meet the needs of its planned population expansion are being made on the principle that 'the organisation of health facilities should be determined solely by what would provide the best service to the public, rather than by the perpetuation of traditional rivalry and fragmentation of services'.

In Warwickshire, plans are well advanced for the provision of clinics, dental surgeries and practitioners' suites to meet the health needs of a new town being developed by Birmingham in the north of the county. A tentative suggestion of a joint major building project here to house out-patient clinics, local health authority staff and certain other council services, such as youth employment, welfare, children's and education departments, could prove to be a major advance in coordination if it becomes operational.

In the plans for Runcorn New Town, near Liverpool, agreement has been reached that general practice shall be the cornerstone of health care, with the hospital and local authorities taking a supportive role, rather than being autonomous. The plan envisages a series of peripheral clinics within ten minutes' walk of any resident, together with a central diagnostic and therapeutic centre. The development of the new town of Bracknell in Berkshire has also offered an opportunity for coordinated planning between the regional hospital board, county council and local executive council with a view to basing the health and medical services for the new part of the town on a health centre.

This same principle is seen in the plans for Thamesmead, the Woolwich/Erith project. Here, however, the opportunity has been grasped to mount a large-scale experiment in medical planning based on a medical school – the department of medicine at Guy's Hospital. It was felt that the planning of an entirely new community offered an excellent opportunity to bridge the gap between medicine in the university and medicine in the home. Guy's Hospital unit, having no statutory powers, acts in a coordinating and research capacity in what could prove to be a unique opportunity of forward-looking cooperative planning.

Call to Action

Much has already been said and written concerning both the benefits and shortcomings of our National Health Service, and much more remains to be said and written. Many theories on the future organisation of the health services are being expounded. The suggestion that 'medicine should be taken out of politics' is a recurrent one, and advocates of the control of a unified service under area health boards or a health corporation are promulgating their views.

The Minister of Health has recently announced his decision to instigate a 'full and careful examination of the administrative structure that is needed not only for today, but looking ten or twenty years ahead'.[36]

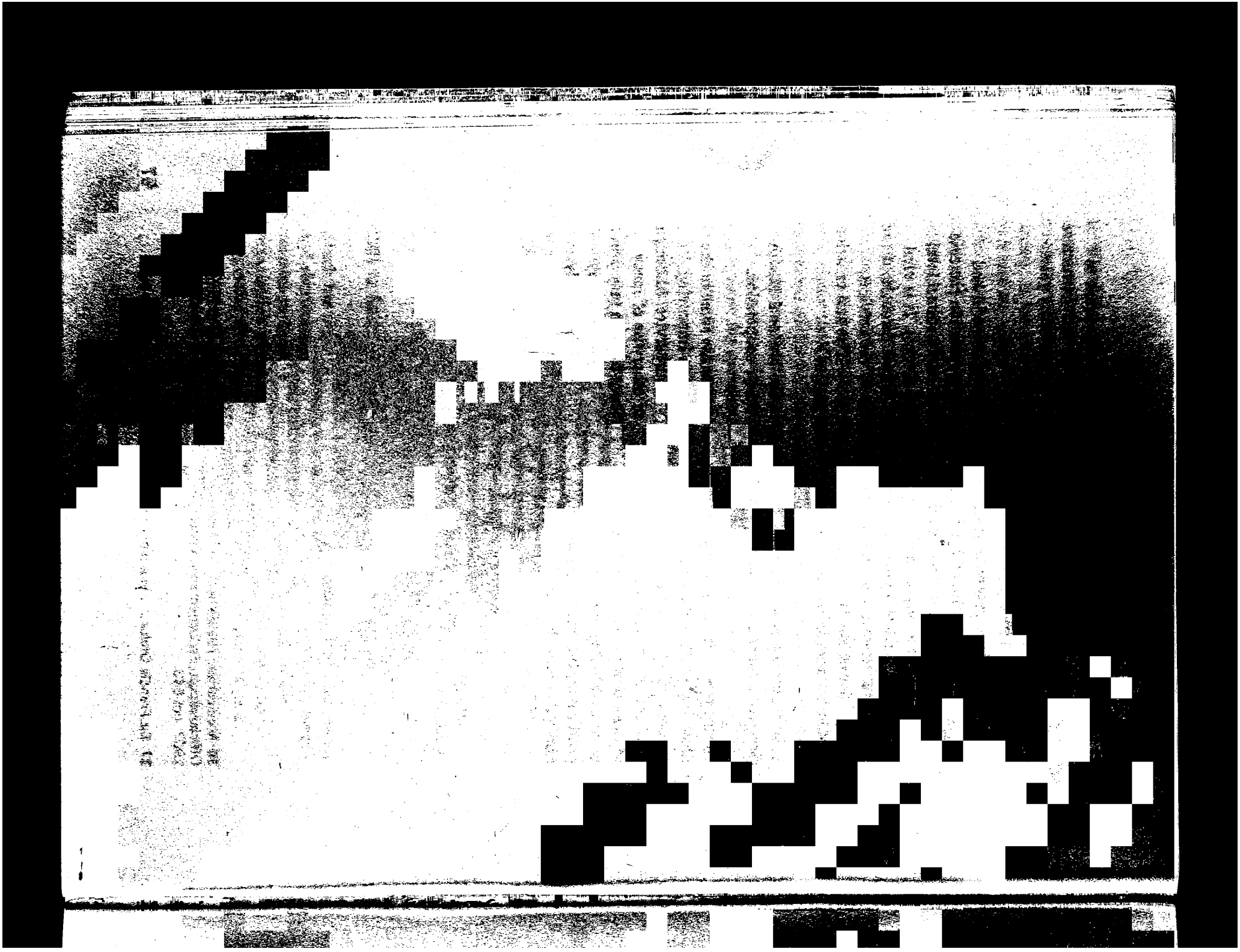
In the meantime, people are born and they die, become ill and recover, and the health and welfare needs of the population increase rather than decrease. Any administrative change on a national level is bound to be a lengthy and possibly a painful process. It is vital that there should continue to be concentrated efforts throughout the country to increase still further the unification of the services, irrespective of any future plans on a national scale. The real criterion should be 'does it improve the service to the patient?'

It is within the power of everyone working in the National Health Service to make some contribution towards better cooperation.

In this report an attempt has been made to summarise some of the ideas and projects which have been found useful in improving cooperation between the three branches of the health service. Although local conditions may well affect the success or otherwise of many of these new projects, it is hoped that this account of them may prove of value, bearing in mind that 'there must be a beginning of any good thing, but the continuing to the end until it be thoroughly finished, yields the true glory . . .'[37]

36 Medical and related services (Administrative structure) House of Commons. Official report. Parliamentary debates. (Hansard) vol 753 no 5. 6 November 1967. col 643.

37 Sir Francis Drake . . . in a letter to Sir Francis Walsingham. May 1587.



Tables and Appendices

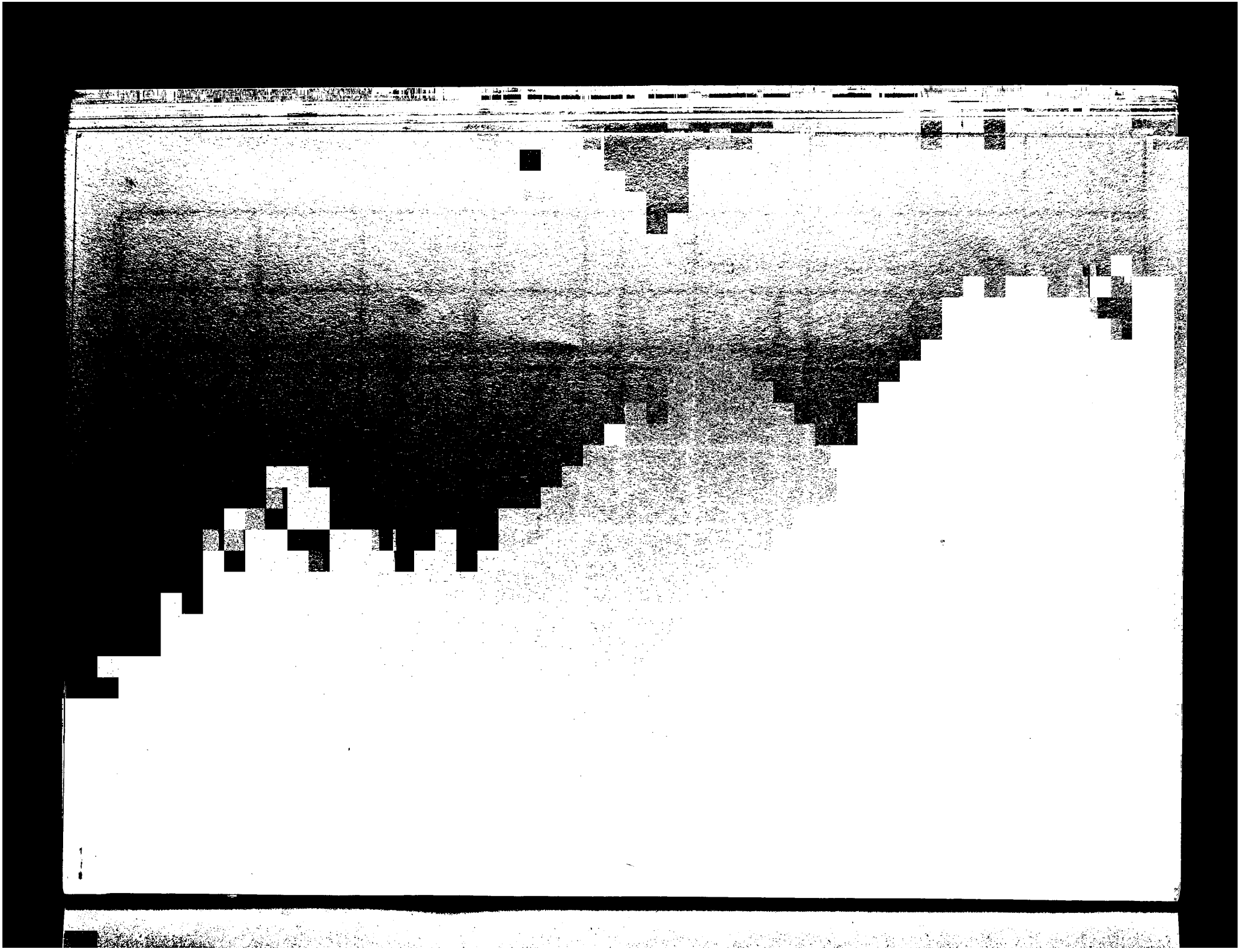


Table 1 Analysis of Replies Received

LOCAL AUTHORITY AREAS		REPLIES RECEIVED				NUMBER OF LOCAL AUTHORITY AREAS COVERED BY REPLIES		
Type	No	None	From Local Health Authorities Only	From Executive Councils Only	From both Local Health Authorities and Executive Councils	From Local Health Authorities	From Executive Councils	TOTAL Number Covered
GLC AND LONDON BOROUGHS	34	0	5	6	23	28	29	34
COUNTY COUNCILS (ENGLAND)	46	2	15	4	25	40	30	44
COUNTY COUNCILS (WALES)	12	2	7	2	1	8	3	10
COUNTY BOROUGHS (ENGLAND)	79 *	10	21	6	39	61	46	67
COUNTY BOROUGHS (WALES)	3	2	0	0	1	1	1	1
TOTALS	174	16	48	18	89	138	109	156
						79%	62·6%	89·6%

* increased by 2 from 1.4.68

Table 2 Organisation of the National Health Service

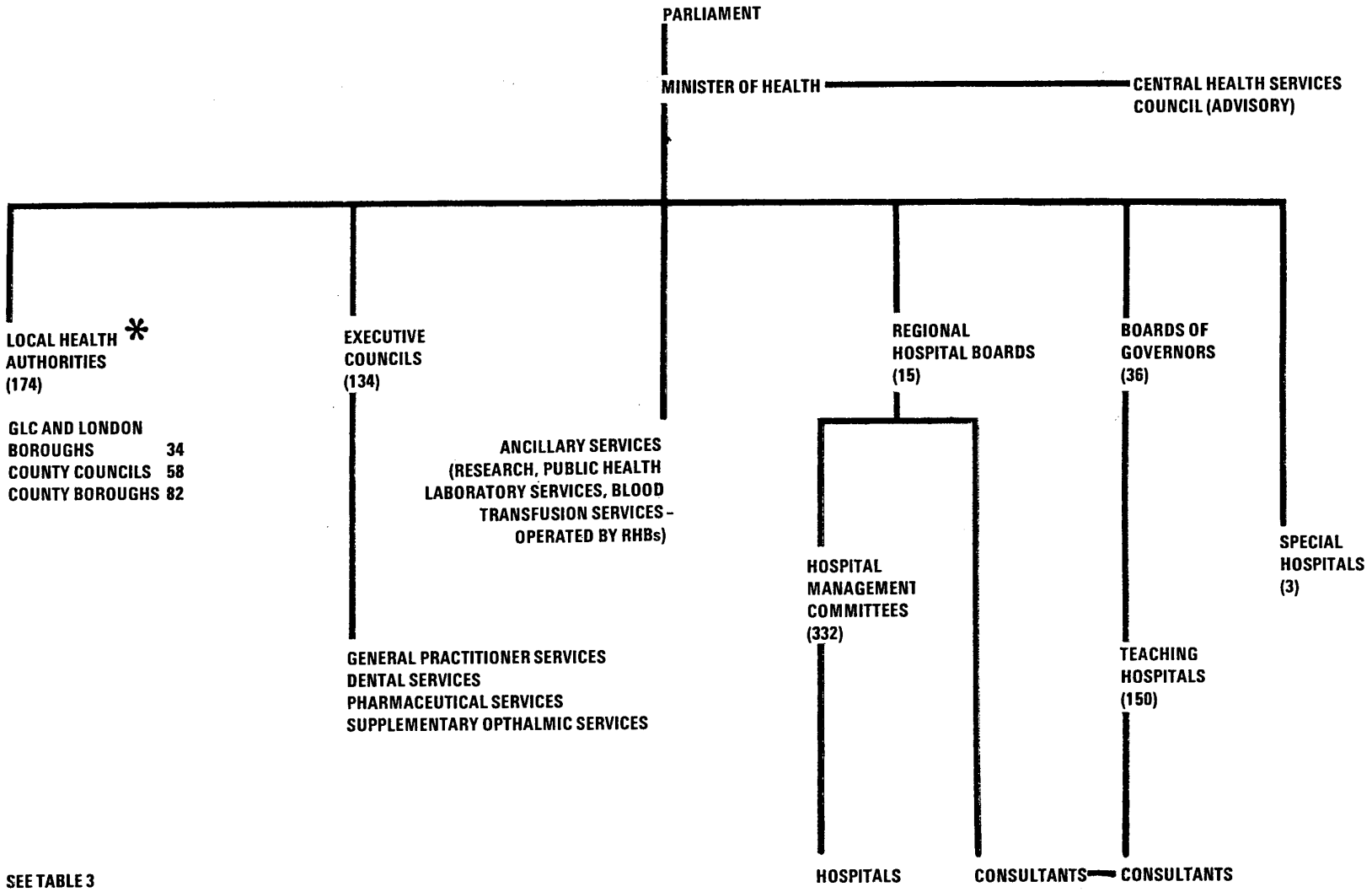
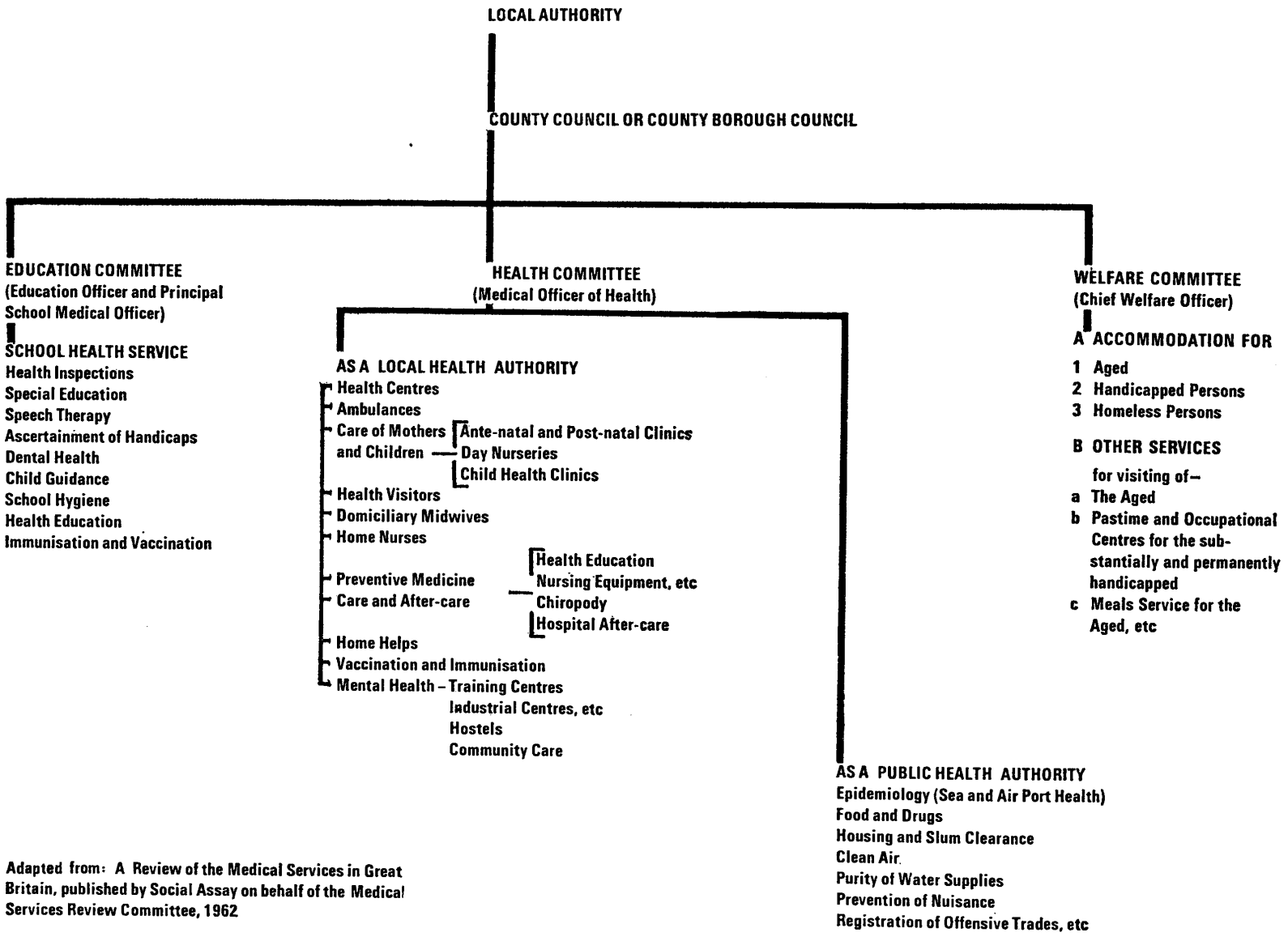


Table 3 Organisation of the Local Authority Services

Table 3 Organisation of the Local Authority Services



Adapted from: A Review of the Medical Services in Great Britain, published by Social Assay on behalf of the Medical Services Review Committee, 1962

Appendix A Letter Requesting Examples of Cooperation

Extract from letter sent by Dr Avery Jones to executive councils and local health authorities in February 1967

Coordination of health services

I am writing to ask for your help in a project sponsored by the King's Fund on the subject of coordination of health services.

In 1966 the Fund made a grant to finance a study of the practical ways in which cooperation may be achieved between the branches of the health service. Dr Margaret McDonald, Assistant Principal Medical Officer of Health of Ealing Borough Council, was seconded to help with the study under the general direction of a steering committee of which I was appointed chairman.

As part of the study we should like to collect further information, from authorities not so far approached by Dr McDonald, about good ideas and practices that have already been introduced and can serve as examples of how cooperation can be achieved between local health authorities, general practitioners and hospitals.

My purpose in writing to you is therefore to ask whether you would be good enough to let me have brief details, with references to published material where applicable, of what you consider

to be good examples of coordination or cooperation in your own area.

It is hoped eventually to produce a report with the aim of encouraging more widespread discussion and adoption of the better ideas and practices in the field of cooperation between the various branches of the health service.

Appendix B List of Reprints Received from Local Authorities

ALMENT E. A. J., BARR A., REID M., *and* REID J. J. A. Normal confinement: a domiciliary and hospital study. British Medical Journal vol 2 no 5551. 27 May 1967. pp 530–535. **BUCKINGHAMSHIRE**

ARDLEY J. Health centres in Blackburn. The Lancet vol II no 7304. 24 August 1963. pp 402–403. **BLACKBURN**

BARKER J. C. Team work in the service of the mentally ill. Nursing Mirror vol 119. 25 December 1964. p 285. **SHROPSHIRE**

CLAYTON T. M. Conjoint clinics and a new health centre at Coventry. The Medical Officer vol CI no 22. 29 May 1959. pp 301–303. **COVENTRY**

ELLIOTT R. W. Future developments in the Health Service and co-operation with general practitioners. Report of the West Riding Health Committee, July 1964. **W.R. YORKSHIRE**

GALLOWAY T. McL. Management of vaccination and immunisation procedures by electronic computer. The Medical Officer vol CIX no 16. 19 April 1963. pp 232–233. **WEST SUSSEX**

GATHERER A. Planning services. The Medical Officer vol CXVI no 21. 18 November 1966. pp 281–282. **READING**

HALL T. Experiment in co-operation: an account of health visitor/general practitioner liaison. The Lancet vol I no 7399. 19 June 1965. pp 1325–1327. **PORTSMOUTH**

HAYTER F. The future role of executive councils in the N.H.S. Excerpt from the papers read before the Health Congress of the Royal Society of Health at Blackpool, 25–29 April 1966. **CHESHIRE**

LEYSHON V. N. Taking cervical smears in the home. Nursing Times vol 62 no 11. 18 March 1966. pp 361–362. **DERBY**

LINDSEY E. M. Towards a comprehensive health visiting service. Nursing Mirror vol 113. 5 May 1961. pp v–vii. **LEYTON**

LYCETT C. D. L. An experiment in co-ordination. The Medical Officer vol XCIV no 21. 18 November 1955. pp 298–299. **WILTSHIRE**

MacDOUGALL I. A. Community care. The Practitioner vol 197. August 1966. pp 152–158. **HAMPSHIRE**

McFARLAND W. D. H. *and* RAMAGE G. An experiment in hospital social work. The Lancet vol II no 7320. 14 December 1963. pp 1267–1268. **STAFFORD**

MANSBRIDGE I. Attachment of district nurses to a group practice. Nursing Times vol 61 no 30. 23 July 1965. pp 1013–1014. **CUMBERLAND**

MILLIGAN H. C. A domiciliary welfare visiting service for the elderly. The Medical Officer vol CXV no 9. 4 March 1966. pp 119–121. **WEST HARTLEPOOL**

OSBORN G. R. *and* LEYSHON V. N. Domiciliary testing of cervical smears by home nurses. The Lancet vol I no 7431. 29 January 1966. pp 256–257. **DERBY**

REID J. J. A. A new public health – the problems and the challenge. Public Health vol LXXIV no 4. May 1965. pp 183–196. **BUCKINGHAMSHIRE**

REID J. J. A. Future of public health. British Medical Journal vol 2 no 5423. 12 December 1964. pp 1483–1486. **BUCKINGHAMSHIRE**

SAUNDERS J. *and* SNAITH A. H. Cervical cytology: a computer assisted population screening programme. The Medical Officer vol CXVII no 22. 2 June 1967. pp 299–303. **WEST SUSSEX**

TYSER P. A. A study in statutory and voluntary provision. Advance copy of paper to be presented at a meeting of the Royal Society of Health, Cambridge. 26 November 1964. **CAMBRIDGESHIRE**

WRIGHT S. L. Co-operation between the local health authorities and the hospital service. Royal Sanitary Institute Journal vol 75 no 7. July 1955. pp 476–484. **CROYDON**

WRIGHT S. L. The mental health services of a local authority. Excerpt from the papers read before the Health Congress of the Royal Society of Health at Torquay, 27 April to 1 May 1964.
CROYDON

Appendix C Recommendations from the Shaw Report

Recommendations contained in the King's Fund publication, *Report on Communications and Relationships between General Practitioners and Hospital Medical Staff, 1963.*

In the case of Out-patients

1 Absence of consultants from out-patient clinics to be notified in advance to general practitioners when appointment made.

2 Telephone and internal communications in every hospital to be equal to the demands made on them; it should be possible for a general practitioner to contact an individual doctor within minutes, or to be told when and where he will be available.

3 Letters from general practitioners always to include treatment already given and, in appropriate cases, some indication of social background.

4 The consultant and general practitioner to decide between them who is to have "overall care" while the patient is attending hospital.

5 Consultants to make sure that their reports on out-patients are also replies to the general practitioners' letters; these letters should be re-read before dictation of the reply.

6 In the case of a deputy seeing a patient with a letter addressed to an individual consultant the reason to be stated; and the deputy to indicate his status and qualifications.

7 A routine to be adopted whereby general practitioners are informed of action taken when a patient is referred by a local authority; also when patients are referred to another department of the hospital.

8 All medical secretaries to be personal secretaries to one or more consultants and to have responsibility for seeing that breakdowns in communications do not occur.

9 Some notification, however brief, to be sent to general practitioners in the case of casualties.

10 Free access to all special diagnostic departments (x-rays, pathology, etc) to be available to general practitioners.

In the case of In-patients

1 General practitioners to be routinely notified of all admissions.

2 List of patients in hospital wards to include the name of the patient's general practitioner.

3 General practitioners to have access to their patients and to their hospital notes at all times, within reason.

4 All deaths to be notified by telephone to the general practitioner as soon as practicable after the event but written confirmation to be sent also.

5 Interim reports to be sent in appropriate cases; in this connection operation findings are particularly important.

6 The short discharge form to be sent off the day *before* the patient's discharge; and the form to include the clinical condition of the patient and the amount of drugs taken out with him.

7 Full summaries to be prepared by the most senior officer possible and sent off not later than one week after the patient's discharge.

8 More discretion to be applied to the routine giving of out-patient appointments to patients on discharge.

9 As in the case of out-patients the personal secretary to assume responsibility for seeing that all necessary correspondence is dealt with expeditiously.

Appendix D Recommendations from the Cranbrook Report

Recommendations contained in the Ministry of Health publication, *Report of the Maternity Services Committee,* HMSO, 1959.

Summary of Recommended Arrangements for the Exchange of Information between Persons Concerned with Maternity Care

A In respect of patients booked for confinement in hospital

1 Booking

(a) priority groups – the hospital will book these cases on its own initiative;

(b) social cases. The hospital will refer to the local health authority for written assessment of social conditions.

All information is supplied to the various bodies with the consent of the patient.

2 In all cases the hospital informs:

(i) the patient's family doctor of:

(a) her booking;
(b) any abnormalities which arise during pregnancy;
(c) her failure to attend clinic if they wish to contact her;
(d) her emergency admission to hospital;
(e) her discharge from hospital;
(f) any abnormalities found at the post-natal clinic.

(ii) the local health authority of:

(a) her booking if they wish the local health authority to carry out health education;
(b) her failure to attend clinic;
(c) her discharge (if possible before she leaves).

In addition:

3 Where the hospital delegates their responsibility for ante-natal care to a general practitioner obstetrician

(i) The hospital fills in the cooperation card stating clearly when they wish to see the patient again.

(ii) The hospital informs the general practitioner obstetrician of the:
  (a) patient's booking;
  (b) patient's discharge from hospital.

4 Where the hospital delegates their responsibility for ante-natal care to a local health authority.

(i) The hospital fills in the cooperation card stating clearly when they wish to see the patient again.

B In respect of patients booked by a general practitioner obstetrician for confinement at home or in a general practitioner unit

1 The general practitioner obstetrician informs:

(i) the patient's family doctor:
  (a) when he books the patient;
  (b) of any abnormalities which arise;
  (c) if the patient is transferred to hospital;
  (d) when the patient is discharged from his care.

(ii) the local health authority that he has booked the patient to ensure that she receives health education and, if she is to have her baby at home, that she books a domiciliary midwife.

2 The general practitioner obstetrician fills in the cooperation card. (If he is doing ante-natal care only for the hospital – he should fill in the cooperation card and inform the hospital of any abnormalities which may arise.)

C The procedure for the domiciliary midwife if the patient is booked for home confinement

The domiciliary midwife:
  (a) sends the patient to her family doctor to ensure that she books a general practitioner obstetrician;
  (b) ensures that the patient receives ante-natal care;
  (c) fills in the cooperation card;
  (d) ensures that the patient receives the necessary health education and other local authority services.

D Procedure for the local health authority

Local health authority:

(a) notifies the hospital in writing of the reasons for admission to hospital of social cases;

(b) carries out any ante-natal care requested by the general practitioner obstetrician or hospital – and fills in the cooperation card;

(c) follows up absentees from clinics for hospital, local authority or general practitioner obstetrician;

(d) ensures that a health visitor or midwife, where appropriate, attends the patient after discharge from hospital.

E Procedure for family doctor

The family doctor:

(a) if his patient attends him in the first instance he ensures that she books with the general practitioner obstetrician and midwife or attends hospital;

(b) if he is requested to do so follows-up absentees from clinics or sees that it is undertaken;

(c) informs the general practitioner obstetrician or hospital of any infectious disease in the family.

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