CHC NEWS

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EDITOR'S NOTE

Some CHCs have told us that CHC NEWS Number 1 was too long, and was difficult to duplicate or circulate. In response to these suggestions we have prepared Number 2 in single spacing and reduced the total length. We are also sending 8 copies to each CHC so that it may be circulated to all members. We would again welcome your comments.

YOUR LETTERS

The letters we publish express the personal views of the writers themselves, and are not necessarily shared by the writers' CHCs or by CHC NEWS.

CHC NEWS from Gabriel Aitman, Chairman SW Herts CHC

The Secretary of the SW Herts CHC has sent me a copy of CHC NEWS No.1. Whilst appreciating all that is said in the Foreword I do not think it appropriate that such a newsletter should have been devised at this stage. It completely preempts the proper decisions of the National Council and indeed the work of the Steering Committee. I do not know which individual CHC discussed the newsletter with Lady Marre or Councillor Collis but certainly this kind of movement to initiate large scale schemes without proper discussion is not the right way of doing things. I am sending a copy of this letter to Lady Marre and Councillor Collis so that they can make known my views most clearly at the next meeting of the Steering Committee.
N.B. My views on whether a newsletter is necessary have nothing at all to do with the issue of the particular newsletter that I have seen, which is very good.

CONTACT WITH THE FPC by David Emerson, Secretary Bath CHC

All the CHCs in the Avon area and Bath CHC (because of the overlap) were recently circularised with a memorandum from the Avon Family Practitioner Committee Administrator. It describes the arrangements by individual contractors for the provision of services and says that the FPC is generally not prepared to respond to approaches from CHCs concerning doctors' practice arrangements "since (a) the arrangements have been made to the satisfaction of the FPC, and (b) they have not resulted in any criticism by individual patients - if they had a statutory enquiry would have taken place and any necessary adjustments would have been made".
The disturbing implication of this memorandum is that the FPC is attempting to tell CHCs what they may or may not do, and the view that arrangements carrying the approval of the FPC may not be challenged is most questionable. I regret this "shoot first and ask questions afterwards" approach which hardly augers well for cooperative relationships between the FPC and the CHCs.

FOUL LAUNDRY SERVICE from Mrs D M Sinstadt, Secretary Plymouth CHC

The Plymouth District Community Health Council Working Parties for the Care of the Elderly and for Mental Health are investigating the provision of an efficient foul laundry service in the Plymouth Health District. I would be glad of information from any district or area where there is already such a smooth service in operation, under the following headings:

(a) method of collection and delivery
(b) number of calls per household per week
(c) where the laundering takes place
(d) method of referral to join the service
(e) cost to patient, if any, and method of payment.

MERRISON REPORT from Julian Knox, Secretary Islington CHC

When the Merrison Committee was set up many hoped that it would recommend more effective means of monitoring and improving practices and delivery of health care. With an eye on the USA and the establishment of Professional Services Review Organisations (PROs) it seemed that British doctors might become less self-regulating; that the consumer, albeit indirectly, might have more of a say about professional standards. However, the committee, reflecting much of the paranoia which continues to afflict the profession, reinforced the "behind locked doors" policy of the GMC, and was concerned that doctors might otherwise become creatures of government.
The committee's proposals regarding doctors trained overseas seems to have disregarded the fact that many foreign doctors were assigned to areas of practice for which they were not specially trained, e.g. surgeons forced to become geriatricians; general physicians into psychiatry, and so on.
As regards professional ethics - and here organ transplants are especially mentioned - the committee again presumed that it is only the medical profession which can make proper decisions. What is ethical may not however be equitable when the needs and feelings of the community are taken into account.

STEERING COMMITTEE

Report by Mr P J Torrie, Secretary, of the second meeting held on Wednesday 25th June, 1975.

At this meeting the Steering Committee again discussed the general principles involved. Throughout its deliberations, the Committee has been acutely aware of the need to avoid any proposals which could infringe the existing rights and duties of individual CHCs. Discussions have shown that some CHCs remain unconvinced of the need for the proposed body, but the majority of CHCs are anxious to proceed, with due safeguards, to form a central supporting body.

The Committee now considers that sufficient progress has been made to enable it to carry out detailed consultation with individual CHCs on the proposals it has drawn up. It will, therefore, through the representatives, issue a document to each CHC containing the proposed structure, functions, establishment and financial provision likely to be required by a central body. The Committee holds the view that by 21st October (the date of the next meeting) it should be possible to assess more precisely the degree of support for the proposals, which will by then have been thoroughly discussed and understood.

The body for consideration by CHCs no longer takes the form of a National Council. The Steering Committee has drawn up proposals for an Association of CHCs, controlled by the member CHCs and strictly accountable to them through their delegates, with a Standing Committee of the Association to act for the members and to provide the required functions and services for them.

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The Steering Committee asked that CHCs should be requested to send one copy of their annual report to the editor of CHC NEWS so that these could be collected in one place for future reference.

STROKE PATIENTS IN THE HOME

A Survey proposed by Dr F Clifford Rose and Dr R Capildeo
The Stroke Unit, Charing Cross Hospital, London

Stroke is the third commonest cause of death in the Western World (after heart disease and cancer). Those people who survive a stroke may remain severely disabled, having to rely on their families and domiciliary services to maintain an existence that is often far from ideal. The DHSS, concerned with the number of disabled stroke patients in the community (estimated as 90,000 in England and Wales) is trying to identify the needs of these patients in terms of community and rehabilitation services, and at Charing Cross Hospital there is a Stroke Team assisting this work. The aim is to improve the care of disabled stroke patients, and simultaneously to enable the NHS to make better use of its limited resources. Basic information about stroke patients is still lacking, yet community health councils throughout England and Wales could help to provide it.

HOW COULD CHCs HELP ?

We suggest that six members from each CHC could volunteer to participate in a specially designed survey that would give them first-hand information about the situation in their district as well as providing information about the national picture. Each member would visit one general practitioner specially selected to be representative of either a rural or an industrial area - this would allow comparisons of standards to be made across the whole country as well as enabling local variations to be discovered. It is estimated that a GP looking after 2,000 patients will see at least five new stroke patients in any one year, so each CHC member would ask for the names of five stroke patients on the doctor's list.* The member would then visit the five stroke patients and, by means of a standard questionnaire, would gather information on the patient's degree of disability, the nature of help received in the home and the nature of any rehabilitation care received. There would also be space on the questionnaire form for the CHC member to put his or her own evaluation of the stroke patient's situation. This questionnaire has already been used in a pilot study by the Charing Cross Stroke Team, on 40 patients visited at home by them, and it takes about half an hour to complete.

If every CHC participated in this study, it would be possible to survey over 6,000 patients throughout England and Wales. The completed questionnaires would be analysed by the computer department at Charing Cross Hospital, and the results would be reported back to the CHCs, and to the DHSS.

This type of project could form the basis for further investigations in which CHCs participate, in order to identify needs and so attempt to improve the care and the quality of life for patients in the community. If the response from CHCs to this proposed survey is enthusiastic, the survey could well be the first major project carried out by community health councils at local and national levels simultaneously.

Any CHC members interested in participating in this survey should arrange for their Secretaries to write to the Editor of CHC NEWS in the first instance.

* The Stroke Team will select and contact GPs to explain the study to them and obtain their consent for the CHC member to visit the stroke patients.

THE ABORTION (AMENDMENT) BILL

by Mrs B A Pittard, Chairman Portsmouth CHC

Over recent months the Media has been concentrating a large amount of its energy on the subject of abortion. This is due largely to the attempts by James White, M.P., to amend the 1967 Abortion Act with a Private Members Bill. His Bill was successful in achieving two readings in the House after similar attempts by both Labour and Conservative M.P.'s had failed. The second reading of the Abortion (Amendment) Bill, in February, caused an uproar in the House, and eventually both pro- and anti-abortionist M.P.'s backed the move to establish an all-Party Parliamentary Select Committee to examine the Bill and consider evidence on abortion. Even the "creator" of the original Act, David Steel, supported this move, although he has made it patently obvious that he considers the Bill a retrograde step, which if enacted would increase the number of back-street abortions.

When James White introduced his Bill, he was reported to have stated that he took no hard line on abortion, and that his aim was simply to "clean up" the abuses of the present law. However, if his amending Bill is to become enacted then it is clear that in practice it would produce even bigger abuse of the law, for the Bill would bring about a significant reduction in abortion services provided by the National Health Service, rather than just controlling the private sector, and could well justify David Steel's fears. Clause One of the Bill would rule out abortion for many of the present acceptable "social reasons" and would, amongst others, preclude those women who had become pregnant because of contraceptive failure, and also many of the 3,000 in the under 16 years age group who are estimated to be aborted yearly.

The Bill would seem, therefore, to go a good deal further than necessary to "clamp down" on present abuses of the law, and it is estimated would prevent abortion for more than 100,000 women every year, who would at present qualify.

It was recently estimated that of abortions undertaken on British women, approximately 82% were carried out through the National Health Service, or the two charitable agencies who provide an abortion service. When one considers that only a mere 18% of abortions might fall into the category of abortion abuse then the Bill does seem to be taking a sledge-hammer to crack a walnut !

Without doubt there are many unscrupulous people who have exploited abortion since the 1967 Act, and the Committee made specific recommendations for closing the loop-holes that allow them to do so. The Department of Health are now taking action on some of these recommendations, but many of the abuses will only be eradicated when the Lane Committee's main recommendations are put into effect - "as a matter of principle hospital and specialist services should be provided to such an extent that patients are not forced to seek therapeutic abortion in the private sector", and that "the National Health Service should review the extent to which it is providing for the needs of women entitled to abortion".

There is little evidence at present to suggest that this part of the Lane Committee's recommendations have been acted upon, and James White's Bill in its present form would make their implementation unlikely.

One possible outcome of the Select Committee is that it will come forward with draft proposals for legislation which will be more acceptable for government backed action to amend the present Act if and where necessary.

At present the Committee is hearing evidence, and it is essential that such evidence reflects the views of the patient, as well as those of the organised pro and anti-abortion groups, and the medical profession. My own personal opinion is that such evidence should be collected by Community Health Councils.

Regional Health Authorities have already been asked to submit evidence, but how can we be sure that such evidence will take into account the views of the patient ? The Wessex Regional Health Authority in its evidence states "we have no statistics concerning the "fate" of those women requesting abortion, but who are refused".

When James White's Bill was being read for the second time the Secretary of my own Community Health Council drew my attention to its implications, and I wrote to the Department of Health and asked if they intended to consult with Community Health Councils prior to the enactment of the Bill, as it would effect a considerable reduction in service. The reply stated that the Bill was now in the hands of the Select Committee and that "in this situation it is not appropriate for the Government to consult with interested bodies or organisations".

I therefore asked that the Committee should be made aware of the existence of Community Health Councils and their role in representing the patients' interests, and was informed that the Select Committee would accept written evidence. If the Bill were to become law, CHCs would find it difficult to help anyone seeking advice on obtaining an abortion since they (the CHCs) would place themselves legally at risk.

It is unfortunate that the National Council of Community Health Councils will not be functioning in time to present evidence to this Committee, for I am certain that in many instances much of the action that we will need to take will be at a national level, and it is essential that where legislation is involved, Community Health Councils must be consulted prior to the bill - drafting stage - a precedent which Community Health Councils must quickly establish.

The concept of Community Health Councils was welcomed by all shades of political opinion, and Government must now show that it accepts them as a viable proposition to be involved at a National as well as local level.

PRESS CUTTINGS

10% CUT IN HOSPITAL PAY BEDS

The Secretary of State for Social Services has decided on a cut of about 10 per cent in the number of pay beds in NHS hospitals, limiting her action to hospitals in which there has been considerable under-occupation. There will be about 430 fewer pay beds from 1 July.

The method of reduction, which is separate from the Government's proposals to phase out private practice from NHS hospitals, is explained in a letter from the Department of Health and Social Security to health authorities in England. In hospitals with 6 or more pay beds the number allowed in future will depend on how many were actually used during 1972 and 1973. If less than three-fifths were used there will be an overall cut of 20%. If only two-fifths or less were used, the reduction will be substantially greater.

No hospital will be affected in which the number of pay beds actually in use during those two years exceeds 60% of the hospital's available pay beds. Those with five or fewer will also be excluded. Of the 722 hospitals in England which have pay beds just over 100 will be affected.

(DHSS Press Release 13th May 1975)

CHILDREN WHO HAVE NO RIGHTS

Handicapped children in long stay hospitals suffer grave emotional and social deprivation with no legislative rights to protect them, according to a report from the Council for Children's Welfare. It claims many stay in hospital not because they are sick, but because there is nowhere else for them to go.

The council is calling on the Government to set up a departmental committee of inquiry to investigate the conditions of mentally and physically handicapped children in long stay hospitals. It has already given evidence to the Donald Court Child Health Services Committee, but believes its brief was too wide to deal thoroughly with the problem of handicapped children. The report, entitled No Childhood says: "It is not an exaggeration to state that the average long-stay hospital is the bastion of Victorian institutionalisation. It needs to be said for the children live in conditions which are in total opposition to all twentieth-century knowledge of child care and development."

(The Guardian, 13th May 1975)

LOCAL HEALTH COUNCIL IN 'GETTING TO KNOW US' CAMPAIGN

Scarborough Community Health Council is taking part in a regional campaign to bring the role of community health councils to the public's attention. Mr B V Smart, secretary of Scarborough District CHC said: "A lot of people still don't know we exist.

This campaign is aimed at telling the public we are here and what we are here for." So far, Scarborough CHC has distributed 10,000 leaflets which explain their role, and CHCs in Yorkshire are to start a poster campaign featuring Jimmy Savile. The posters will be put up in major stores, police stations, health service establishments and doctors' surgeries.

(Scarborough Evening News, 28th April 1975)

HOW SHOULD EACH CHC ORGANISE ITSELF ?

by Harold Beck, Chairman NW Herts CHC

The effectiveness of a CHC is as dependent on the way in which it is organised into groups as on the powers it has to obtain information from the health authorities, the right to inspect facilities and the attributes of its members and Secretary. Indeed each CHC needs to find the most appropriate arrangement of groups for its particular circumstances in order to make the best use of these prime resources.

The advantages and disadvantages of various arrangements of working groups in many kinds of organisation have been studied in some detail. However, the application of organisation theory does not yield a single ideal arrangement for all CHCs since each has its own set of problems. Even where CHCs have closely similar health care facilities within their districts, differences in the membership of the Councils or of the health authorities or other factors may make it necessary to have quite different internal arrangements.

Random enquiry among CHCs in various parts of the country has indicated that every basic type of structure is represented. One CHC is known to have divided geographically; travelling between various parts of the area covered by the CHC is so difficult that the basic structure is one in which members are grouped to "look after" all the health services in the part of the District near their homes. Another has structured according to functions, e.g. public relations, research and internal administration. Structuring by type of consumer i.e. children, the elderly, has taken place as has also division by type of health care, e.g. mentally handicapped, geriatric. One CHC has adopted the simplest structure of all by declining to form any groups. Some Councils have adopted a matrix structure in which project groups are formed from two or more specialist divisions. The most popular number of second-tier groupings appears to be four. Many CHCs have set up third-tier groups, some on a permanent basis, others for intermittent operation and the remainder temporary.

One principle of organisation design is that advantage should be taken of specialist knowledge. Here CHCs face a particularly difficult problem, for among their members are many with a detailed knowledge of aspects of the NHS as it existed two or more years ago. This knowledge can be of enormous value but it can also have an inhibiting

effect on creative thinking with regard to the reorganised NHS. It is probably best to avoid setting up groups to take advantage of this previous experience if they unduly reflect the former structure of the NHS, for example if they concentrate on the hospital sector. Alternatively, if they are to be set up, every effort should be made to ensure that such groups contain "ideas" members without the relevant experience of the old NHS as well as those with it. Another approach to grouping is that of encouraging the acquisition of specialist knowledge. One CHC for example, finding that it had no expert in public relations among its members, deliberately set up a group to concentrate attention on and learn about this aspect of its activities. It is worth remembering that CHCs have powers to co-opt non-members onto their working groups and thus make good any deficiency of expertise in particular areas.

As part of the process of concentration of effort and/or taking advantage of specialisation, individual members may be willing to be responsible for particular aspects of a Council's activities. Thus one member may act as a link with the AHA by attending AHA meetings, looking at AHA minutes and keeping the Council informed of what is going on. Another may be designated "Estates Member" dealing with matters concerning the CHC premises. Links with the Health Care Planning Teams could be on an individual member basis rather than by setting up parallel groups.

Another factor in organisation design is that of economy. For CHCs this applies particularly to the demands on the time of members and of the Secretary. There are limits to the time which each member can devote to the Council and there are restrictions on the time of day when a member is available. Too many groups meeting too frequently in a rigid pattern may in the end exclude the valuable talent and insight of some members with commitments to family, job, local government etc. Similarly the effort required of the Secretary is very much related to the arrangement of groups within the Council and the provision made for their servicing.

The organisation structure should also provide links between committees or groups for purposes of co-ordination. Some see this as essentially the task of the Secretary, others as that of the Council as a whole at its full meetings. Some Councils look to the Chairman, Vice-Chairman and the Chairmen of groups to consult informally with each other with a view to exercising a co-ordinating function. One form of co-ordination is provided by an "inner cabinet" such as a Policy and Resources Committee or an Executive Group. The choice of the means of co-ordination can be related to the predominant style of the Council, for example whether it is authoritarian, participative or laissez-faire. Co-ordination with other CHCs regarding shared health facilities must also be borne in mind when groupings within the Council are being decided upon; compatibility between groups in different Councils is desirable in this case.

Most CHCs have exchanged information with others about the structures they have adopted. What has not been evident as yet is the experience of CHCs in operating their structures, i.e. the difficulties that have been encountered, whether they have been effective, and so on. Knowledge of this would help CHCs to learn from the experience of others.

GUIDE TO SELECTED READINGS

PRIMARY MEDICAL CARE

Long before the NHS was created it was thought that the most rational way to provide health care was to have a system based on the work of general practitioners, nurses, midwives, health visitors and others in the community, supplemented by the specialist facilities of the hospital. The reorganisation of the NHS in 1974 reaffirmed this principle and the following three references discuss some of the implications.

1. THE WORK OF PRIMARY MEDICAL CARE (Office of Health Economics, 162 Regent Street, London W1RD 6DD, 1974, £0.25 post free)

This booklet looks at the debate on the ideal role of the primary medical care team, and tries to establish the direction in which primary medical care is moving and to analyse the implications of the change in roles and working patterns of the primary care team.

It examines recent developments in organisation - group practice, the increasing use of ancillary staff and appointment systems, and the decline in consultation rate. These are changes which should lead to the more effective use of available time, and can mean new and better services for patients. However, the booklet says there are some disquieting trends which suggest that in some practices the workload is being minimised to the detriment of patients and the efficiency of health services. There is a study of workload patterns and a discussion of the difficulty of testing the quality of primary medical care.

The booklet considers the two interconnected roles of primary care practitioners - the technical role of prevention, diagnosis and treatment, and the "pastoral" role of providing understanding and advice. Each doctor needs to establish a balance between the two. A definition of operational objectives is attempted under two headings - the satisfaction of patients' expressed wants, and the performance of specific services.

In conclusion, the booklet says that there is surprisingly little consensus of opinion as to what practitioners of primary medical care ought to be doing. The interested parties, the NHS, health professions and the consumers must determine what priority should be given to each of the possible roles primary medical care might perform, rather than leave practices and practitioners to follow their own individual inclinations with virtually no guidelines.

2. YOUR FAMILY DOCTOR ("Which?" January 1974, Consumers' Association, Caxton Hill, Hertford SG13 7LZ)

This is a report of three surveys, published by the Consumers' Association in their monthly magazine called "Which?". In two of them, adult patients were asked for views on their family doctors, and in the third, some of these doctors were asked about their jobs.

The surveys found that most people were quite happy with their doctor, but about 9% lacked confidence in him, and there were complaints about such things as inconvenient surgery hours, waiting room delays, too short a time with the doctor, and inadequate treatment. About 20% thought their doctor was not particularly interested or concerned about their health.

"Which?" examines these questions, and reports that on the whole, doctors enjoyed their work (especially those in group practice) but they would like to cut down the numbers of patients on their lists. To alleviate some of the problems, the survey recommends appointment systems, training for doctors in establishing good relationships with their patients and in helping those patients with nervous complaints, and that patients should be educated not to go to their doctor with trivial complaints.

The report also includes a description of the way GPs are organised and paid within the NHS, and although the figures are a little out of date, the basic system still applies. It explains how to go about changing doctors, complaining about a doctor and how to get a second opinion.

3. PRIMARY MEDICAL CARE (British Medical Association Planning Unit Report No.4, May 1970, out of print but should be available at libraries)

This is the report of a working party which studied the work of GPs both historically and empirically, and considered how primary medical care might develop. It contains a review of changes in social conditions and the changing pattern of disease, and a detailed look at the development of general practice. Comparisons are made with the experience of other countries.

The working party examines different proposals for change, and urges varied experiments in delivering primary medical care. Its main argument is that primary medicine should be a specialty, taught as such in medical schools and given the same status as other specialties. It sees the GP, in his role as specialist, as the linkman between the hospital and the social services, with his recommendations for care of patients carrying the same weight as those of any other specialist. Group practices and health centres are seen as the new pattern of primary care.

Several possible solutions to the problem of relieving GPs of the burden of certification are discussed, as are various aspects of the organisation of primary medical care - premises, team working, and so on. Some problems of change are foreseen, such as cost, co-ordination of work, and doctors having to accept greater flexibility in work and new patterns of relationship with professional colleagues.

Although this booklet was written in 1970, it is still worth reading for the useful ideas it puts forward regarding primary medical care. CHCs may find it helpful to consider how many of the working party's proposals have been put into practice, in the light of NHS reorganisation and the development of group practices and health centres.

COMPLAINTS PROCEDURES

CHCs may already have been approached by people who want advice on making complaints against GPs, hospitals or other parts of the health service. The procedure for dealing with complaints against family practitioners is governed by the NHS (Service Committees and Tribunal) Regulations, and the main current guidance to health authorities on dealing with other complaints is in circular HM (66) 15. We include here summaries of these two documents and of the Davies report and the report of the Health Service Commissioner (these summaries should not be regarded as exhaustive accounts.

1. NATIONAL HEALTH SERVICE (SERVICE COMMITTEES AND TRIBUNAL) REGULATIONS, 1974 (S.I. 1974 No. 455 amended by S.I. 1974 No. 907)

These are the legal regulations covering procedures for dealing with complaints against GPs, general dental practitioners, pharmacists and opticians. For a complaint to be considered it has to be made by the complainant himself in writing to the Administrator of the Family Practitioner Committee, normally within 8 weeks of the event which gave rise to it. (Late complaints may be considered, and the complainant has the right of appeal to the Secretary of State for Social Services against an FPC's decision not to consider a late complaint.) The complaint must be expressed in such a way that it alleges that the practitioner concerned has failed to comply with his terms of service, i.e. his contract with the FPC.

> The Terms of Service for GPs and pharmacists are set out in the NHS (General Medical and Pharmaceutical Services) Regulations, 1974 S.I. 1974 No.160 amended by S.I. 1974 No.719; for general dental practitioners in the NHS (General Dental Services) Regulations, 1973 S.I. 1973 No.1468 amended by S.I. 1974 No.53; for opticians in the NHS (General Ophthalmic Services) Regulations, 1974 S.I. 1974 No.287 amended by S.I. 1974 No.527.

Each FPC has Medical, Dental, Pharmaceutical and Optical Services Committees and a Joint Services Committee, which deal with the appropriate complaints referred to them by the FPC Administrator. Some cases are determined on the basis of the written statements; in others, private hearings may be held where both parties may make their case and present witnesses. Each party may be accompanied and assisted by a friend, and the friend may conduct the case for the complainant unless he is a "paid advocate". If the decision of the Service Committee is adverse to either party, they may appeal to the Secretary of State, who can arrange for an oral hearing before three specially appointed persons. Evidence is given formally on oath and the parties may be legally represented. (In the event of an oral hearing, the FPC may make - or be directed by the Secretary of State to make - a contribution to a party's costs, in particular circumstances.) In exceptional cases, a complaint can be put before the National Health Service Tribunal.

A book that describes all these points in detail and gives interesting results of all such complaints made in one year is: Complaints Against Doctors by Rudolf Klein (Charles Knight, 1973, £4.00).

2. METHODS OF DEALING WITH COMPLAINTS BY PATIENTS
DHSS Circular HM (66) 15

This circular contains the current procedure for dealing with hospital complaints, although the implementation of the Davies Report (see next item) may supersede it. The circular is written in terms of the old health authorities - Boards of Governors, Hospital Management Committees and their Secretaries. It can be interpreted to mean that the District Administrator (or the Area Administrator in single-district areas) handles all written complaints concerning the hospital for which he is responsible, unless he delegates a senior member of his staff to do this. Any action resulting from the complaint should be agreed with the head of the department concerned. In the case of oral complaints, they should be dealt with on the spot where practicable, or referred to the senior member of the department concerned. In all cases the complainant should be informed of the outcome of the investigation, and told that he may take the matter to a higher authority if he is still dissatisfied.

The circular also gives guidance on the further investigation of complaints which cannot satisfactorily be dealt with by officers, including investigation by one or more members of an Area Health Authority (or if the case is serious or has wide implications, the Regional Health Authority) and the setting up of independent enquiries.

3. THE DAVIES REPORT (Report of the Committee on Hospital Complaints Procedures, HMSO, 1973, £1.45)

Although the report has been officially welcomed, it is not yet known what precise action the Secretary of State intends to take on implementing its proposals. Any changes are, however, likely to be based on suggestions made in the report.

THE CODE OF PRACTICE that the report contains would, if adopted as it stands, give CHCs a clear set of responsibilities in relation to the complaints procedure, though much of it is covered in a general way in circular HRC (74) 4. It suggests that although they should not investigate individual complaints themselves, CHCs should help people to make effective use of the system. This could involve giving information about the procedures and advising complainants, acting on behalf of someone who is unable or unwilling to act for himself, giving its own view on a particular issue to the health authority, or drawing areas of potential complaint to the attention of the health authority. CHCs should be well informed of the local standards of care, especially in relation to long-stay patients. The CHC should also advise people on the course of action open to them if they are dissatisfied with the outcome of an investigation, and should be prepared to act on behalf of that person. The health authorities should inform people of the availability of help and advice from their CHC through patient and staff handbooks, and they should provide CHCs with information on the type and volume of complaints received about the hospital services.

Another suggestion of this report is that Investigating Panels should be appointed by RHAs, with legally qualified and independent chairmen and independent members, to investigate complaints referred to them either by a dissatisfied complainant or a health authority, provided that the chairman is satisfied the complaint could be but will not be taken to court. These panels should provide summaries of the complaints they have received (without disclosing the names of the parties involved) twice a year to the CHCs, health authorities, DHSS, the press and the public.

The Annual Report of the Council on Tribunals (HMSO, 1975, £0.45) criticises this recommendation to set up investigating panels since it suggests these could be confusing to the public who are already faced with several avenues for making complaints. Instead of setting up yet another body, it proposes that health authorities should ensure informal guidance is readily available at an early stage to anyone who wants to make a complaint. In this way it is hoped that the confusing array of different channels will not prevent a person's complaints from being directed to the right place. In addition, the Council says that if the Health Service Commissioner's powers (see next item) were extended, he could deal more appropriately with the type of complaint that would go to the proposed investigating panels. Finally, the Council urges the Government to review all other types of complaints procedures in the NHS when they decide what action to take on the Davies report.

4. FIRST REPORT OF THE HEALTH SERVICE COMMISSIONER Session 1974-75 (Annual Report for 1974-75. 17th June 1975, HMSO, £0.65)

The Health Service Commissioner took up office on 1st October 1973 and he issued a report at about this time last year covering his first 6 months work up to 31st March 1974. The newly published report covers the 12 months up to 31st March 1975.

The Health Service Commissioner is empowered to investigate complaints received directly from members of the public concerning failures in provision of services or incidents of maladministration by the health authorities in England, Wales and Scotland. These have mainly concerned grievances about the treatment and care of patients and failures in communication between patients and the hospital staff. Specific examples include complaints about the length of time that patients have had to wait for admission to hospital without adequate explanation, the repeated postponement of a major operation, the use of patients for teaching and research and the availability of information leaflets to non-routine admissions.

The Commissioner is specifically excluded from investigating actions taken solely in consequence of the exercise of clinical judgement, personnel matters or any action taken by a person providing general medical, dental, ophthalmic or pharmaceutical services for which the FPCs are responsible. However, he does say in the report that it has often been necessary to inform himself about the clinical aspects of cases in order to arrive at proper judgements of those parts of complaints which are within his jurisdiction. Out of a total (for England, Wales, and Scotland) of 612 complaints received, 354 (57.8%) had to be rejected as outside his jurisdiction, 24 were discontinued after partial investigation and withdrawals, and in 106 cases a Results Report was issued. (During the first 6 months to 31st March 1974, 361 complaints were received, 203 (56%) were rejected as outside his jurisdiction, 16 were discontinued and 23 Results Reports were issued). The Commissioner explains that the most common ground for rejection is that the body complained against had not been given the opportunity to consider the complaint, and this is required by the Act before he can take them up.

Health authorities may also refer matters to the Commissioner if they have been unable to resolve them satisfactorily. The Commissioner himself (Sir Alan Marre, who has been the Parliamentary Ombudsman since 1967) is based in London and has a small staff of civil servants and staff seconded from NHS work. There are also investigating units in Cardiff and Edinburgh, and 13 members of the medical profession are available to him to give advice in deciding whether a complaint from a patient involves clinical judgement.

BETTER SERVICES FOR MENTALLY HANDICAPPED PEOPLE

by James R Elliot

One effect of the NHS reorganisation has been to bring about a need for a wide range of members and staff of area and regional health authorities to take an interest in services for mentally handicapped people and their families. Members of community health councils will certainly need to have access to facts and figures, and to have some knowledge of the aims and objectives of a service which goes well beyond the boundaries of the NHS. In recent years it has become clear that at least five separate public agencies, in addition to voluntary organisations, have to combine their efforts if the intentions of the Government, as expressed in the White Paper Better Services for the Mentally Handicapped (Cmnd.4683, HMSO, price 71p) are to be translated into reality. Health, education, social services, employment and housing are all involved in what should be, but rarely is, a combined effort.

CHCs have a clear duty to say whether mentally handicapped citizens originating from their population are getting a fair deal. To do this they will need access to facts about prevalence, about primary prevention, about social and educational needs as well as medical ones. They will need to know enough to be able to play a meaningful part in the public discussion of plans for new services - not just new NHS buildings, but the whole network of supporting services and the wide range of residential opportunities. In visiting establishments which serve mentally handicapped people they will need to be able to form an opinion not only about mentally handicapped people as they are, but as they could be with the benefit of better and more integrated services. From the consumer angle, they need to be able to suggest problem areas which ought to be discussed jointly in Joint Consultative Committees.

With these needs in mind, CHC members may be interested to know of the Mental Handicap Project (Project Director: James R Elliott MBE, FHA; Project Officer: Mrs Joan Rush SRN, Dip.Soc.; King's Fund Centre, 24 Nutford Place, London W1H 6AN).

The Project's aim is to improve services to the mentally handicapped. Work undertaken includes helping to improve the management systems in hospitals for the mentally handicapped; encouraging the exchange of ideas between the various professions and voluntary societies who work for the mentally handicapped; publishing a mental handicap bulletin for workers in the mental handicap field; maintaining an information service based on national and international contacts; advising on mental handicap strategies; advising on the staffing of the mental handicap service; organising day conferences, study groups and residential seminars; experimenting with in-service training for care staff, organising exhibitions; originating publications.

The Project is prepared to offer, while stocks last, at a price of £2.00 including postage:

MENTAL HANDICAP STUDY PACK

containing

One set of Fact Sheets

Sample copy of Mental Handicap Bulletin

Room for Improvement - an illustrated book of ideas on better living conditions for mentally handicapped people

Mental Handicap Papers: Nos 1-5

1. Strategies for Profound Mental Handicap.
2. Strategies for the Mentally Handicapped Security Patient.
3. A Library Service for the Mentally Handicapped
4. Perspectives of the Briggs Report.
5. Education for Care.

Two other organisations relevant to mental handicap, with offices at 24 Nutford Place are:

ASSOCIATION OF PROFESSIONS FOR THE MENTALLY HANDICAPPED (Hon. Secretary: James Elliott) which aims to promote the welfare of mentally handicapped people and their families, by encouraging high standards of care and development of the mentally handicapped, by facilitating cooperation and the sharing of knowledge among all professionals working for or with the mentally handicapped, by offering a unified professional view on the strategies of mental handicap, and by educating the public to accept, understand and respect mentally handicapped people. (Full membership: £2.00 a year; Associate or Student membership: £1.00 a year; Corporate membership: £10.00 a year; details from Mrs Andrea Whittaker, Membership Secretary, 24 Nutford Place, London W1H 6AN.)

CENTRE ON ENVIRONMENT FOR THE HANDICAPPED (CEH) provides advice and information on the design of the environment for handicapped people. A reference library of publications, plans, photographs, etc. is available for use, and advice is given by consultant architects to all those engaged in planning or designing buildings. CEH publishes a quarterly Newsletter containing among other things, reports of monthly multi-disciplinary seminars. (Director: Jean Symons, AADipl RIBA, 24 Nutford Place, London W1H 6AN.)

PARLIAMENTARY QUESTIONS

In this section we present a further selection of questions put to Ministers on various health topics including breast cancer, vaccine-damaged children, women doctors, a national advisory group on mental handicap, and safe packaging of medicines.

BREAST CANCER

In reply to questions from Mr. Frank White (La. Bury and Radcliffe) and Mr. Robert Parry (La. Liverpool, Scotland Exchange) on 25th and 28th April, Dr. Owen indicated that the DHSS has provided £356,200 between 1970/71 and 1974/75 for research into screening programmes and methods for detecting the disease; and that the number of female deaths in the UK from cancer of the breast were 11,984 (1969), 12,034 (1970), 12,472 (1971), 12,540 (1972), 12,834 (1973).

The Joint Working Group looking at this subject recommended that research on specific problems associated with breast cancer screening should be extended, that NHS diagnostic and treatment services should be improved and that the feasibility be examined of substantial investigations of breast cancer screening (including assessment of benefit) designed and controlled to give the maximum amount of information and to lead to progressive development of a national service if results were favourable. Dr. Owen accepted the Group's advice that a national breast cancer screening service is not justified at present, and in consultation with the Medical Research Council will establish extensive screening trials in certain areas to establish the optimum form any service might take. Two joint groups will be set up to advise on the design and execution of population screening trials, and on the validity, safety and improvement of screening techniques. The Health Departments will review with health authorities the need for both improved and treatment facilities and draw the attention of general practitioners to the services which are currently available.

VACCINE DAMAGED CHILDREN

In reply to a question from Mr. John Hannam (C. Exeter) on 29th April, Mr. Alfred Morris replied that Mrs. Castle had met the Association of Parents of Vaccine-damaged Children and had expressed interest in and sympathy with their case. It was explained to them that matters of this kind are being studied by the Royal Commission on Compensation and Civil Liability. Mr. Hannam said that the parents of approximately 250 brain-damaged children were sick and fed up with being shuttled between the Minister and the Attorney-General and resented being accused of trying to attack the immunisation scheme when all they were seeking, like the thalidomide parents, was fair compensation for the damage caused to their children as a result of Government schemes. Mr. Morris replied that he was very aware of the deep feelings of the parents but would be in difficulty if he sought to pre-empt the Royal Commission on decisions of principle. He said he could give no stronger assurance of concern than to say that the Department had submitted evidence to the Royal Commission. He hoped there would be no threat to the immunisation programme, which had saved many lives.

WOMEN DOCTORS

Mrs Castle, in the course of her reply to a question from Mr. Bruce Douglas-Mann (La. Mitcham and Morden) on 29th April, indicated that she was not satisfied that enough was being done to recruit, encourage and ensure the effective deployment of women doctors. She was inviting representatives of the medical bodies concerned and individual practising women doctors to a special conference with herself and her Department in July to discuss the contribution of married women doctors to the National Health Service, to consider the problems faced by married women doctors on re-entry to active medical practice and in combining family with professional responsibilities; and to make recommendations.

NATIONAL DEVELOPMENT GROUP FOR THE MENTALLY HANDICAPPED

In reply to a question from Mr. Mark Hughes (La. Durham) on 22nd April, Mrs. Castle indicated that as announced on 26th February Professor Peter Mittler had agreed to become Chairman of the group which would advise her on the development of mental handicap policy. The members of the group who had been appointed were Mr. J.R. Elliott, MBE FHA (Assistant Director, King's Fund Centre, Nutford Place, London), Dr. G.B. Simon, MB ChB FRCPsych DPM (Consultant Psychiatrist, Lea Castle Hospital, Kidderminster), Mr. W. Tamkin, RNMS SRN RMT (Area Nursing Officer, Stockport Area Health Authority), Mr. M.W. Wren (Director of Social Services, Solihull) and Mrs. Peggy Jay (Chairman North Camden CHC, Member London Borough of Camden Social Services Committee - nominated by the Central Health Services Council). The Personal Social Services Council would shortly nominate a representative to serve on the Development Group, which had already begun work.

MEDICINES (CHILD SAFETY)

In the course of his reply to a question from Mr. Greville Janner on 23rd April concerning the Medicines Commission's report "Presentation of Medicines in Relation to Child Safety", Dr. Owen reiterated that the Government were concerned about the number of children admitted to hospital from suspected poisoning from medicines - averaging for children under five 16,000 a year over the previous four years, thought the number of deaths from this cause fortunately was no more than six per million of children under five - and that he was prepared to examine anything that could reduce the risk of accidental poisoning.

On 8th August 1974 he had announced, on behalf of all Health Ministers, that the Government had initiated urgent consultations with a wide range of professional and trade associations and consumer interests about the recommendations in the Medicines Commission's report, the main recommendation being the need to introduce as soon as practicable unit packaging for medicines containing specified ingredients.

The comments received on the commission's report claimed that it would take at least two or three years from now to extend the use of suitable unit packaging to all medicines containing ingredients in the commission's priority list. Dr. Owen went on to discuss the details of the Government's proposals to introduce limited requirments for the use of dark tinted unit packaging or child-resistant reclosable container.

BOOK REVIEWS

BRIDGING IN HEALTH
Reports of Studies on Health Services for Children
Ed. G McLachlan, Nuffield Provincial Hospitals Trust, 1975, £2.60.

These reports are specifically related to the subject of child health, but may be of interest to a more general readership than those particularly concerned with child health, as their scope is wide.

Of particular interest to CHCs is the paper called Planning the child health services, which looks at the issues involved in the setting up and working of a health care planning team. Topics covered are: the concept of HCPTs; setting up the Team, the meetings of the Team; the working parties; membership; the relationship of HCPTs with CHCs (some interesting points are made here against CHC membership of Teams); information systems and requirements; overlap problems (with other HCPTs and with local government); workload and support staff; relationships with professional advisory bodies; and a discussion entitled "Health districts; are they the right level for planning teams ?"

In their final comments, the authors of this paper urge other Teams not to channel too much of their early energy and enthusiasm into the preparation of a detailed and comprehensive information system. They make the point that the dominant problems can be identified quite rapidly and in sufficient detail by a basic appreciation of the community under review, specialist consumer views (e.g. as discovered from an informal interview with the mother of a handicapped child), and discussions with professionals dealing directly with patients. DMTs must thoroughly appraise the role and function of the teams they establish, and give them a clear brief to work to. Teams must not emerge as privileged groups operating under a cloak of secrecy, but as an open and dynamic medium for health professions to collaborate in the development of better health care for their communities. The paper is followed by an excellent Reading List which covers many aspects of the child health services, and should be very useful for anyone who wants to read further on the subject.

The other papers in this book are likely to be more useful to CHC subgroups with an interest in child health. Paediatrics in hospital and community in Newcastle upon Tyne explores the gaps in the services and produces evidence that child health services consisting of GPs and hospital consultants cannot be comprehensive. The school health service and the school doctor sets out very clearly the issues which will confront the community physician, the area specialist in child health and the child health HCPT. Design and implementation of a developmental paediatric programme evaluates a project which involved four examinations of every child in Derbyshire during the first five years of life. Congenital malformations in Devon: their incidence, age and primary source of detection is the first report of a study aimed at identifying congenital malformations in children as early as possible.

MULTIPLE SCLEROSIS

Office of Health Economics, May 1975, £0.25.

If CHCs are to fulfil their tasks effectively, it is of crucial importance that they inform themselves as fully as possible about the conditions and diseases, particularly the chronic ones, that affect a large number of people. Multiple Sclerosis is a new Office of Health Economics booklet that explains, very thoroughly but readably, the nature of this crippling disease and its implications. Some of the first section, "The nature of the disease" is fairly technical, but the other chapters require no technical knowledge. They cover the geographical distribution of the disease, symptons, prospects, treatment, the cost of multiple sclerosis (this is of particular interest to CHCs, and there is a useful appendix giving comparative costs to the NHS of home and hospital care), social aspects, rehabilitation and the role of voluntary bodies.