CHC NEWS
For Community Health Councils
June 1980 No 55

Consumer views improve planning

CHCs are making a "worthwhile contribution to health care planning", says a report on district planning teams in England* which has been sent to the DHSS as a comment on *Patients first*. District planning teams (DPTs) used to be called health care planning teams. Almost all districts or single district areas (SDAs) have a range of teams which consider health services for specific groups of NHS users — the elderly, children, the disabled, and so on. Teams are multi-disciplinary and sometimes include representatives from voluntary bodies. Their recommendations are fed into the district management team's consideration of the district plan.

The researchers questioned individual DPTs, districts and SDAs as well as CHCs. Just over half (51%) of the districts and SDAs who replied said they favoured a CHC presence on their DPTs.

the teams without a CHC representative recorded satisfaction with their effectiveness as a planning team. When teams did include a representative from the CHC, this level of satisfaction rose to 84%.

CHCs were represented in some way (full member, observer or co-opted member) on 49% of the DPTs.

The researchers conclude that "if representatives or spokesmen for the local community are to be involved in the planning process, CHCs are a convenient and fairly economical way of obtaining such involvement".

** Comments on the contributions of community health councils to health care planning* **by Kate Murray-Sykes, William Kearns and Penelope Mullen, Department of Community Medicine, Kensington-Chelsea-Westminster NW District, 11 South Wharf Road, London W2.**

● Further support for CHCs has come from the Institute of Health Service Administrators in its comments on *Patients first*. The Institute believes that, on balance, CHCs should continue, though it considers that "their role needs to be more carefully and precisely defined in terms of representing local user interests". For more *Patients first* comments about CHCs, see page three.

PREVENTION IN CHILD HEALTH

Photo: Raissa Page

The Government has published its views *on prevention in the child health services* — but has decided not to circulate them to interested parties. A DHSS paper (1) is available on request, but copies will not be sent automatically to CHCs, health authorities or child health professionals.

The paper outlines the "main objectives and content" of preventive child health services in the light of Government decisions (2) on the Court report. "Every effort should be made to maximise the take-up of ante-natal services", the paper says. Families who move frequently and *do not register with a GP often live in* "adverse environments" such as the inner city, and need proportionately more support. "Imagination and ingenuity" may be needed to introduce them to GPs, health visitors and clinics. Mobile clinics are one possibility, and where there are minority ethnic groups clinic staff should have knowledge of the appropriate languages and cultures.

Parents should be invited to attend school medical examinations and encouraged to contribute to their child's assessment. What they say should be "treated with respect", and any worries they have should be followed up. Every school should have a named school doctor and nurse, and "the level of staffing in the school dental service should enable authorities to discharge their statutory responsibilities."

Health authorities should discuss health surveillance arrangements with local authorities, through joint consultative committees or joint care planning teams. Where extra resources are needed to provide the surveillance suggested, they "should be concentrated on areas of greatest need; if necessary, at the expense of more favoured areas".

1. *Prevention in the child health services*, DHSS, February 1980. Available from DHSS, Health Publications Section, Archives Registry, Scholefield Mill, Brunswick Street, Nelson, Lancs BB9 0HU.
2. See circular HC(78)5.

Consultation on hospitals

A consultative paper on *Hospital services: The future pattern of hospital provision in England* has just been published by the DHSS. Details will appear in next month's *CHC NEWS*.

CHCs to get HAS summary reports

CHCs will in future be sent summaries of reports produced by the Health Advisory Service (HAS). At present CHCs have to rely on health authorities for their information about HAS reports.

The HAS is the body which visits health service establishments and advises health and social service authorities of its findings. These authorities will see the summaries before they are sent to CHCs, mainly to check on matters of fact. Authorities' comments will be considered but they will not have an automatic right to make amendments.

INSIDE....

Your letters

Heard but not seen

Michael Quinton, Secretary, Bristol CHC

A member representing Bristol CHC as an observer on Avon AHA had cause to ask a question recently during discussion of a major capital development. This elicited what we believe to have been a very significant piece of information. Neither the question nor the answer was referred to in the minutes. When this omission was questioned at the next meeting, the area administrator propounded the rule that, "contributions made by CHC members at AHA meetings are not minuted because they are only observers".

All the Avon CHCs have discussed this and we would all be interested to know whether this philosophy is applied in other areas. If it is, or has been, has anyone pursued the matter to a higher authority?

What do you think a kidney card means?

Nuala Kent, Secretary, Wirral Northern CHC

A member of our CHC has suggested that carrying a kidney card may itself indicate a willingness to donate other parts of the body. This view was debated at some lengths in our CHC and we resolved to canvas the views of other CHCs on this matter.

Discrimination?

Jean Franks, Secretary, Mid-Surrey CHC

I refer to the summarised report of the Association of CHCs' *Working group on the role and development of CHCs (CHC NEWS 51* page six). I object most strongly to the recommendation that CHC secretaries "should be appointed part-way up their scale if they have had relevant experience outside the NHS".

This not only indicates a complete lack of knowledge of the conditions applying to administrative and clerical posts within the NHS, and of the repercussions that such a recommendation would have, but positively discriminates against candidates already employed in the NHS. I am sending a copy of this letter to Miss A Maddocks, Organising Officer, Health Staffs, NALGO.

Helping the blind on CHCs ....

Michael Mannall, Secretary, Hounslow CHC

Recently the London Borough of Hounslow appointed to this CHC a member who is almost totally blind. This has given us some problems, in that this member finds some difficulty in keeping up with the large amount of necessary paperwork. We have arranged for the Royal National Institute for the Blind to provide a certain amount of Braille translation. I have written to the DHSS seeking help with Braille copies of Departmental documents, and I am writing to various other organisations to see what further help might be forthcoming. Have other CHCs, or Scottish LHCs, had similar problems? If so, could they let us know what success they have had in giving their disabled members the necessary access to the written word?

.... and in the community

Mrs J B Jervis, Member, Rochdale CHC

I would be interested to know if any other CHCs, or individual members of CHCs, have found problems in their areas in respect of letter-writing for blind people. Have any local schemes been adopted to overcome these problems?

The case for more day centres

Fred Webster, Member, Darlington CHC

I have just completed my first three-year stint on Darlington CHC, as a representative of the local Trades Council. On joining the CHC at the age of 64, having been an active trades unionist for 47 years, I decided to give it my all!

By request of the CHC I have visited every hospital and old people's home in the district. I've also attended many seminars, to increase my understanding of the issues involved. All the time two points keep coming into discussions: economic cutbacks, and the need to keep people in the community longer. Hospitals for geriatrics are expensive, and it is also expensive to keep elderly people in full-time residential care.

All the hospitals and homes in our district have long waiting lists. We have just had a tower-block, six-floor hospital foisted upon us, and all the administrators could do for our geriatrics was to stick them on the sixth floor. I shudder at this — some of those old people could be up there in the clouds for the next thirty years!

On the old people's homes, I cannot understand why the planners have not allowed for day centres to be built into their design, so that the large numbers of elderly people living alone in the areas around these homes could go in for day care only. At least they would then be in the warm, and get a chat, a cup of tea and a midday meal The meals on wheels service could then divert some meals to these day centres, saving themselves some of the bother of running around the houses. Maybe more cost could be saved if some of the social services department's visitors put away their cars and worked in day centres instead.

People living all alone, with little help from relatives, do deteriorate much quicker into senile dementia. I learned that at a seminar! Day centres might keep them fresh a few years longer, and would be a fairer way of sharing the limited cake available.

Time to legalise euthanasia?

Mrs E M Lark, 166 Walton Road, Walton-on-Naze, Essex.

With so much pressure on the NHS to keep a strict control on its finances, may I suggest that *now* is the time to consider legalising voluntary euthanasia.

By this I mean that those of us who wish to should be allowed to decide on euthanasia while we are still sound of mind, if not of limb. When we are pronounced beyond the pale of recovery — incapable of leading a rational existence, and perhaps suffering distress and discomfort — we would then be allowed whatever quantity of drugs was necessary for us to pass on reasonably comfortably.

Preferably this should take place in our own homes, but people in hospital should also have the right to decline the prolongation of a limited existence. This seems to me to be the rational way out of the hospital's dilemma.

As an elderly person living in an area with many elderly residents, I feel strongly that a consensus of opinion should be taken on this. Rational thinking is a necessity in this day and age, when it is becoming extremely difficult for the hospital and social services to give adequate attention to long-term suffering.

Let's not cloud the issue with out-dated Christian ethics. We want down-to-earth thinking on the subject — and where better for it to start than in CHCs?

We welcome letters and other contributions but we would like letters to be as short as possible. We reserve the right to shorten any contribution.

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Comment

The Health Education Council recently recruited Superman to help with its anti-smoking posters — and the choice had a wistful kind of logic about it. The HEC could be forgiven for thinking that it needs Superpowers to counter the £80m the tobacco industry spends each year in Britain on advertising and promotion. Between them the HEC and Action on Smoking and Health get about £1½m annually to run their anti-smoking campaigns.

Superman's amazing X-ray vision would also be useful, for penetrating the protracted and confidential negotiations now going on between Government and the tobacco industry. The existing "voluntary agreement" — covering advertising, promotion and other aspects of tobacco use — should have expired early in March, but is being extended while the talks continue.

The situation is depressingly easy to summarise. If tobacco was a new product it would never be allowed onto the market. Every year in Britain, 50,000 people die early and an estimated 50 million working days are lost because of smoking. But the industry keeps about 36,000 people in work and provides the Government with some £2500m annually in taxes — roughly ⅓ of the total cost of the NHS.

Policy on smoking is decided by the Government as a whole, not just by the DHSS — and it is the financial and employment arguments which impress the Treasury and the Departments of Industry, Employment and Trade. So the industry can still maintain its cynical pretence that there is no scientific proof of smoking damage, and continue to veto the Government's preferred health warning: "CIGARETTES CAUSE LUNG CANCER, BRONCHITIS AND HEART DISEASE".

The economic arguments have held back anti-smoking progress for a whole decade, yet there are now encouraging signs of change. In a recent ASH survey, 70% of people were in favour of the right to work in a smoke-free environment, and 81% supported non-smoking areas in cafes and restaurants. Another development is hard evidence (1) that the lungs of non-smokers are definitely damaged by working and living in smoky air.

Strong anti-smoking policies may not even cost the Government money. In 1977, two economists published a "policy package" (2) aimed at reducing smoking by 40% by increasing cigarette tax, reducing advertising and setting up a continuous anti-smoking campaign. Tax revenue would actually rise, they calculate, and savings on sickness benefit would produce an overall reduction in expenditure.

So the outcome of the negotiations is crucial. Junior health minister Sir George Young, in particular, has put his reputation on the line by saying that he admires countries which have banned tobacco advertising altogether. The other thing that should certainly be stopped is the obscene wooing of sport and the arts by tobacco firms — there are plenty of other sponsors willing to take their place.

In the real world it is the Government which has the Superpowers, and it remains to be seen whether Patrick Jenkin's "determination to make progress" can force through anti-smoking policies based firmly on a concern for health.

1. *New England Journal of Medicine, 27 March 1980, pages 720-3.*
2. *The Lancet,* 3 Sept. 1977, pp 492-5.

Health News

ACHCEW launches campaign against new prescription charges

The Budget proposals for new NHS charges — details of which appeared on *CHC NEWS'* front page last month — have provoked bitter criticism from the Association of CHCs. According to the association:

The December prescription charge increase "will cause a great deal of misery if it is allowed to go through";

The ending of exemption from dental charges for people aged 17-20 is "likely to be damaging to the dental health of the next generation of adults", and in the long-run will not be cost-effective;

The proposed £2 sight-test charge "breaches the accepted principle of free public access" to family practitioner services, and is "indefensible" because more disease will go undetected if fewer people have their eyes examined.

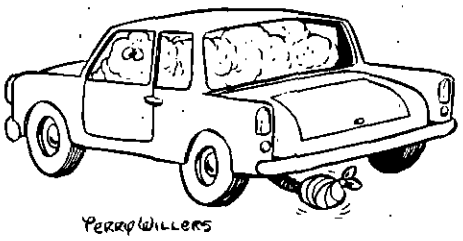
On dental and optical charges ACHCEW has written to Mrs Thatcher, Chancellor Geoffrey Howe and Patrick Jenkin. Mr Jenkin has also been sent a separate letter on prescription charges, which states that ACHCEW is opposed in principle to such charges, "believing that no financial obstacle should be placed between doctor and patient in relation to what the doctor judges to be the patient's need for medication".

ACHCEW is urging the Government to drop the proposal for a £1 prescription charge; to reduce the present charge from 70p to 45p (the pre-April 1980 level); to give more publicity to the availability of prepayment certificates (ie "season tickets"); to make the certificates cheaper; and to increase the range of exemptions for particular diseases.

Since ACHCEW'S initiative the Government has withdrawn its proposal to introduce a £2 sight-test charge. Dr Vaughan told the Commons that the £11m pa would be raised instead by increasing charges for other ophthalmic services.

Lawther's "slippery language"

The Lawther report on *Lead and health* has been attacked for its "worryingly slippery language" and its "contradictions, evasions and reservations"; in the latest newsletter from the Campaign Against Lead in Petrol*.



CALIP points out that while there may not yet be "convincing evidence of deleterious effects" of low lead levels on children's intelligence, it is misleading to infer that doubt only remains about higher levels of lead pollution. Indeed, anyone with the patience to read Lawther line by line can also unearth the remark that recent research is "highly suggestive" of a health risk at low lead levels (see *CHC NEWS 54*, page three).

Another of CALIP's criticisms is that the report contains "no rational attempt to quantify the importance of, or the source of, lead in dust, and no proper discussion of the extent to which this fallout from petrol lead gets into children from sucked fingers and onto food".

Lawther calculates that city children get only 3-10% of their body lead from air, but CALIP believes that this "seriously under-rates" the importance of lead in air. One estimate suggests that on average two-year-old city children get 54% of their body lead from air — 5% direct by breathing, 27% via finger-sucking and 22% through "fallout" onto food.

**CALIP Newsletter No 7*, £1 for four issues, from 68 Dora Road, London SW19.

Abolish CHCs, says health authorities' association

The National Association of Health Authorities in England and Wales (NAHA) wants CHCs to be abolished. NAHA has given a qualified welcome to the Government's consultative paper on the NHS, *Patients first*, although there are doubts about the rigidity of the future

Continued on next page

Health News

Continued from previous page

structure and about the capacity of the NHS to save £30m. The association says that CHCs' performance has been erratic, they have delayed consultations and have assumed a "quasi-management role" through their participation in the planning system.

If the Government does decide to preserve CHCs, NAHA warns that it will press strongly for their powers to be curtailed. It says that councils should lose their power to have closure proposals referred to the Secretary of State. The association's written comments are a remarkable contrast to what was said at the NAHA conference on *Patients first,* when not one voice was raised against CHCs.

The Outer Circle Policy Unit says that the Government's proposals for change will fail. The unit, an independent policy study group of academics and health administrators, says the changes will strengthen the power of the regional health authorities (RHAs) and will lead to widespread disruption. Outer Circle believes that CHCs should stay, should be given observer status on family practitioner committees and closer information links with community physicians. *Health first,* £1.50 plus 21p post, from Outer Circle Policy Unit, 4 Cambridge Terrace, London NW1 4JL.

The Unit for the Study of Health Policy supports the argument that CHCs' functions cannot be assumed by members of health authorities and it wants the CHCs to be strengthened. The Volunteer Centre — the national advisory agency on volunteers — has offered CHCs its "fullest support ... they are in real contact with their local voluntary sector".

The National Council for Voluntary Organisations (formerly National Council for Social Service) gives strong support to CHCs, but wants voluntary organisation representation on the councils to be increased to one half. The National Consumer Council says CHCs do a good job "and could do an even better one if they had a statutory right to consultation on a wide range of issues and not simply on hospital closures". CHCs also win approval from NALGO, the union which represents many health service administrators.

There is disagreement among the RHAs about the value of CHCs when new district health authorities have been created. Seven have indicated support for CHCs and five are divided on the issue. One has kept its views secret and another (NW Thames) thinks that CHCs will not be needed.

Speeding up drug tests

Secretary of State Patrick Jenkin has announced plans to change the application system for companies wishing to launch *clinical trials* of new drugs, by introducing what he calls a "negative clearance system". The Government hopes that this will allow new medicines to come onto the market more quickly.

Clinical trials are tests of new drugs on patients, ie people suffering from the condition the medicine is intended to treat. Only after testing drugs on animals, and then on healthy human volunteers, may a drug firm apply to the Committee on the Safety of Medicines (CSM) for a *clinical trial certificate* (CTC). The application must be accompanied by detailed reports of all the tests so far, as well as full details of the proposed experiments on patients. Without a CTC the firm cannot conduct clinical trials. At present the CSM reportedly takes between three and six months to consider all this evidence and make a decision.

The Government's new scheme would permit a drug firm to supply the CSM only with summarised accounts of research so far and to apply for *exemption* from the need for a CTC, supporting its application with details of the proposed trials and with only *summarised accounts* of the research it had done so far. It would then be up to the CSM to respond quickly — within about five weeks. Unless the CSM notified the firm that it suspected that the proposed clinical trials could involve an unacceptable hazard for patients, the exemption would be granted. Firms would still be required to report any adverse reactions in clinical trials, and the CSM could withdraw its exemption at any time.

CHCs and the Association of CHCs have not been included among the consumer bodies being formally consulted on the proposals. But copies of the consultation letter (number MLX 125) are available from Mrs Harrison, Room 1427, DHSS Medicines Division, Market Towers, 1 Nine Elms Lane, London SW8 5NQ. Comments should reach Mrs Harrison by 16 June.

Rural dispensing

The Government will implement the main recommendation of the Clothier Committee which studied problems of dispensing medicine to people in rural areas. The Clothier Committee called for a national committee to consider applications by GPs or pharmacists who wish to set up dispensaries in country districts. At present patients who live more than a mile — as the crow flies — from a pharmacy may have medicine dispensed by their GPs. There has been a long-standing conflict between chemists and GPs about this and patients have been the losers. Now a body independent of the DHSS will regulate arrangements. Three pharmacists and three doctors will be on the committee. Lay representation will be provided by three people to be appointed by the Secretary of State, and there will also be a lay chairman.

Shifting the financial burden of prescribing to FPCs

In an effort to circumvent cash limits some hospitals are sending outpatients to their GPs for prescriptions rather than prescribing for them at the hospital. The practice has arisen because items on prescriptions issued by GPs come out of the family practitioner services budget, which is open-ended, whereas those dispensed by hospital pharmacies come out of the cash-limited hospital services budget.

GPs and CHCs in areas where this is happening have made strong protests about both the inconvenience to patients who have to make special journeys to their GPs, and the overall higher cost to the NHS of an increase in individual items dispensed by retail chemists. Although it is very difficult to make cost comparisons between the different systems of hospital and retail chemist prescribing, it is claimed that hospital pharmacies can dispense drugs more cheaply than retail chemists as they obtain them in bulk and supply them to outpatients for longer periods and therefore in larger quantities.

DHSS permanent secretary Sir Patrick Nairne states in a letter circulated to all AHAs and RHAs that the practice of shifting the onus of prescribing to the GP is "inappropriate". He cites circular HN (76)69, which confirmed that the duty of prescribing for patients rests with the doctor who has clinical responsibility for their treatment. This includes hospital doctors treating outpatients. Health authorities are reminded that their funds are allocated on the assumption that the guidance in the circular is followed. If it is not, Sir Patrick warns that there will have to be a "review of the basis of allocation".

Reducing state spending on the sick

For the first eight weeks of a worker's illness state sickness benefit is to be replaced by flat-rate sick pay out of employers' pockets. Proposals laid out in a Government Green Paper* have attracted unfavourable reactions from medical bodies, trade unions and employers' organisations. The Government would like to abolish entitlement to sick payments during the first three days of illness, to reduce employers' national insurance contributions by 0.5% and see low-earners paid less than the suggested £30 minimum rate of sick pay.

Social security minister Reg Prentice is seeking views on whether after two weeks of sickness there should be a higher rate of pay for employees with children and whether sick pay schemes should be able to get advice from the DHSS Regional Medical Service concerning proof of individuals' fitness for work. The Government says that many people are at present better off claiming sickness benefits than when they are working and its proposals aim to make sickness money taxable and cut the number of civil servants. It admits that families with children will be worse off. Comments to the DHSS by 30 September.

**Income during initial sickness: a new strategy* Cmnd. 7864 (HMSO £2).

CHCs' VIEWS ABOUT DENTAL SERVICES

by Aubrey Sheiham,
Department of Community Dental Health
The London Hospital Medical College

Public concern about dental services has been growing over the past few years. It stems from greater awareness about preventing dental disease, together with rises in dental charges and the growth of *private dentistry.*

CHCs have found that a disproportionate number of the enquiries and complaints they receive are about dental services. The complaints are so widespread and varied that the Association of CHCs was *prompted to obtain funds from* the Nuffield Provincial Hospitals Trust and to commission a detailed study* of the views of CHCs about dental services.

All 228 CHCs and those voluntary groups dealing with health services were sent *requests for their views, and* information about dental queries which they had dealt with. The response rate from CHCs was 85%. Over one in five CHCs sent more than a hundred pages of material, and we are very grateful for the labour and time given by these CHCs and all those voluntary bodies who sent us material.

It is not possible to measure what the public actually feel about dental services from this kind of study. What can be assessed is the range and extent of problems which CHCs and voluntary groups come across and the effectiveness of the proposed solutions.

Rather than an extreme or desperate situation, the survey revealed a widespread but low level of complaints and enquiries which appear to have been exacerbated by the trend towards private dental practice over the last few years.

About one third of CHCs *who responded indicated that* they were satisfied with dental services, but concern about dental services is as widespread in the north as in the south of England. The issues that concerned CHCs can be grouped into six areas. They *are:*

- Problems in finding an NHS dentist;
- Difficulties in getting emergency treatment;
- Confusion about the nature of the dentist/patient contract, pressure to accept private treatment, confusion about charges;
- Complaints about the quality of treatment, especially that involving dentures, and problems with the complaints procedure;
- *Particular* problems facing those with special needs;
- Concern about preventive measures.

To widen the availability of NHS dental services, CHCs recommend that the experimental salary-plus-bonus schemes be extended to more areas, and that a more favourable distribution of dentists willing to do NHS work would be achieved by *extending the designated area* scheme which exists for GPs.

The problem of getting emergency dental services should be alleviated by the recent agreement on sessional fees between the DHSS and the British Dental Association (DHSS circular HN(FP)(79)50). CHCs should ensure that emergency schemes are implemented, publicised and monitored (see *CHC NEWS 51*, page one).

To reduce confusion about the dentist/patient contract, the public should be made more aware that they have *no right* to dentistry, privately or on the NHS. The current confusion about dental charges *and whether or not people are* getting NHS treatment could be reduced if circulars were available which clearly spelt out the situation.

The form which patients have to sign (FP17) should be improved to make it comprehenible to a wider range of people. Dentists should discuss alternative treatments and explain that if people complete form FP18 they can pay extra for more expensive dentistry than the NHS otherwise provides for, and still remain NHS patients.

Charges for dental treatment should be reduced or preferably abolished. Other methods of remunerating the dentist should be introduced. The present fee-for-item system *encourages repair rather than* prevention.

Problems about dentures can be improved by insisting that all dental laboratories providing NHS work are registered with the Family Practitioner Committee (FPC). That will remove the laboratory expenses from the dentist and improve the quality of laboratory work.

The complaints procedure needs some radical changes. Suggested changes include the appointment of completely independent chairpersons and clerks at service committee hearings set up by FPCs to investigate complaints. And as these procedures are frequently seen as inadequate, lodging a complaint against the dentist with the General Dental Council (37 Wimpole Street, London, W1) may have more effect.

There are a number of groups who are particularly disadvantaged by the present organisation of dental services — the disabled, young children, the elderly and patients in long-stay hospitals. Their dental problems can be reduced by expanding the *hospital and community dental* services. Dentists in these services should spend more time treating these groups and liaise with those general dental practitioners who do accept certain categories of disabled people.

Because only very limited resources are allocated for providing the public with knowledge about dental services and dental health education, CHCs often have to cope with demands for information. The public should *have access to an adequate* prospectus of the services dentists offer, explaining that all dental materials used in the NHS have to conform to accepted standards. The public will then be in a better position to question the ethics of dentists who offer two standards of treatment — NHS and private.

The two major dental diseases, dental decay and *periodontal disease (gum* disease), are almost entirely preventable. Why then are they not prevented? Because most of the resources have been allocated to treatment, and preventive efforts have concentrated on water *fluoridation. Insufficient* emphasis has been placed on the causes of dental diseases — sugars and bacterial plaque — and on the use of fluoride tablets. CHCs should press their area health authorities to allocate more resources to *prevention, and work with* health education officers and community dental officers to provide information on prevention.

The survey has highlighted some of the shortcomings of the dental system and the changes which CHCs would like to implement. Some of the changes will require structural alterations to the system. Other reforms can be achieved by the concerted efforts of groups concerned about dental services, including CHCs and ACHCEW.

* *The user's views of dental services,* by T Lobstein and A Sheiham. Report to ACHCEW, May 1980.

Terms of service for...

PHARMACISTS

In 1978, 307 million National Health Service prescriptions were dispensed in England and Wales. Some were dispensed by pharmacists working in hospitals. Most of the remainder were supplied over the counter in chemists' shops. This article explains the terms of service for pharmacists who dispense prescriptions in the *NHS general pharmaceutical service* — ie in retail chemists' shops. The basic rules are set out in Schedule 4 of Statutory Instrument 1974 No 160, The NHS (General Medical and Pharmaceutical Services) Regulations 1974.

Everyone who gets NHS treatment from a GP or a dentist is entitled to medicines and certain other items (eg surgical appliances, contraceptives) as part of the treatment. Almost every chemists' shop dispenses NHS prescriptions. A patient takes the prescription form to a chemist and may pay the NHS prescription charge (now 70p per item). "With reasonable promptness", says the Statutory Instrument, the chemist must dispense the medicine, in a "suitable container".

Every chemist who wishes to participate in the NHS pharmaceutical services applies to sign a contract with the Family Practitioner Committee (FPC). (Chemist in this context might mean a company, such as Boots, or an individual with a private business.) The chemist is then included on the FPC's *pharmaceutical list.* Chemists are not employed by the FPC, they are independent contractors. The list gives their names and business addresses, as well as the hours during which they have contracted to keep the shop open.

The contract also requires the chemist to take part in the out-of-hours service. When the shop is closed, it must display a notice telling the public where emergency prescriptions are being dispensed.

Like other professionals, chemists have a code of conduct and this is published by the Pharmaceutical Society of Great Britain. The Society has a role similar to the General Medical Council for doctors, or the General Dental Council — it registers qualified pharmacists, as they are properly called, and it regulates the profession.

Like any other shopkeeper, the chemist orders and pays for stocks of medicines from drug companies and wholesalers. But every month the chemist sends all the prescription forms to the national Prescription Pricing Authority. When the PPA has calculated the cost of the dispensed ingredients, an allowance for containers, for overhead costs and for a dispensing fee, it tells the local FPC how much to pay the chemist for the month's work. The dispensing fee and the other allowances are negotiated with the DHSS by the chemists' representative body, the Pharmaceutical Services Negotiating Committee (PSNC).

There is little the FPC can do about the steadily shrinking numbers of chemists' shops and their distribution. The PSNC has succeeded in bargaining for a special scale of payments for *essential small pharmacies* — those which dispense less than 27,500 prescriptions each year and are more than 2 kilometres from the nearest pharmacy. And the recently announced *rural dispensing committee* will help to regulate the rivalry between chemists and dispensing doctors in country areas.

Complaints that pharmacists are in breach of their terms of service should be made to the FPC. The FPC's *pharmaceutical services committee* is empowered to investigate. Recent cases of complaints reported in the journal *Family practitioner services* include unethical advertising, errors in dispensing, and altering a prescription without the prescribing doctor's knowledge. However, a pharmacist is authorised to use professional judgement when a doctor (or dentist) has not set out a full prescription, and may in such a case dispense enough medicine for up to five day's treatment.

Another situation requiring the exercise of professional judgement is giving advice to patients. The Society's code of conduct lays down that a pharmacist should not discuss treatment in a way that may

OPTICIANS

Three types of professionals provide *general ophthalmic services* under the NHS. *Ophthalmic medical practitioners* (OMPs) are doctors qualified to test sight, and prescribe — but not supply and fit — glasses. OMPs are not allowed to prescribe any other form of treatment, so patients with eye conditions which need additional treatment must get it from their GP or the Hospital Eye Service.

Ophthalmic opticians (OOs) can test sight and prescribe glasses, but can also supply and fit them. *Dispensing opticians* (DOs) may only supply and fit — though good fitting is important if a prescription is to achieve the desired effect. OMPs and opticians often work together in premises called *medical eye centres.*

Opticians and OMPs are self-employed — they do NHS work on contract with their local Family Practitioner Committee (FPC), and are free to accept or refuse any patient. Unlike GPs they have no "list" of patients, and their commitment to NHS patients is limited to the particular sight test, or item of supply, replacement or repair, which has been agreed.

Opticians' *terms of service* when doing NHS work are set out in two Statutory Instruments (2). FPCs must maintain an *ophthalmic list,* giving the names, practice addresses and working hours of all OMPs, OOs, and DOs, contracted to do NHS work in their area.

NHS sight tests are free. The OMP or optician must examine with "proper care and attention", and will offer to prescribe new or replacement glasses if this seems necessary. The patient's GP will be notified if any other treatment seems desirable, or if it appears that glasses are "not likely to secure a satisfactory standard of vision". Patients who don't keep sight test appointments may have to pay a charge. Private sight tests are available, but any prescription subsequently issued is not valid for NHS glasses.

NHS prescriptions are valid for a year, and can be dispensed by any optician on the FPC's list — patients don't have to go back to the optician's where the prescription was issued. Currently NHS frames cost the patient between £1.84 and £9.27, and the full range is illustrated in the DHSS leaflet *Your sight and the NHS* (3). Opticians are not required to display the full range of NHS frames, though the DHSS says they should. Discussions with the profession about including this in the terms of service have been "put on ice" by the present Government.

NHS lenses may be fitted to private frames, provided they are the right shape, but private lenses may not be fitted to NHS frames. Patients must meet the whole cost of private frames or lenses — they are not allowed to "pay the difference". Contact lenses are not available on the NHS, unless a hospital consultant decides that they are clinically necessary.

Patients under 16 or still at school can get NHS *children's glasses* free, and help with NHS charges is available for people with low incomes. There is normally a charge for repairs to and replacement of NHS glasses, though patients can appeal on the grounds that this "was not necessitated by an act or omission" of theirs.

An article about GPs' terms of service appeared in the April issue of CHC NEWS, on page six. Dentists' terms of service were explained last month, on page eleven.

ASKING THE RIGHT QUESTIONS

WHY DO RESEARCH?

*by Susan Clayton**

CHCs are under threat of death, and in the debate on their strengths and weaknesses it may be useful to look at the effectiveness of some of the activities they perform. This article considers the value of research carried out by or on behalf of CHCs, to find out the views of patients on ways in which specific health services might be improved. The article is illustrated by examples drawn from research by the author for the Newcastle, South Tyneside and South West Cumbria CHCs.

What are the advantages of this kind of research? A major benefit is that—assuming the work is carried out competently — it enables the CHC to obtain a more balanced and extensive view of a service than that which would be obtained from talking to patients on hospital visits, and from the comments of patients who themselves approach the CHC. An unknown proportion of the latter group may have had very atypical experiences.

Secondly, research can be used to find out the general satisfaction of patients with particular services, and to explore the extent of specific problems which have been brought to the attention of the CHC. Problems might include such topics as the provision of special diets for hospital patients, the time spent waiting in out-patient clinics, and the availability of home confinements. Thus patients can be asked about their experiences of certain NHS services, and their views on the strengths and weaknesses of those services and ways in which they might be improved.

Asking for *strengths* can help to ensure that good things are not eliminated in the search for solutions to problems, and it also ensures that the final report reflects some of the positive aspects of the services under review. Asking patients for their ideas on improvements throws up many useful points, but it may also be necessary to ask patients what they dislike about the care they received, because often patients have experienced problems but are unable to see any solutions.

Suggestions for change

The third major advantage is that such research may provide useful information for decision-making. The staff who have power to make decisions affecting the care of patients usually desire to take patients' needs into account, but they often have limited and incomplete knowledge of these needs. There is also a danger that staff may "filter" patients' needs through their own perspective on the service. In addition, many of the issues raised by patients are likely to involve their social and emotional needs, and although staff are becoming increasingly aware of the influence of these factors on the progress of medical treatment they may not yet be as knowledgeable in these areas as they would wish.

Some criticisms and suggestions for changes raised by patients will of course already be well known to staff, and in some of these cases there may only be very long-term solutions, but often CHC research can *speed up* the introduction of improved styles of care. For example, although staff may know of the existence of problems, they may not have been aware of just how important these issues were to patients, or of the numbers affected. Some research findings, on the other hand, are likely to come as a surprise to staff: there may be few complaints about areas which staff see as unsatisfactory, or patients may be critical of aspects of care which staff had thought were catered for satisfactorily, or the research may raise points with which staff are completely unfamiliar.

There are many problems in conducting any research involving social questions, but a major problem for CHCs is finding people with the skills, enthusiasm and time to carry out this activity. The workload of most CHC secretaries is such that they do not have time to run research projects themselves, yet little money is available for CHCs to pay for research to be carried out. Thus they usually rely on volunteers to do most of their research work, supported by the secretary and perhaps overseen by an experienced researcher.

However, even where people can be found who are willing to do the work, they may only be willing to investigate the specific areas of care which are of interest to them, or of which they have some prior knowlege. Unfortunately these do not always coincide with the areas of most concern to the CHC. It may, for example, be difficult to find people with the skills and interests to investigate urology and gynaecology clinics, or services for mentally handicapped adults suffering psychiatric disorders. In addition CHCs may find themselves in a "Catch 22" situation, for anyone willing to carry out the research is likely to be involved with the CHC by virtue of their membership of a political party or consumer pressure group. In the eyes of many medical personnel, this may make them biased and unsuitable to do the research.

Interpreting the results

It may also be difficult to persuade people to carry out research with the care which is essential if the findings and conclusions are to be supported by the majority of CHC members, and taken seriously by the health service personnel who finally receive the report. The design and administration of research is a complex process, and the danger is that unless the research adheres closely to well-established practice — for example in the way in which the group of patients to be interviewed is selected — the whole research project may be said to be "invalid" by its opponents and its findings ignored.

Even where research is prepared and administered as objectively as possible the interpretation of results is always difficult, as it often involves a number of subjective judgements. What does it mean, for instance, if 70% of patients are satisfied with an aspect of a service? Is that a good or a bad result? CHC members have to use their own judgement in interpreting findings, but it is inevitable that people will differ greatly in their interpretation of results.

It can also be difficult to decide what recommendations, if any, might follow from patients' comments. For example, in one of my research projects patients were asked if they would like to see any changes in hospital visiting arrangements. Many replies were received, and these could have been used to advocate changes in visiting times. However, consideration also had to be given to the fact that, in an earlier question, three-quarters of the patients had indicated satisfaction with the current visiting times.

A similar problem also arises where patients see improved staffing levels as the solution to nearly all problems. While an increase in the number of staff might help to reduce problems, in many cases other factors are equally or even more important: for example, ward organisation, initial and on-going staff

Continued on next page

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Photo: Waltham Forest Guardian

SOME HINTS ON INTERVIEWING

*by Judy Berry**

How can CHCs find out what the public thinks about local health services? Survey research is a means of providing information about a selected population, and in most cases *interviewing* is the basic method used. Information collected in this way — about people's circumstances, conditions and opinions — is helpful in evaluating and planning the provision of services.

If CHC members are going to do interviewing, it is important to remember that this is a highly specialised job and some training will be necessary. But don't be put off by this, because once you know how to interview you will find the experience most rewarding and interesting. This article sets out some points which may be useful to CHC members intending to carry out interviews.

Preparing for the interview

It is absolutely essential that you are clear about the objectives of the project, and have some knowledge about why the survey is being carried out. Members of the public are very likely to ask for details, so you must be able to explain things simply and clearly. Practise your explanations on friends or relatives before you start the survey.

In some surveys, you will know the names of the people you have to contact. It is helpful if you have a notebook in which all the names and addresses of contacts can be written down. Try to keep a systematic record in your notebook of times of visits and lengths of interviews.

When planning your day, give some thought to the people you will be talking to. For example, if you are carrying out a survey of elderly people don't call too early in the morning. It is probably best to wait until about 10.30am. Don't call on old people after dark unless a specific appointment has been made. Sometimes neighbours are concerned to see strangers approaching an elderly person's home, and it is a good idea to let the police know that a survey is being carried out in the area. Make sure that you have some form of identity card, preferably with a photograph attached.

Practise interviewing on friends and relatives, and do at least three practice interviews before starting out. First-time interviewers will find it quite difficult to co-ordinate looking at their subject and writing things down. It is very important that you do not alter either the wording or the order of the questions, and the better you know your questionnaire the better you will handle the interview. Don't arrive at the door with a clipboard in your hand. Have it in a briefcase, basket or bag — or even inside a newspaper.

On arrival at the home

If you have an appointment, make sure that you keep it. Don't assume that the person who answers the door is the person you want to speak to. On the doorstep, say briefly who you are, but don't say you are from "the CHC". People are often confused by initials. Give your name and say you are from the community health council.

If your project is finding out the views of elderly or handicapped

Continued on next page

Photo: W Midlands RHA

**Judy Berry is a principal administrative assistant with the West Midlands RHA, and before that did research for the Continuing Care Project.*

ASKING THE RIGHT QUESTIONS

WHY DO RESEARCH?

Continued from previous page

training, and the whole style in which most medical consultations are currently conducted.

After a report showing the research findings has been prepared, CHCs are faced with the difficult job of deciding what emphasis to put on the research's recommendations on any particular topic of care, while bearing in mind the less clearly identified needs of other aspects of health care. For example, if funds are limited, CHCs may have the invidious task of deciding whether to recommend that expenditure in other areas of service should be reduced in order to provide money for some newly identified need. My research in the maternity field led to many suggestions for extra expenditure, yet *Priorities for health and personal social services in England* (HMSO 1976) recommended cuts in expenditure for maternity services, and I too suspected that there were other areas of the NHS where any additional money might be better spent.

When the CHC has finished its research and presented a report and recommendations to the relevant authorities, its work is by no means complete. The way the report is received will obviously depend on the quality of the research, but it will also be influenced by such aspects as the press publicity it receives, the committees it is referred to, how threatening it appears to staff, and the influences and pressures on the individual officers who decide whether or not to follow up issues. CHCs have only limited control over some of these factors, but they can at least follow up the progress of reports conscientiously over a period of time, to ensure that proper consideration is given to their findings.

CHCs are a very necessary channel of communication between patients, the community and NHS staff. Research which aims to identify patients' views on ways in which services might be modified or improved is a small, yet an important part of this communication. It takes time to do good research, especially if CHC members have to learn research techniques. Administrators' confidence to allow CHCs the freedom they deserve sometimes grows slowly, perhaps because of an understandable concern to ensure that patients' rights to confidentiality are adequately safeguarded.

However, it is pleasing to see that some interesting CHC research reports have now been published, and are being used constructively by NHS staff for the benefit of patients. There is a real danger, though, that little research of this nature will be commissioned if CHCs are abolished. Management often feels that it has other problems which are in greater need of detailed investigation, and voluntary bodies do not have the legal rights to investigate topics of concern.

Research into patients' views and experiences *is* important, for it is one of the main ways in which the NHS can obtain detailed knowledge of the social and psychological needs of patients. Through such research, patients' ideas for improvements in *specific* hospitals and community services can be gained.

Further reading:

On the contribution and limitations of social policy research

The limitations of social research, by M D Shipman, Longman, 1972.

Social policy research, edited by M Bulmer, MacMillan, 1978.

On research techniques

Survey methods in community medicine (second edition), by J H Abramson, Churchill Livingstone, 1979

Methods of social research, by M Stacey, Pergamon, 1969.

Survey methods in social investigation, by C A Moser and G Kalton, Heinemann Educational Books, 1971.

Questionnaire design and attitude measurement, by A N Oppenheim, Heinemann Educational Books, 1966.

A handbook for interviews, by J Atkinson, HMSO 1971.

HINTS ON INTERVIEWING

Continued from previous page

people, don't say this on the doorstep. There is nothing worse than being told you are a "geriatric". Say instead that you are talking to different groups of people about their experiences. Remember that no-one *has* to answer any of your questions. You are relying on their co-operation, so it is necessary to ask them if they are willing to help. Give some indication of how long the interview will take. If you think it will take an hour, say so. If your contact has not got that long, make a more convenient appointment.

The interview

Before you begin, make sure that your subject is comfortable. Try to sit facing him or her, so that he or she can't read your questionnaire. If the interviewee becomes aware that you are filling in forms, some of the spontaneity of the reply will be lost. Before starting your questions, run through the following points:

- Give your name, say who you are working for and show your authorisation card. You may have done this at the door, but it is worth repeating.
- Explain why you are talking to this person, and how he or she was chosen for interview. For example, you may be talking to everyone who has visited a certain clinic, or to a sample of mothers whose children have been inoculated. You must know what the sampling procedure was, and be able to explain it.
- Explain the purpose of the survey in more detail than you did on the doorstep, as simply as you can.
- Make sure you say that the survey is confidential. It is best to give each subject a code number, so that no names appear on the questionnaire.
- Ask your subject whether he or she has any questions before you begin, then get your papers out and start.

The speed at which you ask the questions must be governed by the speed at which your subject talks and thinks. Don't talk too much yourself or give your opinion. Avoid saying anything which could bias your subject's answers. Don't rush your subject — give him or her time to think. Pauses while you write down answers are quite natural, and it is very important that you do write the answers down immediately.

Try not to let your informant wander away from the point of the interview, but remember that sometimes this is a necessary part of building up a relationship with your subject. It is very difficult to draw the line between showing your interest, building up a good relationship and keeping control of the line of questioning. This ability only comes with practice. It is a good idea to leave a short leaflet, thanking your subject for co-operating and explaining once again the purpose of the survey.

It is very important to remember that your interview does not begin with question one and end with the last question, it begins from the moment you arrive at the house and lasts until you leave. The *quality* of the interview will depend on how well you explain the purpose of the study, and on the kind of atmosphere you have managed to create.

In this article I have not covered the method of asking questions, nor the way answers should be recorded on questionnaires. It is important that interviewers do have some training in these techniques. What I hope I have done is make explicit certain things that interviewers might not otherwise think about until it is too late, and the quality of the information has suffered. CHCs have a role as collectors of information about local health services, and you are best able to argue your case if you are well-informed. Enjoy your interviewing — you will learn a lot more about the people in your district than you ever imagined!

SAFEGUARDING STANDARDS IN NURSING SCHOOLS

by Miss Maude Storey, Registrar, General Nursing Council

Inspecting and approving nursing schools is one of the main duties of the General Nursing Council (GNC) for England and Wales. The council, which is a statutory body, has a duty to protect the public by ensuring that professional standards of nursing are maintained, and has control over who can legally use the title "nurse".

The GNC's central function is the registration of all qualified nurses. (There are separate councils for Scotland and Northern Ireland.) Entry to the profession is by training and examinations controlled by the GNC.

Since NHS reorganisation in 1974 nurse training schools have been centred on health districts or areas. To ensure provision of the broadly-based nursing education which the GNC requires each school usually incorporates a range of hospitals, both general and specialised, and offers students work experience in the community.

As well as requiring schools to offer varied practical experience the GNC lays down a number of conditions for official recognition of a training school. These include:
— Adequate supervision and teaching by qualified nurses in all wards and departments;
— A carefully planned curriculum covering the training syllabus laid down by the GNC;
— Standards of nursing practice, equipment and facilities which permit the teaching of good nursing care.

If training schools fail to maintain the required standards approval may be withdrawn in respect of particular wards, departments or even hospitals. It is very rare for approval to be withdrawn from a whole school. Indeed in the last few years there have only been three cases of approval being partially withdrawn — all of these involving hospitals for the mentally handicapped.

Withdrawing approval is never an easy decision for the council to take. It has to be made when a hospital or school has failed to heed the recommendations of the council following repeated inspections. In such cases, the GNC must balance the immediate risk to patients of a reduction in nursing levels and the risk to future patients of inadequately trained nurses. Withdrawal of approval only occurs after full consultation with the relevant area health authority. Although no new students are accepted, withdrawal does not prejudice students who are already in training. If they wish they may transfer to another school, but they are encouraged to remain, and the GNC keeps in touch with the school to check on their progress.

The traumatic effects of such action can be justified when one looks at the outcome — as in the case of one of the three hospitals for the mentally handicapped mentioned above.

The hospital had initially been approved as a training school for nurses of the mentally subnormal in 1924. In 1945 the GNC appointed its first inspectors, who visited the hospital two years later. Routine inspections of all training institutions are made every three or four years, and this hospital became the focus of some concern. It was visited several times during the 1970s and the GNC amended its full approval to a "provisional" one. When conditions still did not improve the inspectors recommended that approval for the hospital as part of a training school should be withdrawn. Major causes for concern centred on:

1. The quality of teaching and supervision — staff were inadequately qualified, and over-burdened because of low staffing levels. Teaching was unplanned and the staff showed almost total unawareness of students' needs — medical staff in particular had little interest in nurse training programmes. The kind of work experience offered to the students was greatly below requirements.

2. The quality of life for the patients, and the hospital environment itself — the facilities were appalling. Wards were stark, depersonalised and almost completely lacking any privacy. Washrooms and lavatories were unheated and primitive. Poor facilities and staff shortages had led to a lack of professionalism and a deterioration in standards of care for patients which caused grave concern to the inspectors. Many patients were unkempt and the visitors noticed at least one young female patient without underclothing, even though she was in the company of male patients as part of an attempted resocialisation programme. It was apparently assumed by staff that incontinence was inevitable in the severely handicapped. Large numbers of patients were engaged on domestic work which was of undoubted value to the hospital, but was not based on any assessment of individual patient need.

Photo: Liz Heron

The area health authority (AHA) initially opposed the GNC's withdrawal of approval and embarked on an appeal to the Lord Chancellor, the procedure for reversing such a decision. However, after lengthy discussions the AHA accepted the council's decision, and with the full support of the inspectors it took steps which it hoped would lead to re-approval. Over an 18-month period the inspectors made a series of visits to the hospital, during which new teaching programmes and wider opportunities for the students to gain work experience were discussed.

In March 1978 the inspectors made a formal visit. They were able to report on a number of changes at the hospital. Ten wards had been selected to provide a varied range of experience for students. Staff in these wards were genuinely enthusiastic about training nurses. Many wards had been redecorated and one completely upgraded.

Satisfactory training programmes had been arranged and the teaching department was much improved. Efforts were being made to recruit more qualified teaching staff and links were being established with a nearby general hospital, and with social services and local education authorities, to broaden the areas of experience open to students.

Responsibility for all the occupational, industrial and employment activities of the patients had been given to the adult patients' training and education department. The wide range of activities now available meant that individual work programmes related to each patient's needs and abilities could be set up. And a nursing officer had been appointed to organise recreation for the patients.

The inspectors were very impressed by the amount of hard work done during the two year period and the progress that had been made. They commended the efforts to establish a satisfactory training environment in spite of the many physical constraints, and also the willingness demonstrated by all the staff to become involved in nurse training.

Re-approval on a provisional basis was agreed following this visit.

Finally it should be mentioned that not all cases of withdrawal of approval are due to the GNC's intiative after inspections — some are prompted by AHAs which have become concerned because of changed circumstances at a nursing school.

Asking the public through the local press

By Irene Watson, Secretary, Hull CHC

In January 1978, Hull CHC was called upon to consider its first proposal for closure. The unit in question was the Townend Maternity Home, a small unit of 17 single rooms situated near the city centre Probably more than any other hospital in the Hull health district, this maternity hospital holds the public's affection and when the proposals were made public there was a huge outcry.

This home was to a large extent a general practitioner unit. The reasons put forward by the Hull district management team (DMT) for closing it were that it was under-used and that plans existed to upgrade two wards at the 100 bed maternity hospital to the east of the city for GP use, which would mean that the GPs' patients would have the special care facilities of a big maternity hospital immediately available.

Although this article relates to the Townend, an interesting feature that can hardly be ignored, is that occupying the same site is the Hull Hospital for Women. Originally the proposals were to close both these units. However, after discussion with the consultants, the DMT decided that the women's hospital should continue for the time being to operate as a five-day week gynaecological unit and would eventually close, when new facilities were provided.

The CHC objected to the closure of the Townend for a number of reasons which need not be listed here but, in September 1979, the council was notified that the Minister of Health had given formal notice of the closure of the Townend Maternity Home. He had, however, specifically requested that the CHC should be consulted on possible alternative uses before any final decision was taken on whether or not to retain or sell the premises.

A special meeting of members of the CHC's planning sub-committee produced a list of possible options which were subsequently reduced to three that were considered to stand a chance of success. These were placed in priority order as follows and submitted for discussion by the full council at its meeting in November:-

- To accommodate the transferred services from Westerlands Children's Hospital, which is in a village to the west of Hull and is administered by Beverley health district. This was in anticipation of plans to close this hospital and provide purpose-built accommodation also to the west of Hull.
- To accommodate mentally handicapped people who have lived all their lives at home and whose parents are now ageing. The local mental handicap society has appreciable funds that could be put at the disposal of the health authority if required for alterations or additions.
- To provide short stay accommodation for the elderly. There is a growing need for this — to relieve relatives caring for elderly people and to assist in rehabilitation after a spell in hospital.

The CHC decided to seek the co-operation of the *Hull Daily Mail* in obtaining the views of the public on these options. The editor readily agreed, on condition that all replies should, initially, be received at the *Hull Daily Mail* and that this newspaper should have an "exclusive". The result was — they did us proud. An article headed *Your chance to decide* appeared on the front page with a coupon for the public to indicate their preference. The next day the same article was reprinted inside.

There were 508 replies. The home for the mentally handicapped received 247 votes, the home for the elderly — 190, and Westerlands — 69.

During the following month of January, the *Mail* produced an article, *Townend: How you voted*, and the result of the survey was forwarded to the Hull DMT for inclusion with the council's suggestions. The DMT then came up with arrangements to close the women's hospital at the same time as Townend — making room for

LOADING THE DICE AGAINST BETTER HOUSING

By the Adamsdown and Splott Health Group, Cardiff

If anybody has ever told you that bad housing has nothing to do with bad health, ask some of the people who live in cold, damp and leaky houses what they think. Some tenants in Adamsdown, an inner city area of Cardiff, have had their health so badly affected by the cold and the damp that they want to be rehoused. However, when the local neighbourhood law centre acting on their behalf, approached their general practitioners (GPs) for medical reports to back up the housing applications, some of the doctors refused to help. For support they quoted guidance issued by the Welsh General Medical Services Committee of the British Medical Association.

The guidance specified two ways to get medical support for housing claims. Either the council's housing department could ask the community physician to see the patient, or the patient's GP could be requested to examine the patient. The GP could claim a fee, though the patient would not be charged. GPs were advised not to issue patients with certificates, but to give them a copy of the BMA guidance to take back to the housing department.

Our health group was very disturbed when it learned of this policy. The group consists of local tenants and residents, and was formed with the backing of the Adamsdown Community Trust, mainly to campaign for a health centre. To us it seemed that the GMSC guidance loaded the dice heavily against people trying to get better housing. At a time when housing authorities are under heavy pressure through public spending cuts, how realistic is it to expect them to initiate a process which could well result in an extra person or family to rehouse in the precious few units available? Further, what about "vulnerable" homeless people who apply to the housing authority for help under the Housing (Homeless Persons) Act 1977? To prove that they require consideration as "vulnerable" — ie they are mentally ill or physically handicapped — usually means they must get medical evidence. If a housing authority disputes that a person is "vulnerable" under the Act, it is vital for that person to have independent access to medical opinion, and a chance of challenging the council's view.

The health group felt strongly that the BMA's advice would have the effect of artificially reducing the number of people officially acknowledged to be in need of rehousing on medical grounds. It felt that if GPs in Wales are indeed under heavy pressure from patients to supply medical priority certificates, then this is a reflection of the depth of the problem of unfit housing. A proper response from the BMA would be to point out the consequences to health of poor housing and to call for more resources to be spent on housing. Simply to devise a scheme to deal with the worst cases is wholly inadequate.

The health group took up the issue with Cardiff CHC, the Cardiff and South Glamorgan Trades Councils and the Welsh BMA. We also asked Cardiff housing department what happens at present with certificates from doctors.

Cardiff CHC raised the matter with the Welsh Association of CHCs which is trying to find out how the guidance came to be issued. The Association of CHCs for England and Wales also wrote to the BMA. The BMA quotes in its reply an opinion

consideration of two of the CHC's options instead of one.

The final proposal put to the DMT by the CHC was that, as the women's hospital was the one most comparable to Westerlands, this should be used for the transferred children's services, leaving the Townend to accommodate either the mentally handicapped or the elderly. It was pointed out regarding these two options that the public's priorities were also the council's.

There has been an appreciable amount of interest shown in the method adopted for this public opinion poll and it was encouraging to receive commendation from a trade union as well as the district adminstrator. The only objections curiously were from the social services department, which considered that as all the options chosen had some social services implication, there should have been prior consultation between the council and that department before arrangements were made with the *Hull Daily Mail*. We pointed out that this was purely an opinion poll and if the Hull DMT felt there was merit in any of the CHC's options then it would be for the team to initiate discussions with the social services.

Regarding the preparation of the coupon and the report on the result, I prepared the text to accompany the reply coupon although the editor decided the lay-out it should take. I also worked very closely with a reporter on the follow-up article. One other point that should be mentioned, and that is that in any exercise such as this it is important that the reporting staff should be prepared to publish precisely what is requested, in order to avoid misunderstandings such as we encountered with the social services department.

voiced by a director of housing in a Welsh Consumer Council report of 1976: "All too often these certificates are given freely by the practitioners in an attempt not only to assist the patient but also to ease the pressure on the GP. The judgement of a family's general practitioner is often too subjective".

The health group believes that family doctors are best placed to know the people involved and their environment. In Cardiff at least, the community physician rarely makes a home visit, but relies heavily on a report from the housing applicant's GP. The result is that the a queue of medical cases is created and only the tip of the iceberg gets helped. People with heart and chest complaints, and those with psychiatric disorders are trapped in unfit housing for years, with no hope of creeping into the qualifying category.

Whilst family doctors in our locality have now been advised by the Welsh BMA to supply medical reports to the Adamsdown law centre, when these are requested on housing problems, the guidance has not been withdrawn. Unrepresented people still have to wrestle with a rule which many doctors have been interpreting very strictly. The BMA's response to the problem of unfit housing does nothing for those whose lives are shortened by poor housing, and the future holds out even worse prospects, with housing finance being so drastically cut by central government.

Venice without the canals

By Graham Girvan, Secretary, Bexley CHC*

Over recent months the relationship between Bexley CHC and the London Borough of Bexley's social services department has been questioned. The local authority, the DHSS and the regional health authority's legal department all state that commenting on the workings of the local authority is outside the scope of the CHC. However I believe that this view should be challenged and reviewed.

CHCs were established to represent the views of the consumer and monitor the health services in their district. Health care is not the monopoly of the NHS. Increasingly, co-operation and collaboration between the area health authority and the local authority are being seen and used as partial answers to the problem of financial starvation. Each type of authority has a distinct role to play in the health of the community. There are different systems of funding. There are different methods of accountability and there are different professional bodies involved. However, both authorities exist to serve the consumers of the district.

An elderly woman may be taken to a day hospital by ambulance one day. The next day she may be taken to a local authority day centre by social services transport. She may receive meals-on-wheels and a visit from a home help and be visited by the district nurse. A physically handicapped man may receive physiotherapy as a hospital out-patient, attend a local authority centre, be helped into the bath at home by a nurse, and go on a social services holiday. Whilst there are differences between the services provided by the NHS and local government, there are also distinct and necessary areas of overlap. Services for elderly people, provision for mentally ill people, facilities for those people with a physical or mental handicap, all involve the co-operation of both authorities.

Indeed machinery for this co-operation has been established and encouraged; local authority representation on the area health authority; half the CHC members being appointed by local government; joint consultative committees; and, in our area at least, co-option of one area health authority member onto the local borough's social services sub-committee. All these formal procedures should enable joint discussion, awareness and planning. Contact between staff at all levels is encouraged. There are social workers in health centres and attached to GP practices. Health visitors attend social service team meetings and there are regular meetings between the district management team and senior social service officers. All make for better liaison and understanding between staff.

Since the work of the two authorities overlaps, it seems reasonable for the CHC to be concerned with the effectiveness of both services. When the CHC is concerned about the services provided by the area health authority, it is able to raise these concerns. However, if it is similarly concerned with those of the local authority, should it remain silent? I believe that the CHC should monitor and investigate those local authority services which are linked with health. These might include environmental health, housing and other services. However perhaps we should primarily direct our attention to the services with direct consumer contact.

For CHCs to attempt to be involved with the health services in the community, without examining and commenting on those provided by the local authority, is analagous to describing Venice without mentioning canals or Trafalgar Square without Nelson's column. It is possible, but a crucial contributing factor will be missed.

**The opinions expressed are not shared by all members of the Bexley Community Health Council.*

Photo: Raissa Page

Healthline

Patients and consultants

Can a consultant refuse to continue seeing a patient in an outpatient clinic once the patient has been accepted and treatment started? And does a patient have the right to be accompanied by a friend during a visit to a consultant?

Apparently a consultant has the right to decide not to carry on seeing an outpatient at any time and for any reason. If this happened the patient would have to return to the GP for further advice. Though it seems unlikely that a consultant or other doctor would normally object to a patient taking a friend into a consultation, the patient does not have a *right* to do this.

Brain death

If someone is on a life-support machine do the doctors make the final decision as to whether or not to switch off the machine or do they have to get the agreement of the patient's relatives?

If the doctors decide that "brain death" has occurred, they may switch off the machine — the relatives are not involved in this decision.

Brain death is when all the functions of the brain have permanently and irreversibly ceased. In 1976 the Conference of Medical Royal Colleges and their Faculties in the United Kingdom published a now widely-accepted report expressing the opinion that "brain death" could be diagnosed with certainty.

Exemptions from VAT

Do we have to pay Value Added Tax (VAT) on our annual report?

If a publication can be described as a book, booklet, brochure, pamphlet or leaflet it is exempt from VAT, according to a leaflet published by HM Customs and Excise, no matter how it has been produced — printed, photocopied, typed or handwritten. CHC annual reports would normally come into one of the above categories. However, items liable for VAT at the standard rate include diaries, yearbooks and posters, so in the rare event of an annual report taking this form VAT would probably be payable. The leaflet advising printers and the public about what printed matter is liable for VAT is No. 701/10/79 and it is available from your local Customs and Excise office.

Patient participation groups

We are attempting to set up a patients' committee at our local health centre. Are there any organisations who can help us do this?

The first patient participation groups (PPGs), as they are usually called, were started in the early 1970s, with a view to improving communications between doctors and patients. There are now 27 PPGs in England and Wales. Information about existing groups is available from the Central Information Service for General Medical Practice, 14 Princes Gate, London SW7 1PU. The National Association for Patient Participation in General Practice co-ordinates the work of PPGs and arranges public meetings. Further details from its secretary, Hazel Ackery, 28 Heol-y-Deryn, Glyncorrwg, Port Talbot, West Glamorgan.

Patients' savings

A local consultant wants to take a group of long-term elderly mentally handicapped patients on holiday abroad. A number of nurse escorts will be necessary to accompany the patients and look after them. The AHA will pay their salaries while they are abroad but will not pay their fares. As the patients rarely spend their weekly pocket money they have all accumulated considerable sums of money. We wondered if some of this money could be used for the nurses' travel expenses but the AHA says not.

The AHA is right — it cannot legally use mentally handicapped patients' money for a purpose which only indirectly benefits the individual patients.

The Healthline column publishes selections from our information service. This service is for CHC members and staff, and for others interested in the NHS and the work of CHCs. To contact the information service, write to or ring CHC NEWS, 362 Euston Road, London, NW1 3BL (01-388 4943).

Parliament

Insurance-financed NHS?

DHSS officials have begun a study of insurance-financed health services in other countries. Advantages these can offer over the NHS include greater patient choice and flexibility, said Patrick Jenkin. Any radical change in the basis of financing the NHS would depend upon very careful assessment of all the advantages and disadvantages, and would have to be the subject of widespread public consultation. Proposals for change are not anticipated in the near future (Reg Race MP, Haringey, Wood Green, 25 March).

Underground advert banned

The Pregnancy Advisory Service, an abortion charity, was told by the DHSS to remove its advertising posters from London underground stations because it had not submitted them to the Department for prior approval, thus contravening a condition for the registration of pregnancy advice bureaux, explained Dr Gerard Vaughan. Bureaux' advertising material should not imply that they do more than advise clients or that they can arrange abortions for anyone approaching them. As this poster omitted any reference to advice it was considered to have failed to meet DHSS standards (Renee Short MP, Wolverhampton NE, 24 March).

Administration costs

In 1978/79 the proportion of NHS expenditure spent on headquarters administration in England was 0.67% by RHAs and 3.22% by AHAs (George Foulkes MP, South Ayrshire, 26 March).

Spending on the elderly

To maintain the existing level of health care spending on those aged 65 and over in real terms would necessitate an average growth in health expenditure of 1% a year over the next ten years (Renee Short MP, Wolverhampton NE, 10 March).

CHC surveys

Surveys such as that carried out by Bolton CHC on the disabled in Bolton are regarded by Under Secretary of State for Health, Sir George Young, as "very useful activity" (Alfred Morris MP, Manchester, Wythenshawe, 25 March).

Kidney treatment

An estimated 40 new patients per million population need to start treatment for chronic renal failure by dialysis or transplant every year — in England in 1978 about 20 new patients per million started treatment. UK treatment rates for patients under 45 are in line with other Western European countries but in the older age-groups treatment rates are much lower. Very few patients over 65 are accepted for treatment and 4,624 of the 5,858 people who died in England in 1978 from kidney failure were over this age. Renal services "cannot be exempted from the general economic situation or from the need to keep within cash limits" according to Dr Gerard Vaughan.

Information is not collected centrally on the total number or cost of kidney machines in NHS hospitals or on shortages of staff to run them but at the end of 1978 they were being used by 2,893 patients. Staff shortages are generally due to a lack of qualified nurses willing to work in renal dialysis units and the DHSS will be co-operating in local campaigns with health authorities later in the year to attract nurses who have left the health service (David Alton MP, Liverpool, Edge Hill, 31 March, 3 April; Sir Timothy Kitson MP, Richmond, Yorks, 31 March; Renee Short MP, Wolverhampton NE, 26 March).

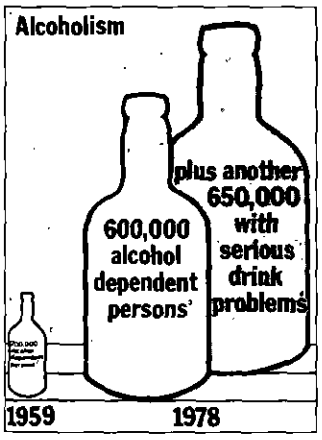
Scanner

Asbestos

SPAID, the Society for the Prevention of Asbestosis and Industrial Diseases has launched a newsletter called *SPAID News.* The first issue contains articles on cancer prevention as well as several about asbestos. From SPAID, 38 Drapers Road, Enfield, Middlesex EN2 8LU. (Three issues per year for £1).

Drinking

The Alcoholism Community *Centre for Education* Prevention and Treatment — (Accept) aims to encourage sensible drinking. It publishes *It's your life: a guide to survival in a drinking culture. 65p inc post, from Accept, Western Hospital, Seagrave Road, London SW6.*



Countdown on drinking is by David Davies, medical director of the Alcohol *Education Centre. The* pamphlet is the latest of the BMA's advice series and stresses the long-term harm of heavy drinking—eg five or six pints of beer every day. From *Family doctor publications,* BMA House, Tavistock Square, London WC1H 9JP (40p plus 12p post). *Alcohol and the unborn child — the fetal alcohol syndrome* is a report by the National Council of Women. It reviews the literature on alcohol in pregnancy and warns that even moderate drinking may endanger the baby's mental development. From National Council of Women, 36 Lower Sloane Street, London SW1W 8BP (£1.25 plus 25p post).

Living like others

A King's Fund working party has been looking into locally-based services for the mentally handicapped. Its report* contains practical advice for service planners and providers about residential care, using ordinary housing and *integration within the* neighbourhood. The working party's principles were that: mentally handicapped people have the same human value as anyone else; the right of the mentally handicapped to live like others in the community; and the individuality of the mentally handicapped person. **An ordinary life* from King's Fund Centre, 126 Albert Street, London NW1 7NF (£1 plus 25p post).

Stacks of stats

Two collections of statistics have been published about family practitioner services, hospitals, staffing, diseases, finance, social services, and so on. Some tables contain figures for 1978, the latest year generally available. *Health and personal social services statistics for England (with summary table for Great Britain) 1978* (HMSO £8.50). *Health and personal social services statistics for Wales No 6 1979* (HMSO Cardiff £5.25).

Cash limits

The National Association of Health Authorities (NAHA) says the cash limits system is *harmful to sound financial* management in the NHS. It particularly attacks the annuality rule which permits health authorities to carry over from one financial year to the next only 1% of *underspent funds. The paper, The annuality rule and the NHS,* is available from NAHA, Park House 40 Edgbaston Park Road, Birmingham B15 2RT. Send a large SAE.

DHSS leaflet M11 updates the information about eligibility for free dental treatment, glasses, prescriptions, milk, and vitamins for people on low incomes. The invalid care allowance and how to claim it is the topic of leaflet NI212.

Health and safety

A study of accidents in *factories shows that managers* in industry are not doing enough to protect the workforce from the sources of danger.

Effective policies for health and safety (HMSO £1), a report from the Health and Safety Executive (HSE), *suggests that firms with high* safety standards are also commercially successful and argues that safety policies need not make an enterprise unprofitable.

An HSE report on *Industrial air pollution 1978* (HMSO £2.50) says lack of care in the maintenance of equipment is often to blame for smoke and fumes. *Factories making solid* smokeless fuel create severe air pollution.

Workers in the rubber industry run special risks of contracting lung and stomach cancer, concludes the HSE report *Mortality in the British rubber industries 1967-1976;* (HMSO £2.50). The *Health and Safety Commission Report 1978-79* (HMSO £1.75) reports slow progress towards better standards of health and safety at work.

Publications in brief

Long term psychiatric patients: a study in community care looks at how mentally ill people can cope and be cared for without being hospital in-patients. From Personal Social Services Council, Brook House, 2-16 Torrington Place, London WC1E 7HN (2.50 inc. post).

The Government sponsored Independent Scientific Committee on Smoking and Health has published its second report, *Developments in tobacco products and the possibility of "lower risk" cigarettes* (HMSO £1.75).

Disabled Living Foundation has a new *Catalogue of publications* — DLF, 346 Kensington High Street, London W14 (free).

Health for sale? by Nick Bosanquet is about the impact of private medicine on the NHS. From Socialist Medical Association, 9 Poland Street, London W1V 3DG.

Retired people as voluntary workers are under discussion in *Time to give?* — from the Volunteer Centre, 29 Lower King's Road, Berkhamsted, Herts HP4 2AB (£2.50 inc post).

Hospital meal survey looks at types of hospital breakfasts, their cost and nutritional value. From DHSS Catering and Dietetic Branch, Hannibal House, London SE1 6TE.

Directory of CHCs: Changes

An updated version of the Directory of CHCs was last published in October 1978, and each CHC was sent a copy. This version is now out of print. Work on a 1980 version is now in progress, and an announcement will be published in *CHC NEWS* as soon as this is available. Meanwhile changes to the 1978 directory will continue to be published each month on this page. Please notify us of any alterations in address, telephone number, chairman or secretary.

Page 2: North Tyneside CHC Chairman: Coun. Mrs S M Murray.
Page 6: Brent CHC Chairman: Coun. Ted Drabwell.
Page 9: Dartford and Gravesham CHC Manor House, Swanscombe Street; Swanscombe, Kent, DA10 OBS. Tel: no change.
Page 9: Maidstone CHC Chairman: Mrs Anne-Marie Nelson.
Page 13: High Wycombe CHC should just be called **Wycombe CHC.**
Page 15: East Birmingham CHC Chairman: Miss B Wilson.
Page 16: Halton CHC Chairman: Mrs Ann Entwistle.
Page 16: Warrington CHC Secretary: Mrs M E Roylance.
Page 19: Brecknock and Radnor CHC Chairman: Miss F G Eadie.
Page 21: Montgomery CHC Chairman: Coun. Mrs Kathleen Silver.

News from CHCs

☐ Nearly £30,000 is to be spent on extra clothing for patients at High Royds mental illness hospital, following complaints by **Leeds Western CHC** about shortages of underwear and nightclothes. Members first drew attention to the shortages after a visit over a year ago, but it took a local TV programme on which the district administrator and a CHC member appeared before the money was forthcoming. Problems with the hospital laundry were blamed for the shortages, and since this is not to be re-equipped the CHC will be monitoring its performance closely.

☐ Negotiations between **Plymouth CHC**, the county transport committee and the local bus company have resulted in a 30% reduction in fares between the city and Moorhaven mental illness hospital, on three days of the week. The CHC is also opposing the closure of Devonport Hospital, which its DMT says should have been closed 20 years ago. The DMT was unable to guarantee that transfer of services to the new Derriford DGH would not drain resources from other district services.

☐ **SW Herts CHC** has expressed its support for patient participation by publishing the newsletter of a newly-formed patients' committee. Since last November, the Abbots Langley Patient/Doctor Association has reviewed surgery clinic arrangements, set up a transport scheme and a parents' support group, and held discussions on health visitors, prevention, health screening and repeat prescriptions. Writing in the CHC's annual report, the PDA comments: "Whilst any exercise in consumer participation causes anxiety at the outset, our experience so far has been richly rewarding and in a small way is making the health of our community a more cooperative endeavour".

☐ Over 70 GPs' receptionists are now attending a training course at **Barnsley** college of technology, following pressure from the town's CHC. The course, planned jointly by the college and the Barnsley FPC, aims to improve receptionists' understanding of their work and attitudes towards patients. For £12.60, the receptionists are attending 20 sessions at the college, and at the end will receive a certificate.

☐ **North Camden CHC** has asked Patrick Jenkin to reverse his decision to disband the National Development Group for the Mentally Handicapped. The CHC's letter to Mr Jenkin comments: "To disband the group now must be to dash once again the hopes of a much underprivileged section of the community.... The NDG was established to advise, and it cannot be said that no more advice is needed".

☐ A 20-minute film about the work of CHCs is to be made at York University, financed by a grant from Wakefield AHA. The film will feature scenes from the work of various CHCs in the Yorkshire region, and will be made at the university's audiovisual centre, the director of which is **York CHC's** chairman Harry Creaser. The film's presenter will be William Roache — better known as "Ken Barlow" of *Coronation Street*. Gordon Tollefson, secretary of **Wakefield Eastern CHC**, is organising the project, and the film should be ready for showing early next year.

☐ *Over 3000 people viewed anti-smoking posters designed by school-children aged 8-12, when they were displayed in a Nuneaton museum during the final phase of a competition organised by* **North Warwickshire CHC.** *The CHC took this initiative because of members' concern about smoking by school children, and all schools in the district were sent details of the competition by the area health education officer. Five hundred posters were submitted, revealing a great deal of knowledge amongst children of the dangers of smoking. Gift tokens for the purchase of art materials were awarded to the winning schools, and all entrants were given a CHC bookmark.*

☐ **Doncaster CHC** has persuaded its FPC to retain a GP surgery at Denaby Main, since patients would have had to travel two miles to their nearest GP if it had closed. **Durham CHC** has carried out a survey of patients in West Pelton, where a GP has retired and not been replaced. Of 677 former patients of the GP, 501 said they would be interested in transferring to a replacement doctor, as against 141 who said they would prefer to continue with their new doctors.

☐ Mrs Juliet Baxter, chairman of **West Berkshire CHC**, has been elected chairman of the Pre-School Playgroups Association.

☐ In a press release **Bromley CHC** has listed the criticisms and recommendations which it made following a programme of regular visits to local hospitals and clinics. Replacement of vehicles is not a high priority in the district and the CHC expresses concern about the ambulance at St Lennard Hospital being frequently out of use. A psycho-geriatric day hospital would be of great benefit to ex-patients but funds are still unavailable.

☐ GPs in the Wolverhampton area have been warned by the AHA of the importance of proper counselling before rubella vaccination. **The letter, issued following pressure from Wolverhampton CHC,** points out that rubella vaccination should not be offered "unless a woman is sure that she is not pregnant and will not become pregnant for three months following vaccination", because of the risk of causing birth defects. OPCS figures show that 66 pregnancies were terminated in England and Wales in 1978 because of recent rubella vaccination. The letter also notes that the DHSS poster *Catch German measles before it's too late* makes no mention of this hazard, and suggests that the accompanying DHSS leaflet should be available wherever the poster is displayed. The CHC has sent copies of the letter to all the other **West Midlands** CHCs, suggesting that they consider asking their area medical officers to take similar action.

☐ **North Derbyshire CHC** has asked its AHA to consider setting up an emergency dental service, along the lines recently suggested by the DHSS in circular HN(FP)(79)50 (see *CHC NEWS 51).*

☐ The Flowers and London Planning Consortium reports on the future of London's health services will be disastrous for the **Kensington, Chelsea and Westminster South** district, according to the CHC's latest newsletter. The Westminster Hospital would lose its new A and E department and children's beds, and so would no longer provide the local community with a full range of services. "Within a few years" it could close completely, all without local consultation. The CHC is supporting the hospital campaign committee, has held a public meeting, and is lobbying MPs.

☐ Jo Robinson, a member of **City and Hackney CHC's** Women's Health Working Group, has been invited to rewrite part of the Consumer Association's book *Pregnancy month by month*, following her critical review of it in *CHC NEWS 50.*

☐ **Barking CHC** has expressed "general dissatisfaction" with the **Association of CHCs,** and has withdrawn from membership. But **Lancaster CHC** has now joined ACHCEW, for the first time.