CHC NEWS

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EDITORIAL

This is the third issue of CHC NEWS and, as you know, there will be another issue in November. Depending on the outcome of the Steering Committee's work, there could also be a fifth issue in January or February next year. Many of you have been sending in letters and articles and I would like to thank you very much for them. Anyone else who has views and comments to make should not hesitate to write, or telephone if it is more convenient:

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The Stroke Patients Survey, which was proposed in the last issue, has created a very enthusiastic response. Any CHCs who have not yet made up their minds but who think they could participate should contact me. If CHCs from all parts of England and Wales do join in, they will not only be able to gather information of particular value to their local work, but will also be making it possible for the first time to build up a picture of national patterns of care for stroke patients in the home.

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The way CHCs can influence the planning and provision of family practitioner services seems to be unclear and the information on chemists shops in this issue (page 13) has been included because several CHCs have reported problems in their districts with the location of chemists' premises or with the hours of opening.

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There should also be a mention of the DHSS's Annual Report for 1974, which was published recently. It is well worth reading if you want to know what all the different parts of the Department do. Apart from the NHS there are sections dealing with the personal social services, social security and supplementary benefits. However, the Report lacks the kind of statements and statistics that make much impression on the outsider, and a more useful document to look forward to is Health and Personal Social ServicesStatistics 1975 which should be published by the DHSS at the end of the year.

RUTH LEVITT

Note The letters and articles we publish express the personal views of the writers themselves and are not necessarily shared by CHC NEWS or any other party.

YOUR LETTERS

HEARING AID CENTRES from G.J. Hoult, Secretary, Leeds (Eastern) CHC

This Community Health Council was disturbed to learn that the main hospital was the only place in the district where hearing aids could be repaired and supplied with batteries and cords. For many old people, the journey to the hospital is a major undertaking, and even within the hospital they can feel bewildered and helpless. As a result of negotiations between the CHC and the DMT there are now 17 centres around the periphery of the City where cords and batteries for NHS hearing aids can be obtained. With the cooperation of the hospital's audiometry department, these centres can also service and repair the aids. It is hoped that sub-centres can be organised in old people's clubs and local community associations so that the provision of batteries and cords can be further improved. This is an example of the kind of exercise through which CHCs can be successful in obtaining better services for patients. (See news on page 14 - Ed.)

ANOTHER VIEW ON CHC NEWS from A. Gill, Chairman, Darlington CHC

I am surprised and dismayed at the letter which appeared in CHC NEWS No.2 regarding the issue of a newsletter to CHCs. While Councils are just getting off the ground and working with an absolute minimum of staff and funds, such a newsletter is a lifeline and a means of obtaining a cross-fertilisation of ideas. So far as initiating schemes is concerned, no CHC is obliged to implement any schemes it does not want to but there is a lot to be gained by working together for the purpose of obtaining valuable information. I am sure that the National Council will want such a medium when it is set up and the Steering Committee must be thankful that it has been possible to have one meantime.

MALE MIDWIVES from Miss Esme Few, Area Nursing Officer, Berkshire AHA

I would like to comment on the article "Male Midwives" which appeared in CHC NEWS No.1. In the penultimate paragraph it states that, "it appears that in England there are no courses to allow men to become health visitors, because they all insist on midwifery experience." The facts are as follows: Training for men in health visiting skills and techniques was pioneered in Aberdeen some years ago and more recently one or two other training courses accepted men for training. Their qualification could not be recognised in law nor by the statutory body, the Council for the Education and Training of Health Visitors (CETHV), although they did practise their skills in a limited way as Health Visiting Officers. The law was changed by Statutory Instrument No.1822 (NHS Qualifications of Health Visitors) Regulations 1972, which came into operation on 1st January 1973 wherein the health visitor specified in previous legislation as "a woman" became specified as "a person" thus paving the way for men in health visiting. In order to comply with the rules laid down by the CETHV, which require the health visitor to be a qualified State Registered Nurse with an acceptable obstetric qualification, arrangements were made by the CETHV for specially planned obstetric courses for men. These are a pre-requisite for taking the health visiting training course. Currently these courses are held at Chiswick and Newcastle Polytechnics and at Aberdeen. Thereafter, the appropriately qualified men may apply to any recognised health visiting training course in the country to take the training and, following successful completion and examination results, will be awarded the CETHV's Health Visitor Certificate and may practise their profession.

HEALTH CENTRES : SHOULD PATIENTS HAVE A SAY ?

Two doctors from South Wales give their views and experiences

1. Dr Alistair Wilson, MA, MRCGP

When, in August 1973, our health centre was opened, it was considered that the patients (10,000) should be encouraged to become involved in running their general practitioner services. It was decided that this could best be done by calling a general meeting open to all patients, from which a Patients' Committee could be elected. At the first general meeting a committee of 8 was set up, and at the second general meeting this was increased to 13. The chairman is a retired teacher, the secretary a young industrial worker. One of the members is also a member of the local Community Health Council.

The Patients' Committee now meets with some members of the practice health team, (7 doctors, 4 practice nurses, 1 nurse/receptionist, 1 receptionist, 1 health visitor and 1 district nurse), every 5 or 6 weeks. In future, it is hoped that the liaison social worker will also attend.

Initially the Committee discussed immediate difficulties: the doctors' week-end rota arrangements, the surgery appointments system, parking facilities, redecoration, the provision of picture rails, the health education programme. Now, however, we have worked out how to provide a new facility - a limited screening service for the over 60s, to whom letters, signed by the senior doctor and the secretary of the Patients' Committee, are being sent soon after their 60th birthdays.

At a recent meeting, the main matters discussed were: the waiting time for barium meal X-rays, the Open University training of doctors, the James White Abortion Amendment Bill, the health education programme for the next session, and euthanasia. From the outset it was agreed that there should be public lectures on the theme "Look After Your Health" and there has already been a lecture on "The Open University and Doctors" but not yet on abortion or euthanasia.

The Patients' Committee approached the CHC concerning the waiting list for barium meal X-rays. The CHC wrote to the local officer of the Area Health Authority, and in the light of the reply that was received, the Patients' Committee reconsidered the matter and decided what they thought should be done. One of the doctors and a member of the Patients' Committee will visit the CHC office shortly to present what is considered to be a reasonable solution to this problem.

At the last Patients' Committee meeting, one of the doctors said that there had been some difficulty in getting a violent mentally ill patient into hospital at a holiday time. After discussion, in which 2 doctors, the health visitor and members of the Patients' Committee participated, it was decided to ask a psychiatrist to give a lecture on the subject "The Care of the Mentally Ill in Home and in Hospital". In this way, these and any other difficulties can be discussed in an amicable way.

What is also needed, I think, is that patients should be encouraged to attend the Patients' Committee meetings to give their opinions, advice or complaints. There should also be more frequent general meetings for the same purpose. What is envisaged is cooperation between

the health centre staff and the patients rather than confrontation. The aim is to involve as many of the 10,000 patients as possible and to utilise their unique and varied experience to assist the practice team in providing a better service.

Our local Patients' Committee is an example of grass roots democracy in an NHS which is, more and more, being controlled at all levels by appointed and not elected bodies. Our relations with the CHC are excellent; the CHC Secretary has already spoken to one open meeting of the patients. Is there any good reason why this cannot happen at every other health centre ?

At a conference in February 1975 organised by the Valleys Community Project at Abervan, on the subject of "Health in the Valleys of South Wales", I gave the report of the primary care discussion group, which was attended by members and two secretaries of CHCs, and by the secretary of our Patient's Committee. The recommendations were:

(1) There should be more community participation in the primary care service:

   (a) CHCs could ask local doctors for appointments to visit their surgeries or health centres. In this way, barriers between doctors and the CHCs can be broken down.
   (b) The appropriate CHC could "associate" with the Patients' Committee.
   (c) There should be increasing democratic control of the health service.

(2) There should be central exchequer control of health services finances but with a larger and wider distribution of funds, particularly to areas of greatest need.

(3) It should be an essential part of primary care that general health education should be provided for the community particularly at risk.

The Secretary of the Patients' Committee stated that if doctors were prepared to discuss the provision of health services with their patients, this could benefit both patients and doctors and could provide a better service for the community.

2. Dr Julian Tudor Hart, MB, DCH, FRCGP

In 1974 I was nominated to serve on an advisory committee on general practice set up by our Area Health Authority. My fellow committee members turned out to be very progressive doctors, critical of the profession, of high personal integrity and whose own work was of high quality. They had vigorous views on the substantial changes needed to bring primary care into a state befitting the last quarter of the 20th Century. Our plans for initial data collection were spinning along fine, when I suggested that one area of our plans would benefit from cooperation with the CHC.

There was a horrible silence, during which I could reflect on the sad state of good intentions that lack any realistic social strategy to bring them about. There were some jocular remarks on what could be expected from that quarter, and my rude suggestion was passed over without further comment.

The same year, the District Administration convened a meeting at our health centre to set up a committee to assist in its running. With the unanimous support of the 2 doctors, 4 nurses and health visitors, and 2 receptionists associated with the centre, I proposed that

the CHC be invited to send a representative to serve on the committee. The District Administration representative said he thought this would contravene the letter and spirit of the 1974 reorganisation; and anyway, the CHC must at all costs avoid contamination with decision-making lest this impair its watchdog function; he would have to consult higher up before agreeing to such a thing. We insisted that health centre teams should be entitled to include patient representation in any form they wished, but sure enough I got a letter a couple of weeks later, telling me that the CHC could not be represented, as professional matters would be discussed !

I quote these experiences to make two points. Firstly, although even the Financial Times (21.1.73) described the future CHCs as "enthralled slaves of the old authorities" - and they doubtless have their full share of Old Boys' and Old Girls' networks who still dominate so many of our traditional paramedical mass organisations - doctors and administrators are still for the most part united in fearing the CHCs. They are dead keen on progress, but at just that pace that they find comfortable, and in those directions they deem desirable. They have yet to learn that the real pathway to a more just and rational NHS will lie in an alliance with patients.

Secondly, in social institutions where loyalty and obedience proceed upwards to a central group of experts who are nominated rather than elected, all disputes are privately contained, and democracy is represented by an opportunity to vote once every five years for a Government whose Secretary of State for Health and Social Security may differ significantly from his predecessor and may control his senior civil servant; or may not. Otherwise, there is simply a complaints procedure; the people have no representation in the decision making process at any level, while the experts know best and they alone can be completely objective since they do not use the service by normal pathways. This is not a future danger, but our present state and it is a disaster course for both our health service and our society.

Doctors wield immense power. It is a delegated power; it is delegated to us by the mass of the laity and to them we doctors must be accountable. "Delegation upwards, accountability downwards" is the slogan that should be upheld by every CHC and every other group seeking a democratisation of medical care.

Medical scientists worthy of that name know well enough that most decisions in the NHS are not technical but social. They know that our intelligence data is dreadfully incomplete in those areas that matter most, and that most of our statistics tell us much less than we could discover simply by sitting in our waiting rooms. They know that medical science cannot be effectively applied by a passive and uninformed public, and that care-providers who are serious about their work cannot plan our advance without consumer-criticism and consumer participation. The very unequal distribution of resources in the NHS by area is more closely linked to the proportion of well-off people in the population served than by any other factor (see article by Noyce, Snaith & Trickey in The Lancet (1974), 1, 554). The reasons for this are social and not technical and will hardly be remedied by the present social composition of RHAs and AHAs. Furthermore, for each patient, the cost of laundry is 2½ times, of food nearly 3 times, of cleaning more than 4 times, and of domestic staff nearly 6 times as great in acute hospitals as in those for the mentally retarded; are the reasons for this technical or social ? Who will have the sustained determination to put it right ? Who says Britain is so poor that we cannot afford to care decently for the handicapped, or deliver the discoveries of medical science to those whose lives depend on renal dialysis or anti-haemophilic globulin ?

Nobody denies that planning and administration in the NHS requires expert advice and an understanding of medical technologies; but these experts must themselves explain and justify their technologies to one another and to lay civil servants. Why should they then not explain and justify them to those who are expert on the needs and daily burdens of unprivileged life as it is lived by the mass of the people, who know their problems by having them, not by reading about them in books ? When we have those experts taking a proper share in decision-making and responsible to electors rather than anonymous civil servants, we shall be on the way to the NHS we need.

The CHCs should not be content with a kennel and a watching brief; they will watch better if they fix their eyes now on the driver's seat.

GUIDE TO CIRCULARS

PLANNING TASKS 1975/76 - 1976/77 : REVISED TIMETABLES
DHSS Circular DS208/75 25 June 1975

In CHC NEWS No.1 we listed various sources of Departmental guidance on the planning system. Since then, the Guide to Planning in the National Health Service has been published, and the Consultative Document is hoped to be ready by the end of the year.

This circular DS208/75 has, however, been issued to clarify the changes to the timetable of planning tasks that were originally defined for this year and some points of importance to CHCs will be mentioned here. The main factor that has caused the original timetables to be revised is the uncertain financial position. It was not until after the Chancellor's Budget Statement in April that information on the amount of money that would be available for the NHS became known. Without this information, the DHSS was unable to issue useful guidance to the health authorities.

The position in relation to CHCs now is that between September and December this year, AHAs will formally consult with their CHCs on the Capital Programme for 1976/77 - that is, the programme for spending on major buildings and equipment in the coming year.

CHCs will also be consulted by AHAs when the development of strategic plans is taking place. This should happen in Spring 1976, when the Department's Consultative Document (on priorities and strategies for the health and personal social services over the coming 10 years) has been published and discussed.

The circular also asks DMTs to gather information and statistics on general features of the district and on specific features of provision for particular health care groups by the end of March 1976. The data will be used to complete forms similar to those included with the Guide to Planning, when the new planning system gets properly under way next year.

SUPERVISION OF THE ETHICS OF CLINICAL RESEARCH INVESTIGATIONS AND FETAL RESEARCH

DHSS Circular HSC (IS) 153 June 1975

This circular contains information that CHCs are likely to find particularly important. It concerns methods for supervising medical research, and the point of its publication is to urge AHAs to ensure that this supervision meets the standards recommended in two reports from the Royal College of Physicians. The circular sets out the main points of the report and state the DHSS' specific advice.

In all medical institutions where any form of experimentation in man is carried out, ethical committees should exist to approve all projects for research. Each ethical committee should be composed of doctors experienced in clinical investigation, and a lay member. The DHSS recommends that AHAs should consider choosing a member of the appropriate CHC to be the lay member. The object of the ethical committees is to safeguard patients, healthy volunteers and the reputation of the profession and its institutions in matters of clinical research investigation. All medical staff should be aware that whatever other approval or licenses they have obtained for their proposed investigation, the approval of the ethical committee is required in each case.

Whenever the experiment concerned does not involve benefit to the individual, a full explanation in the presence of a witness should be given, and the patient must feel completely free to decline to participate or to withdraw at any stage. If the individual agrees to participate, this should be recorded together with the signatures of the witness and the person giving the explanation. Consent should also normally be obtained when the experiment is intended to benefit the patient, but there may be some cases where this is inappropriate or inhumane. Ethical committees should examine these cases with particular care.

The DHSS suggests that the use of children or mentally handicapped adults in clinical research investigations that do not directly benefit the patients are not necessarily legal, even if they involve negligible risk, and the consent of a parent or guardian has been obtained. (An extract from a Medical Research Council report discussing this subject is included with the circular.)

Ethical committees also have to approve the use of fetal material (i.e. material from a child within the womb, and the DHSS recommends that no fetus other than a previable one (i.e. one which is less than 20 weeks old) weighing less than 300 grammes (about 10½ oz.) should be used for research.

FAMILY BENEFITS AND PENSIONS

Leaflet FB 1 April 1975

This booklet has been specially produced by the DHSS to assist individuals and bodies, such as CHCs, to help people in claiming their rights. It gives details about benefits such as pensions, rebates, allowances, exemptions and refunds, and explains how they can be obtained.

The leaflet was circulated to CHCs recently, and further copies can be obtained from: DHSS, Leaflets Unit, Block 4, Government Buildings, Honeypot Lane, Stanmore, Middlesex HA7 1AY. (free of charge)

DO HEALTH SERVICE STATISTICS MAKE SENSE ?

by the King's Fund College Information Room

In order to function, CHCs need information. They must know about the needs and demands of the population they serve, and the way in which health service resources meet them. This information should be historical (what has happened), current (what is happening) as well as forward looking (what might happen). This sort of information will come from four main sources - anecdotal information obtained from talking to patients, potential patients and health service staff; information obtained during visits to health service premises; information from the surveys that some CHCs are now mounting; and health service statistics.

All these sources are important, but the particular ones being most frequently used by health service managers are the statutorily collected statistics. Because of the great reliance placed on these statistics in the running and planning of the various aspects of the service, it is crucial that CHCs gain an expertise in interpreting them. In this paper we will try to highlight a few of the problems in using health service statistics.

The great majority of statistical systems have been set up by DHSS and the type of data collected and the way in which it is collected is determined primarily by the particular needs of the Central Department. This fact of life has two important consequences for those involved in District management. The volume of data required by authorities further up the line is so great that Districts have little time to develop information systems for their own needs, and because they lack the resources to collect information relevant to their needs, they have to rely on the statutorily collected information which is frequently inappropriate.

The way in which waiting list information has been collected is a good example of how centrally determined statistics are inappropriate to local needs. Each district records the number of people waiting on a particular day (31st December) broken down by hospital and specialty. Thus a CHC is presented with a figure such as 324 people were on the Orthopaedic waiting list for the Rutland Infirmary on 31st December 1974. This figure may be useful for the DHSS but at local level it really isn't very helpful.

Being on a waiting list can mean a lot of things. Some people are genuinely waiting for admission but all lists contain a significant proportion of people who have moved, died, had their operation at another hospital, refused to be admitted when offered admission, or whose complaint has resolved without medical interference. A CHC would thus want to know how frequently the waiting list was updated and how many people were genuinely waiting for admission.

The date on which the count is made obviously affects the number of patients on the list. The DHSS Return is made for 31st December and as most clinical units ease up on admitting waiting list cases over Christmas figures collected on this day may be totally unrepresentative of the picture during the rest of the year. A figure taken on one particular day is thus not very helpful.

Even if you obtain a reasonable estimate of people actually waiting for admission on a representative day what does it mean ? There is obviously a large difference between being told there are 300 patients waiting when 150 patients are admitted from the waiting list each month (i.e. the waiting list represents about 2 months work) and the position where

there are 300 on a list and only 150 patients are admitted a year (i.e. the waiting list represents 2 years work). It would be reasonable for a CHC to be very worried about the latter but not the former situation.

This problem of knowing precisely what a statistic purports to measure is highlighted when you review statitistics about the use of hospital beds. An empty bed (as defined by DHSS) is one empty at midnight. A patient may be discharged in the evening and another patient be admitted to the bed next morning but that bed will still be recorded as having been empty for that day. This fact must be remembered when interpreting figures about bed occupancy. A geriatric bed is not as you might think a bed filled by an elderly patient. It is a bed under the responsibility of a consultant geriatrician. If a District has no consultant whose contract states that he is a geriatrician, then they have no geriatric beds. The way in which the term is defined explains to some degree the vast difference there is in the provision of geriatric beds in different districts.

When reviewing health service statistics CHCs will be trying to make judgements. Are health service facilities being effectively used ? Are the needs and demands of your population being served ? These are very difficult questions and to answer them you must have an idea of the standards you wish to aim at. In the NHS managers have tended to fight shy of standards and instead have relied on comparing one authority with another. This approach is fraught with danger. Not only does the way in which terms are defined militate against making useful comparisons but the resources (buildings and people) that are available even to similar clinical teams in the same district are frequently so dissimilar that meaningful comparison is impossible.

Statistics can become bewitching. Do not be taken in by the myth that the more statistics you have available the better decisions you will make. The more data you try to digest the more impossible it is to dissect out the important from the trivial. Only ask for statistics if you have a purpose for them - don't seek them just because it was a good idea at the time.

A CHECKLIST FOR HOSPITAL VISITING

by Charlotte Williamson, Northallerton CHC

Although hospital visiting seems very simple and common-sensical, in fact it requires the practice of three distinct skills: perception, organisation and interviewing. Some members of Northallerton CHC have found this checklist a useful guide to visiting.

BEFORE THE VISIT

* Read relevant DHSS circulars, checklists of voluntary organisations and books on the quality of patient care for the specialty you are to visit.

* Hold a meeting of all the people going on the visit.

* Discuss which subjects to cover in questions and observations.

* Share the questions out between the members.

* Ensure that the visit is arranged at a time convenient to the patients.

DURING THE VISIT

* Ask questions in a neutral way that does not show what answer you may be expecting. What ? How ? When ? questions elicit fuller replies than Why ? questions and do not put people on the defensive so readily.

* Work the questions naturally into the conversation.

* If you are taking notes, explain what you are writing down and why, to allay any suspicions.

* Be receptive to any suggestions of problems or shortcomings that staff may point out to you. Try also to sense things they only hint at.

* Do not express your own opinions or make suggestions for improvement while you are going round. Hasty or inappropriate comments will forfeit the respect of staff and make them reluctant to act on your formal recommendations later on.

* Talk to junior staff as well as senior staff even if this is difficult to manage, so that you get a range of views, and show that you value everyone who works in the Health Service.

* When you talk to patients, explain who you are and why you are visiting the hospital.

* Try to talk to patients outside the hearing of any member of staff.

* Explain what you have discussed with patients in general, reassuring terms, when you rejoin the member of staff showing you round. Do not repeat anything a patient said.

* Be sensitive to any vague feelings of concern or unease you may have, as these are useful.

* If you see something that disturbs or surprises you, do not disbelieve or dismiss openly any explanations staff may give you, but try and get the facts on the matter, not opinions presented as if they were facts.

AFTER THE VISIT

* Make a note of facts, impressions and queries immediately after the visit, otherwise you will forget them.

* Try to analyse what the staff have communicated in symbols and gestures as well as in words, e.g. a very good tea or a lavish lunch.

* Remember that staff will always feel ambivalent towards CHC visitors: they hope you will understand their work because much of what they do is good or caring, but they also hope you will not understand, because some of what they feel is uncaring.

* Hold a meeting of all who went on the visit. Talk over your feelings as well as your findings.

* If you intend to make public any written report on your visit, send it first to the staff for their comments.

CHEMISTS' SHOPS - INFORMATION FOR CHCs

If a chemist (who may be an individual or a firm or a corporate body) wishes to open a shop for dispensing medicines prescribed under the NHS, he first has to apply to the DHSS to have his premises registered as a pharmacy. (This is in fact done through the Pharmaceutical Society of Great Britain which is the licensing body of the pharmaceutical profession.) When the premises are registered, the chemist applies to the Family Practitioner Committee for a contract to dispense medicines under the NHS. The contract specifies the terms and conditions of service (see CHC NEWS No.2 page 13) and includes requirements relating to opening hours and participation in the out-of-hours rota service. If a chemist wishes to have different opening hours from those specified, he has to apply to the Hours of Service Committee of the FPC. (This committee specifies the minimum opening hours and the rota systems that chemists are obliged to observe, and keeps these arrangements and any special cases under review.)

At present there is no statutory control over the location of chemists' shops, although the Pharmaceutical Society did suggest this to the previous Government when the NHS Reorganisation Bill was in preparation. A chemist is only likely to open a shop on a given site if the balance of NHS and over-the-counter business he could expect would be economically worthwhile. Where the distances between chemists' shops are considerable, the FPC may approve a scheme whereby prescriptions can be brought to and medicines collected from a central point, by arrangement with local chemists.

Some areas operate an emergency on-call service so that medicines can be dispensed and delivered by a pharmacist when no chemists' shops are open. This is a voluntary service and the pharmacists who participate in it can claim a special fee from the FPC. The pharmacists may prefer to receive emergency calls only from doctors and the police, so that abuses may be avoided. All chemists are required to display a notice when they are closed, stating which is the nearest chemist to be open, and several local newspapers print details of the rota systems.

AREA CHEMIST CONTRACTORS COMMITTEE

There is an Area Chemist Contractors Committee in each area, and it has the same name as the AHA. It is made up of chemists who practise in the area and is consulted by the FPC on a wide range of matters relating to the pharmaceutical services. It also appoints members to the FPC, the Area Pharmaceutical Committee (which provides professional advice to the AHA), the Pharmaceutical Service Committee (which investigates complaints made against pharmacists), the Hours of Service Committee, and other FPC committees where pharmaceutical representation is required.

If CHCs are concerned about the provision of chemists' services in their district it may be very helpful to meet the Chairman and Secretary of the Area Chemist Contractors Committee. They should be able to provide a great deal of useful information about the way the services are being run and what can be done about any local problems. They can usually be contacted at the same address as the Family Practitioner Committee.

Useful References

Circular HRC (74) 9 issued in February 1974 called Local Advisory Committees explains in detail the functions and constitutions of the Area Chemist Contractors Committee and the Area Pharmaceutical Committee.

Circular HRC (74) 20 issued in March 1974 called General Practice Pharmacy Services summarises the arrangements for providing NHS pharmaceutical services and points out some aspects of the regulations governing the work of chemists.

PRESS CUTTINGS

MRS CASTLE'S STATEMENT ON 'DEMOCRACY IN THE NATIONAL HEALTH SERVICE'

Mrs Barbara Castle made a detailed speech about the NHS on July 11th 1975, and in it she announced that, following representations that had been received on the proposals contained in the consultation paper issued in May 1974, she had decided that CHCs would be entitled to send one of their members to attend meetings of their AHAs, with speaking but not with voting rights. She also stated that the number of local authority members on Area and Regional Health Authorities should be increased to one-third of the total. She had further made provision for the appointment of two members to the AHAs and RHAs drawn from those working in the NHS other than doctors or nurses.
(See DHSS letter of 6th August to all CHC Chairmen.)

MORE PEOPLE TO GET HEARING AIDS

Mr Alf Morris has announced that from September 1st 1975, people who are hard of hearing and are in employment or receiving education may obtain a behind-the-ear hearing aid on the NHS. (However, not all hearing aid centres will be able to issue these immediately.) Those priority groups of the hard of hearing who may now obtain behind-the-ear aids on the NHS are:-

(a) workers and students,
(b) war pensioners requiring aids for accepted disabilities,
(c) mothers with young children under the age of 5 years,
(d) children and young people up to the age of 18 (21 if still receiving full-time education,
(e) people whose head-worn aids have been replaced by body-worn models on leaving school,
(f) people with an exceptional medical need not already included in these groups, and
(g) people with an additional severe handicap such as blindness.

HEALTH SERVICES IN SCHOOLS

by John Churchill, *Secretary, West Somerset CHC*

West Somerset CHC has an ongoing programme for visiting schools, so that it can see what facilities exist for medical and dental treatment of school children. Health services in schools are provided through the collaboration of the AHA and the Local Education Authority (the LEA providing the rooms, etc., while the AHA organises the clinical staff). It is therefore important to cooperate with both authorities in arranging these visits and presenting reports and West Somerset CHC has established the following procedure:

1. A visiting team from the CHC has the right to visit any school or any part of a school.

2. The Chief Education Officer arranges each visit (the date being set by the CHC) so that he can explain to the School Governors and the Head Teacher the work of the CHC and their reason for the visit.

3. The CHC's visiting team met the DCP before any visit commenced to establish the *pattern and content of school medical examinations.*

4. During the visit, representatives of the School Governors and the Head Teacher will meet the visiting team.

5. The Education Department and the AHA (or DMT, if appropriate) are asked for their comments on the visiting team's report so that these may be considered with the *report at a meeting of the full* CHC.

6. The report may include observations about relevant factors (e.g. toilets and changing facilities) even if these are not a direct NHS responsibility.

7. Medical Officers working for the school health service may be asked to suggest schools which the CHC may visit, particularly those that are known to have some problems.

Almost 30 schools have been visited to date using this procedure, and the AHA has, as a result of the CHC's reports, initiated negotiations between the AHA and Education Department staff so that guidelines for improved standards of provision for school medical examinations can be worked out.

Editor's Note

Circular HRC (74) 5 may be a useful document for CHCs to see if they are investigating *school health services. It is quite a comprehensive summary of the* AHA's responsibilities on this area. The section on school health services explains the purpose of providing medical and dental inspections and treatment, and includes details of ophthalmic services and arrangements for the supply of hearing aids, and for medical services connected with the education of handicapped children.

BOOK REVIEWS

GOING HOME ? THE CARE OF ELDERLY PATIENTS AFTER DISCHARGE FROM HOSPITAL
Report on the Continuing Care Project, Age Concern Liverpool, 1975
(Available from Age Concern Liverpool, Liverpool Old People's Welfare Council, 6 Stanley Street, Liverpool L1 6AF. Price £1 excluding postage.)

This concise and readable booklet describes a project carried out in Liverpool in 1974 to discover how the full range of voluntary and statutory services could be used to improve the care of old people after being discharged from hospital. It started with an analysis of the health and social conditions of the elderly population in Liverpool and assessed the organisation and work of the available aftercare services. It reported that these services were not properly coordinated, that each service was not clear about the limits of its responsibilities and that the services were not designed with the needs of the elderly in mind.

The project therefore then turned its attention towards possible remedies that would involve finding the most effective way of mobilising current resources. Several ideas were tested using the existing hospital staff and administrative procedures, but none of them was found to be suitable. The chosen solution involved using a member of the research team as an "aftercare organiser". Selected wards in 2 Liverpool hospitals cooperated over a three-month period in which 311 elderly patients had their discharge coordinated by this team member. The work involved contacting various outside agencies including social work, home help and housing departments, local DHSS offices, community nursing staff, GPs, ambulance service organisers and several voluntary bodies, so that specific help for each patient about to be discharged could be arranged.

This experiment worked successfully, and certain lessons were learned as a result, e.g. that some services take a longer time to arrange if their provision has to be preceded by assessment of the patient; and, the fewer the number of people involved in making a referral, the more likely it is that the right action will be carried out. The project's conclusion was that the appointment of a permanent "aftercare organiser" in all hospitals caring for patients over 60 would be desirable because the discharge of each individual can then become the responsibility of one person who is particularly familiar with the way the appropriate health and social services work, and can therefore ensure that the best efforts are made to organise their provision.

Finally, the report sets out a description of the qualifications and responsibilities of such an "aftercare organiser", and a crude financial estimate of costs and benefits which would result from the appointment. An important point that is emphasised concerns the training of existing professional staff involved in the care of the elderly. "Aftercare organisers" alone will not be able to improve matters - they need the understanding and cooperation of hospital and outside agency staff, and a development of the view that aftercare is a positive aspect of the total healing process.

"THEY GET THIS TRAINING BUT THEY DON'T REALLY KNOW HOW YOU FEEL"
by Mervyn Fox. (Action Research for the Crippled Child, Vincent House, 1 Springfield Rd., Horsham, Sussex, RH12 2PN, £1.25)

There are many ways of finding out the good and bad points of a particular aspect of the health service. One method which is well within the reach of CHCs and can provide much more useful information than any number of statistics is simply to ask the people who use that branch of the health service to talk about their experience of it. This is what Mervyn Fox has done in his book, which contains the transcripts of nine of the many interviews he conducted with the parents of handicapped children.

Dr. Fox is Principal Physician (Child Health) with Camden and Islington AHA, but the people he interviewed did not know he was a doctor - apart from one who told him "You don't really act like a doctor do you ? You listen ..." They talked freely about their problems, and the overall impression gained is of the tremendous amount of insensitivity that exists in the health service. One mother was told "Oh well, don't worry too much, he probably won't survive beyond seven". The overwhelming need felt by the parents was for information - for someone to give them a simple explanation of terms like "hypothyroidism", "microcephaly", and "cerebral palsy" and an idea of how they might expect their child to progress.

Most of the parents had not found much help from the expected sources. Their contact with Health Visitors was infrequent or non-existent, and the majority of them did not know that a Health Visitor's training includes nursing. School doctors were not found to be a source of help - parents often did not know if their child had seen the school doctor or what his recommendations were. A recurring problem the parents faced involved trying to get the professionals to agree that there was a problem.

The book is compelling reading - parents' stories are told in their own words, with some brief scene-setting from Dr. Fox, who hardly intrudes on the interviews at all. In his conclusion he examines the incidence of marital breakdown and mental illness among the families of handicapped children. Such families are at risk, and Dr. Fox stresses that professionals must take care to try to see the whole of the picture and to work harmoniously with each other, "within a flexible plan offering each family access to a single co-ordinating individual aware of each and every facet of medical, educational, and social care, aware of the functioning of the particular family internally and in the community, and able to offer not just a crisis intervention service but what so many parents have expressed as their prime need - 'a continuity of competent and compassionate contact' orientated to prevention and dedicated to communication."