LOCAL AUTHORITY PERSONAL SOCIAL SERVICES

EVIDENCE TO THE COMMITTEE APPOINTED jointly by the Home Secretary, the Secretary of State for Education and Science, the Minister of Housing and Local Government and the Minister of Health to review the organization and responsibilities of local authority personal social services in England and Wales, and to consider what changes are desirable to secure an effective family service.

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Preamble

The Royal College of General Practitioners is concerned to develop and maintain the highest possible standard of medical care for the people of this country. It is the responsibility of each individual practitioner not only to diagnose and treat his patient, but also to mobilize all those health and welfare services which can maintain his patients in bodily and mental health and speed their recovery in times of illness. The development of general practice is therefore bound up with the future of the health and welfare services of the country, and it is with this aspect of the committee's work that the College is concerned.

Certain trends and changes in general practice during the past 20 years are worthy of mention as they reflect the changing demands that will be made on the health and welfare services.

1. Since the 1946 Health Act all persons have a right to general-practitioner services. This has reduced the need for many traditional local authority services. Women can obtain antenatal care from their family doctor; many prefer to have child welfare care from him, and infants and children are now treated by him rather than at child welfare and school clinics. While able to handle today's demand, the practitioner must be prepared for wider future responsibility.

2. Changes in social customs such as the increased number of women at work, and a more level spread of incomes may have led to the virtual disappearance of private nurses and midwives, and acute or maternity nursing homes. This has resulted in an increased demand for local authority nurses, midwives and home helps. Furthermore, patients are relatively content to take services as they find them when they are put to no direct cost.

3. Greater understanding of the relationship between health and social well-being, together with the fact that people do not have to pay directly for family doctor care, has resulted in an increased interest in social services by the doctor, and he increasingly refers patients to these services.

4. Account must be taken of the present day attitude of patients, and the parents of children, who tacitly assume a right to perfect health. This trend will continue and is bound to place an increasing load on the health-care services.

5. Increased longevity has resulted in an increased demand by doctors for supporting services for their older patients, and medical care has more to offer to patients of all ages.

6. The great advances in treatment of mental illness have resulted in more

patients being treated at home, and those that are admitted to hospital are usually discharged back to the care of their family doctor. There is an increasing need for mental health workers to complement the treatment given by general practitioners.

7. More and more practitioners are forming themselves into groups, so that they may practise from central specially designed premises. This will not only increase the efficiency with which they work, but also encourage the use of other services in close association with them. The 'Charter' for general practice, if accepted by the government and the profession, is bound to increase this tendency.

In the development of these centres lies a golden opportunity to bring together in close co-operation the curative and preventive services. There is no doubt that the best personal health service can be given by doctors and nurses working together in conditions where they can get to know one another and develop personal respect and confidence.

No better arguments for the need for co-operation between the local authority services and general practitioners can be found than those set out in *The field of work of the family doctor*, H.M.S.O. 1963. No better analogy is needed than that of the smooth working relationship between the hospital specialist and his ward sister, nurses and other members of the hospital staff.

The weakness of the health and welfare services

The basic weakness of health and welfare services lies in the multiplicity of agents and organizations involved. The health services are divided into three. One part is administered by the local authority, and paid for through rates and Treasury grants, the other two, hospitals and general-practitioner services, are paid only through the Treasury. First tier local authorities administer health, welfare and children's services, while housing is administered through second tier local authorities. In addition, there are separate organizations for pensions, national assistance, probation service and rehabilitation.

Too often laymen controlling individual services through committees are unable to appreciate the wider issues and are inevitably parochial in their approach.

It is not uncommon in times of illness for a patient or his family to be involved in practically all the above services at the same time. It is difficult for the general practitioner to mobilize the best help for his patients in this confused pattern. There is a danger of overlap between departments and risk of over-staffing of social services as a whole.

More important is the problem of lack of understanding and consequent development of mistrust between different workers and the different committees that control them. In particular, general practitioners are poorly informed of what can be done by the local authority and other social services, and many workers are ignorant of the development of practice and thought in family doctoring and approach individual doctors reluctantly.

Planning for the future has become difficult. An investigation by the College shows the haphazard and often unsatisfactory way in which

general-practitioner services have been developed in new towns. Groups of practitioners in established towns who wish to build central premises have difficulty in planning them if they do not know the degree of co-operation that they can expect from local authorities.

In the maternity services the planning of early discharge schemes involves all three branches of the health service. It may well be in the interest of the national economy to plan similar schemes for instance for routine surgery, when the plans for building new hospitals get under way. Such schemes may necessitate local authorities employing more staff. It is natural that lay committees should resist this in the interest of the ratepayer, even though the increase of expenditure in their field may lead to a decreased proportion of the national budget being spent in health and welfare services.

The need for co-ordination

1. The success of official maternity liaison committees in some areas, and the degree of co-operation that has been achieved in areas where there is an understanding between the branches of the health service, suggest that there is a strong case for the formation of *area* or *regional planning committees* representing all three branches of the health service. It is difficult to assess the effectiveness of these committees if they do not have statutory powers, particularly in the control and distribution of financial resources. Nevertheless, even without these powers they would increase understanding between different branches of the service.

2. Planning authorities of new or existing towns should have a statutory medical planning committee representing regional hospital boards, executive councils and the local authority.

3. There is as much reason for a general practitioner to have his own nursing staff as there is for a hospital consultant in his ward. The best results can be achieved where doctor and nurses are accustomed to work together. We advocate the attachment of *health visitors, nurses and midwives to general practitioners.* While this is most easily organized in group practices, experience has shown that the difficulties of attachments in rural areas and to single-handed doctors are not insuperable.

4. Consequentially on the implementation of recommendation 3, it should be possible gradually to abolish local authority maternity and child welfare clinics, as group practice centres increasingly concern themselves with preventive health care.

5. General practitioners require help in selecting and approaching social services appropriate to each particular problem. The health visitor with increased training in case work is at present the person best qualified to carry out this role. A case can be made, however, for a radical revision of the training of the health visitor who will work as a member of the general-practice team. She must become as versatile in her sphere as her general-practitioner colleague is in his, or some other worker may be provided with the advanced training necessary if this need is to be met.

6. It has been argued that large group practices require a full-time 'medicosocial worker'. We doubt if there would be sufficient work in any

practice to warrant this, and there are not many trained medicosocial workers available.

Local authorities should employ an increased number of medicosocial workers but they should be employed on an area basis. They should be used to co-ordinate welfare and social services, and would advise health visitors working with general practitioners or have referred to them some of the more difficult problems.

7. Mental health officers can best help general practitioners with the mentally ill if they work closely with practitioners that they know and who know them. The work load of a practice, even of a group practice, does not make it practicable to allocate a mental health officer to each, but they should be deployed so that they normally work with the patients of a fixed number of general practitioners who would get to know them well, and meet them regularly to discuss patients in their joint care.

8. The school health service should gradually reduce its activities to that of an 'occupational health service', and in advising on the education of handicapped and educationally subnormal children. The school health service should in addition expand its activities in health education, adopting a teaching role in schools at all levels.

Routine examinations of school entrants and school leavers could be done best by their own doctor who knows the child and its family. The family doctor is better placed to assess the importance of minor deviations from the normal than the part-time assistant county medical officer who normally does this work.

9. There is a need for a close relationship between county or county borough services and those such as disablement resettlement officer services and youth employment services of the Ministry of Labour, the National Assistance Board and the Probation Service. The closer their offices are together the better. Suboffices should be formed in the smaller town and districts of large authorities, where all the local authority welfare, health and other social services could be brought together. They should include medicosocial workers as mentioned in paragraph 6. This type of arrangement would make it easier for individuals, by themselves or through doctors and health visitors, to obtain appropriate help.

10. *Training.* In the past medical undergraduates gained practically no knowledge of welfare and social services. This situation is improving, and, in addition, plans for postgraduate vocational training for general practitioners are developing rapidly. This should include opportunities for young doctors to meet welfare and social workers to hear about their work, thus achieving improved mutual understanding.

It is equally essential that local authorities' welfare and social workers of all kinds should, during their training, receive lectures on their work from experienced practitioners, with special emphasis on the need for help in dealing with the problems of patients.

11. *Resources.* It is unrealistic to suppose that the country can afford to allocate an ever increasing proportion of its man-power and finance into the social services. First priorities must be given to a better use of the

available resources.

The Royal College of General Practitioners would, however, like to see experiments in a development of a new worker whose duties would fall between those of the district nurse and the home help. This worker would be trained in simple nursing skills and would relieve the district nurse of time-consuming routines, thus freeing her for work in the more technical skills of nursing.

In addition there is need for experiment in the recombination of various existing skills according to the special needs of community health care at general practice level. For instance, the combination of nursing plus health visitor training with an added element from that of the psychiatric social worker. A further combination might be the addition of secretarial skills to basic nursing training.

Area health boards

In November 1962 the Medical Services Review Committee (the Porritt report) suggested a redeployment of the three branches of the health service into area health boards. Increasing interest has been shown in this concept in the last two years, and the Royal College of General Practitioners is watching with interest the experiments in this field that are now being carried out in Wales. We believe that other experiments of this type should be carried out. A major criticism of the Porritt scheme is that the removal of the health service from the local authorities would weaken the present arrangements for social services. This is not necessarily so, as the local authority health service directly supports hospitals and family doctors in their care of the sick, while the welfare and other social services provide a *milieu* in which the sick can be treated. It should be possible to arrange co-operation between area health boards and local authorities by the medical social workers and the like. It is both feasible and practical to separate the personal health services of local authorities from those concerned with environmental hygiene.

Another suggestion that has been made is that the local authority and general-practitioner services should be united, leaving the hospital services separate. The Royal College of General Practitioners cannot support this idea.

The importance of volunatary service

The Royal College of General Practitioners believes that one of the dangers of a welfare state is that the future citizen may lose his sense of responsibility for himself, his family, and his community. For this reason, it is vital that every encouragement should be given to organizations and individuals to give voluntary service in all branches of the social service.

Organization may need financial support from public money, and it is therefore proper that there should be some control from grant-giving statutory bodies.

The need for further experiment

We wish to stress that adequate experiment should be carried out before regulations are drafted or action taken on a national scale. A doctrinaire

approach unsupported by practical experience led to many of the weaknesses of the 1946 Health Act.

For example, we consider that the case for the attachment of health visitors, nurses and midwives to general practitioners has now been proved. On the other hand, the roles of the medicosocial worker and psychiatric social worker in general practice have not yet been fully investigated.

Whatever decisions are taken now or in the future, they should not be assumed to be static, there will always be room for reassessment and reappraisal. Different areas will have different problems, and therefore each authority must have latitude in establishing services best suited to their needs.

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CLINICAL TRIAL

HAY FEVER

Report on 162 cases treated by repository method in 1966

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THE TERM 'HAY FEVER' WAS adapted from the laity by Elliotson (1831). This condition was first described by Botullus of Padua (Opera Omnia 1565) as being typified by headache, sneezing, nasal irritation and itching. Joseph Binniger (1673), Bermingerus (1673), Valerianus (1678), Lodellus (1683), De Reveuve (1691) all associated this picture with a sensitivity to roses. Bostock (1819), himself a sufferer, stressed the seasonal character of the symptoms. These could be relieved by avoiding contact with pollen (Cazenove 1837). The diagnosis was confirmed by nasal instillation of pollen (Blackley 1873).

Treatment was by multiple injections (15 to over 50) of aqueous solutions of pollen (Noon and Freeman 1911). The pollens were obtained