CHC NEWS

For Community Health Councils

March 1982 No 74

CLAMP-DOWN HITS CHCs

by Mike Gerrard, Secretary, Association of CHCs

There is some evidence that regional health authorities have been clamping down on the activities of CHCs in recent months. An increasing number of CHCs are asking me for advice about how to overcome obstacles placed in their path by their RHA. To illustrate this I would like to give three examples — each from a different region.

In two of the three cases, the CHC's activity could be described as controversial. Brent CHC had associated itself with a campaign in its community, while Cambridge proposed spending money in advancing the case of a local complainant. Salford CHC, however, was considering nothing more subversive than putting on a series of public seminars on women's health.

One way or another, it was alleged that all the CHCs were acting beyond their powers, and in one case that a "political" posture was being taken. Since there is some opposition amongst CHCs to "political" activities, it is worth saying that any resolution of a CHC may have political implications — as may those of health authorities and family practitioner committees — and that the CHC was doing nothing that had not been done before.

The CHC regulations (Statutory Instrument 1973 No 2217) do not actually state what a CHC may or may not do. Circular HRC(74)4 gave some kind of indication in appendix five, but this guidance has now been superseded by the new circular on CHCs, HC(81)15. The situation at present is that CHCs may do anything or nothing within the terms of the National Health Service Act 1977. The only restrictions are that CHCs' budgets have to be approved by the RHA, and that their expenditure has to be acceptable to it.

These are the sanctions the RHA holds. An enquiry carried out by ACHCEW in 1980 showed that RHAs' interpretations at the margin of what is acceptable vary, with a number claiming to "judge each case on its merits in the circumstances prevailing." Recent insistence by Ministers that CHCs are essentially local bodies which should not be involved in national policy issues, coupled with Mr Jenkin's wish that they should not become "pressure groups for patients", may have shifted the threshold of what is not acceptable to RHAs, with the results observed.

CHCs were not created to shun controversy, nor to decline to provide health-related services to the community where necessary. New ground has to be broken sometimes, and changes in attitudes can mean that previously accepted positions become disputed. Any CHC therefore can find itself at some time facing a potentially controversial decision.

The other important factor is the RHA. If my assumption is correct, it is likely that regional chairmen have been asked to "keep an eye" on CHCs. The impact of that "eye" will depend on how liberally this new task is interpreted. But CHCs should be warned, and should be ready to put up a fight if they believe they are right.

● For more details see back page.

Our missing pages

We apologise for the size of this issue of *CHC NEWS* — eight pages rather than our usual 16. We have been short-staffed since mid-October, and we are unable to fill our vacant assistant editor post because of the uncertainty surrounding our future funding arrangements. We have put off reducing the size of the magazine as long as we possibly could, and we hope to return to 16 pages as soon as circumstances permit.

Several bundles of last month's *CHC NEWS* came apart in the post and their contents were returned to us. If any CHC has not received *CHC NEWS 73*, or has had a smaller than usual supply, please let us know so that we can sned out the missing copies.

The funding campaign

Support is growing for the Association of CHCs' campaign to retain Government funding for *CHC NEWS*. By 24 February, 72 Members of Parliament had signed an early day motion recognising the "central role played by *CHC NEWS* in the successful operation of CHCs", and warning Secretary of State Norman Fowler that any change in the magazine's funding basis "can only have an adverse influence on the effectiveness of CHCs in the reorganised NHS".

Labour and Social Democrat MPs have been in the forefront of those sending messages of support to ACHCEW. Labour's health spokeswoman Mrs Gwyneth Dunwoody said she has "long been a devotee" of *CHC NEWS*, and deputy party leader Denis Healey expressed his "strong support". Social Democrat leader Dr David Owen attacked the Government's decision as "shortsighted", recalling that as Minister for Health he had been involved with establishing *CHC NEWS* — with central funding — in 1975.

Support from Conservative MPs has been muted, with former Social Services Secretary Patrick Jenkin taking the opportunity to spell out his opposition in some detail. He told ACHCEW that magazines about the NHS were always able to finance themselves through a combination of advertising and subscriptions, and "it was never entirely clear to me why the CHCs felt it necessary to have public funding for their own journal ... I did not actually take the steps to phase out the grant to ACHCEW for *CHC NEWS*, but I must confess to you that it had occurred to me that it would be a sensible thing to do". Former junior health minister Sir George Young said that although he read *CHC NEWS*, and. quite often appeared in it, he felt that it was up to ACHCEW to fund it.

INSIDE....

Your letters

Support the BMA on this one!

Cyril Beales, Member, Newham CHC

Hospitals can seriously affect your health if your doctor is too tired to cope, and many opinions are now being expressed about the long hours worked by junior hospital doctors. How can we be sure that such doctors, having worked 120 hours in one week, can still make safe judgements as they come to the end of such a long work period? Doctors admit that they tend to make more mistakes under these conditions.

Legislation must be introduced to bring these working hours down to a maximum of eighty hours per week, as recommended by the British Medical Association.

It also has to be remembered that there are many more doctors in junior hospital posts than can ever hope to become consultants. Certainly the time is ripe for change in the current antiquated career structure.

PS: Since you published my article *Is US health care a glimpse of our future?* in *CHC NEWS 71*, many people have asked me if I am against the provision of private hospitals of all kinds. The simple answer is No — but I am certainly against hospitals whose prime aim is profit.

Who's brainwashed?

Dympna le Rasle, Member, Waltham Forest CHC

Penny Cloutte's article in *CHC NEWS 72*, on TV advertising aimed at children, shows an admirable concern for the physical and psychological health of children. I agree with what she says about the harm caused by sweets and bottlefeeding, but I am also concerned that the psychological wellbeing of children may well depend on them being cared for by someone who loves them — ie their mother, or where family circumstances are appropriate their father. Most of us choose to have our children, and to suggest that most women regard staying at home to care for them as being an "unpaid childminder" is an insult.

It is this attitude that is harmful to women and children. Those of us who give up paid employment to care for our own children often do so because we want to, and believe this to be in our family's best interest, not because we've been brainwashed by advertisements or because the Government tells us to. Women are in just as much danger of being brainwashed by Penny Cloutte's attitudes. Many women who go to work have to leave their children with childminders, who are often underpaid, or in nurseries staffed with underpaid women. They do so because they need the money, and given the choice they might well prefer to stay at home.

If Penny Cloutte really wants to help she should stop undermining the status of those of us who spend part of our lives in the home caring for our families, not as "unpaid childminders and servicers of men" but because we want to and believe it is right to do so.

The fluoridation debate

P Clavell Blount, Chairman, National Anti-Fluoridation Campaign, 36 Station Road, Thames Ditton, Surrey KT7 ONS

Professor Neil Jenkins is wrong when he says in *CHC NEWS 71* that public water fluoridation " is fundamentally a scientific issue". It is fundamentally a moral/political issue. The question of *primary* importance is not "Does it reduce tooth decay effectively, and is it safe?" It is "Are people to be allowed to choose what they and their children will and will not consume, and what bodily treatment they will and will not have, for the maintenance of health and the prevention of disease?"

One regrets that proponents of fluoridation seem to be unable or unwilling to grasp this question. It is this inability or unwillingness on their part that has caused this issue to drag on and on, year after year, to the considerable annoyance of most people.

The moral/political question quoted above has not yet been resolved, and until it has been all other questions about fluoridation are so many red herrings. The only place where this question can be resolved for the nation is Parliament. The issue will undoubtedly continue to drag on and on until it has been fully and properly debated and voted on in Parliament, and the decision reached has been accepted by the general public. That our Government should "funk" such a debate is a sad reflection on the way in which our country has been governed during the last two decades.

No change please

Fiona Drake, Secretary, South East Cumbria CHC

The Comment in *CHC NEWS 71* mentions a proposed shift of emphasis towards prevention and health education. We hope that there will be no reduction in the present wide range of excellent materials covered by the magazine, which is most informative for members and staff of CHCs, and indeed for many other health service professional people. There is already a journal called *Health Education News*, published by the Health Education Council, which will be read by many *CHC NEWS* readers.

Handing over to ACHCEW

Lucille Langley-Williams, Secretary, Isles of Scilly CHC

A letter in *CHC NEWS 72* suggested that two or three pages of the magazine should be handed over to ACHCEW. This is a brilliant idea, and we can only wonder why the rest of us did not think of it.

R Valerie Dabbs, Secretary, East Cumbria CHC

We agree that much of the information in ACHCEW's *Standing Committee News* could usefully be printed in *CHC NEWS*, by handing over a page to ACHCEW, but we would be reluctant to see as much as three pages handed over unless the size of *CHC NEWS* was increased accordingly. We also recognise that some of the information in *SCN* may not be appropriate for publication in *CHC NEWS*, which is available to a much wider readership than CHC members.

Insurance pitfalls

Roger Poole, Assistant National Officer, National Union of Public Employees, Civic House, 8 Aberdeen Terrace, London SE3 OQY. Tel: 01-852 2842.

As part of a trade union campaign to defend the concept of an NHS funded out of national taxation and free at the point of need, Nupe is doing research into private medical insurance. We are concerned that privately insured people are not aware of the limitations on their insurance policies, which could mean that they are left with very heavy medical bills if the cost of their treatment exceeds the amount for which they are insured. We would be interested to hear from CHCs about any such cases that may have been reported to them. We would also like details of cases where people have tried to take out private medical insurance and have been refused cover, for whatever reasons. Please send details to me — they will be treated in the strictest confidence.

Mind-blowing enquiries

Dag Saunders, Secretary, Salop CHC

In the Healthline section of *CHC NEWS 69* you commented on telephone directory entries for CHCs. It is quite an instructive experience to ask Directory Enquiries for the telephone number of your own council. My experience in trying to obtain the numbers of two CHCs in other parts of the country, both of which had been in their existing offices for five years, was little short of mind-blowing.

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

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Comment

When the reorganisation blueprint *Patients first* appeared, in 1979, it said there was a "strong case" for consultants' contracts to be held at district level rather than by region. But the consultants had no intention of being employed by the new "less remote" DHAs, and in the end the DHSS had to capitulate. The response to *Patients first* also underlined the general dissatisfaction with family practitioner committees — yet the DHSS is now allowing them to become independent health authorities.

Concern is also growing about unit management. The new units will be run by an administrator and a director of nursing services "in conjunction with a senior member of the medical staff", with "maximum delegation of responsibility down to unit level". According to the *British Medical Journal* this move by the DHSS towards unit autonomy has come about "partly in response to the complaints of doctors and others who harked back to the days before 1974, when the hospital secretary and matron were often powerful characters whom consultants could influence.".

Last November, at a conference on NHS reorganisation, a consultant gave an extraordinary talk. Barnsley CHC secretary Alan Hicks was there, and says it went like this: "The medical profession saw the present restructuring as their opportunity to take command. They had already won the first and second rounds, ie contracts to be held at regional level and FPCs as independent authorities. Out of 16 members on the new DHAs three or more would be medical men. The district management team of six would have three medical men. If they worked together they would be able to control all decision-making. The matron was to be restored to power in the guise of director of nursing services, and would no doubt pay obeisance to the consultants... the medical profession believed they were in the process of breaking up the NHS and taking it back to the days of pre-war medicine, when they were in total command".

What does all this add up to? Could there be any truth in such an amazing speech? Looking back, will we remember 1982 as The Year of The Doctor?

Health News

Government health insurance plans are still alive

The Government has not yet entirely ruled out the possibility of introducing compulsory health insurance as a way of helping to finance the NHS. Press reports suggesting that this option has been abandoned by DHSS Ministers are "slightly misguided", according to a DHSS spokesman. Ministers are now considering the report of the inter-departmental working party on alternative finance for the NHS, and although no further statement has been promised they have not yet decided what further action should be taken, nor have they decided whether the report itself should be published.

The growth of private health insurance could have tragic consequences for the NHS unless it is carefully controlled, according to Paul Torrens, a professor of health services administration at the University of California. Writing in *The Lancet* about experiences in the USA (1) he warns of five major problems: the fragmentation of policy and planning, the creation of two classes of health care, the loss of scarce personnel from the NHS, a rise in the cost of health care without a corresponding improvement in people's health, and increased spending on medical technology.

1. *Lancet*. 2 January 1982, pages 29-31.

Children's welfare

Since last October former members and staff of the Children's Committee have been working on their own initiative to assess potential support for a permanent advocacy group for children. The group includes professionals from the fields of health, education and the social services, and hopes to report on its findings at the end of April. Submissions to the Chairman, Professor Nicholas Deakin, c/o the National Council for Voluntary Organisations, 26 Bedford Square, London, WC1. Tel: 01-636 4066.

Personal care in pregnancy

An important new report on GP obstetrics has been hailed as a milestone by doctors. The *Report on training for obstetrics and gynaecology for general practitioners* is by a joint working party of the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of General Practitioners (RCGP). It calls for a greater involvement by GPs in the medical supervision of pregnancy and birth, and proposes the establishment of Maternity Services Liaison Committees in every district to integrate services. The report expresses sympathy with women who request home births to escape high-technology consultant units, and suggests that GPs can help to humanise hospital deliveries. The Colleges are asking for comments on the report by 1 May. Copies from the RCOG, 27 Sussex Place, London NW1 or the RCGP, 14 Princes Gate, London SW7.

Clearing the air

CLEAR — the Campaign for Lead-free Air — has been launched, with a wide spectrum of support including the Association of CHCs, Friends of the Earth, the Health Visitors' Association, and at least 139 MPs including leaders of the Labour, Liberal and Social Democratic parties. CLEAR wants to see the Government's promised cuts in lead in petrol brought forward, with lead-free petrol introduced by early 1985. The CLEAR handbook *Lead-free air... a legacy for our children* costs £1.50 inc post from 2 Northdown Street, London N1 9BG.

Real growth?

The Government's NHS revenue plans for 1982/3 have been criticised by the National Association of Health Authorities (NAHA), which fears that the estimate of a 1.7% real growth in services is unrealistic. Plans for spending allow for only 9% inflation on prices and 4% on pay, yet inflation forecasts are higher than this, and NAHA claims that the growth allowance may be swallowed up by increased numbers of elderly patients and pressure from advances in medical technology.

Accountability for spending

The DHSS has announced plans to make health authorities more accountable to it for the money they spend. Beginning later in 1982/83, Ministers will lead annual reviews of each region's long-term plans, objectives and effectiveness. One aim will be to ensure that regions are using resources in accordance with Government policies — eg by giving enough priority to services for the elderly, the handicapped and the mentally ill. The Department believes that successive reviews will "enable Ministers to measure the progress made by regions against the agreed plans and objectives, as well as to determine action necessary in the year ahead". For more details see circular HN(82)3.

Receptionists under fire

GPs' receptionists are a very unpopular group — often showing "classic bureaucratic symptoms of officiousness, inflexibility and high-handedness" — according to a National Consumer Council report on bureaucracy (2). Of the 2000 people surveyed throughout the UK, many commented "with particular force and eloquence" on the behaviour of receptionists. Comments included: "You have to be sick by appointment", and "Autocratic and awkward... make me feel I am a criminal for being ill". It was also alleged that receptionists sometimes attempt to diagnose and prescribe over the phone.

2. *Bureaucracies*, £2 inc post from the NCC, 18 Queen Anne's Gate, London SW1.

● Article on receptionists, next page.

The receptionist's dilemma

Receptionists in general practice have been characterised as "battle axes" and "dragons" by the popular press. Why are they so often seen in this negative way?

One answer is because of their structural position in general practice — the receptionist is the intermediary through whom virtually all contacts between patients and their doctors are made. She has to cope with the needs and demands of both patients and doctors — and these may be in conflict. Patients often want to see a doctor as soon as possible, while the doctor may be concerned to finish the surgery session "on time" or to limit the number of home visits. The receptionist is in the middle, having either to cope with irate patients unable to get an appointment when they want, or to bear the wrath of doctors who wanted to finish surgery earlier.

The receptionist's role is to a large extent administrative — controlling scheduling procedures in such a way that the organisation of general practice runs smoothly. However, the receptionist has an important social role and may also have an active influence on who sees the GP, where and when.

The researcher Rudolf Klein (1) found that receptionists and the way they work were responsible for nearly half the "expressions of dissatisfaction with general practice" which reached family practitioner committees. This suggests that ease of access to GPs and the activities of receptionists matter a great deal to patients.

Further evidence of patients' dissatisfaction with receptionists is available in my survey of a random sample of over 1000 adults, interviewed in late 1977(2,3). Over a quarter of the sample said they sometimes had to insist when talking to the receptionist, eg to get an urgent appointment or a home visit. Thirteen per cent said that the receptionist was not always courteous, 15% that she "talked down" to them, and 17% felt that she was more of a barrier between themselves and the doctor than a help. When the responses to these questions were combined, it was found that nearly two fifths of the sample made one or more negative comments about receptionists, and 13% were highly critical, making three or four negative comments.

Greater criticism of receptionists was made by parents with children under 16. People who are more likely to have required urgent appointments or home visits will have had more experience of the controlling role of receptionists. Parents with young children are an obvious group in this category, and the survey data support this. In addition, more criticism of receptionists is found among health centre attenders, and to a somewhat lesser extent those attending large group practices. One explanation of this is that receptionists are likely to operate with more rigid, formalised rules in larger organisations.

*by Sara Arber**

The doctor's buffer

The extent of criticism of receptionists varies between practices, being influenced by the operating policy of the practice. For example, where the doctors in a practice have a policy that patients should not be "fitted in" or that home visits should be minimised, the receptionist is the one who must put this policy into practice and so bear the brunt of anger and frustration from patients who have difficulty seeing the doctor. As a GP recently said to me, "Doctors get the receptionists they deserve", implying that GPs who are more concerned to have a controlled existence and to minimise their workload have receptionists who appear as barriers, seeming "officious" to patients because they act as a buffer for the doctor.

The number of receptionists employed in general practice has increased rapidly in recent years (2). Practices are reimbursed by the FPC for 70% of the salary of two whole-time-equivalent staff per GP. A high proportion of receptionists work part-time, because of the split surgery hours and because many are married women with family commitments. One result of part-time work is that there is often a large number of reception staff working in a practice. For example, if a practice of five GPs had the maximum staff for which it could be reimbursed, and half worked part-time, there would be 15 ancillary staff. So receptionists may find it harder to get to know patients, and there may be a lack of continuity for doctors, who may have difficulty interacting with large numbers of receptionists. In some practices, receptionists take on some of the social functions of the doctor, chatting to patients, taking a personal interest in them and their family, and reassuring them. This is most likely to happen where a receptionist has been with a practice for a number of years. The range of work performed by receptionists in general practice varies both according to whether specialised tasks are split between different personnel — telephonist, appointments clerk, filing clerk, receptionist, typist, practice manager — and with the policies of the practice. In some practices receptionists write out repeat prescriptions which are signed by the doctor, or they decide on and allocate home visits. A useful handbook by Michael Drury provides a comprehensive account of the more technical side of the work of a GP's receptionist (4)

Little training

There is little information on how receptionists see their work role. One recent small study of 85 receptionists in Aberdeen reports that 40% "expressed doubts about the extent to which their job had sufficient status in the eyes of doctors", and two thirds felt this about their status in the eyes of the public (5). Concern was felt by over half about the adequacy of feedback given to them by doctors about their work. Over 90% said that they obtained "job satisfaction", but a quarter felt the job created undue stress and another 15% were undecided about this. The main problem isolated by this study was the lack of communication between receptionists and doctors, particularly in terms of feedback about the standard of their work, and it was felt that many doctors did not fully understand or appreciate the demands of the receptionist's job. Over 80% felt their training had been appropriate to their post.

The majority of receptionists have not attended formal training courses, but have learnt "on the job", primarily from other receptionists at the practice. The training schemes which are available, such as training sessions run by some FPCs, tend to emphasise the technical side of the receptionist's job, whereas the important skills of communication and understanding the social and psychological factors influencing consultation and illness behaviour are less frequently covered. Short courses along the lines of the one described by Anderson are ideal (6). This course of six two-hour sessions gave an equal emphasis to more factual issues (eg medical ethics and confidentiality, dealing with requests for home visits and advice, and the primary health care team) and to the interpersonal, behavioural aspects of the receptionist's work (eg conflicts in the role of the receptionist, communication skills, and coping with aggressive and anxious patients).

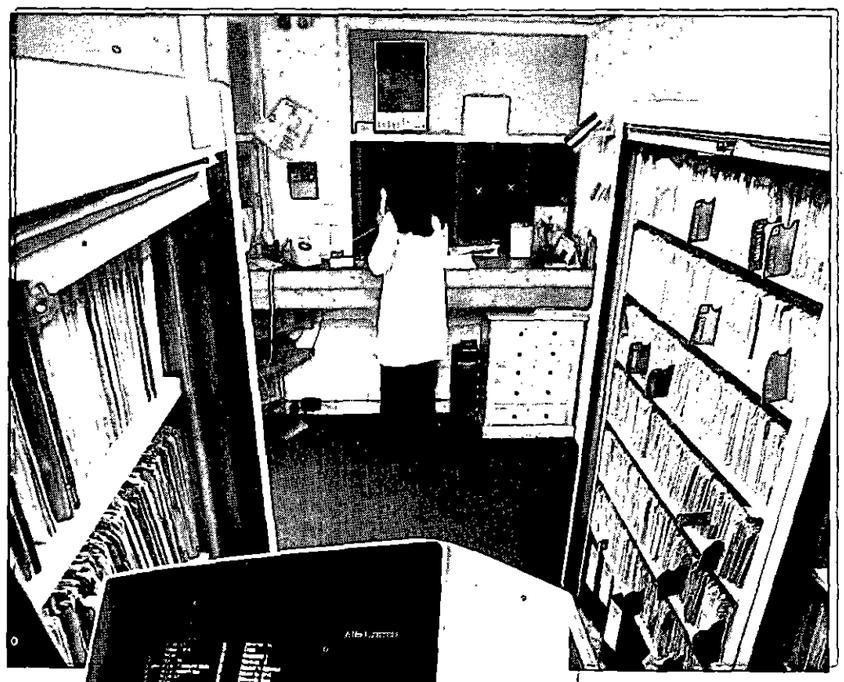

Photo: Liz Heron

Photos: Medeconomics

Poor pay

Two continuing problems for receptionists are poor pay and inadequate contracts of service. Sometimes there is no contract of service at all. Anderson found that the majority of receptionists on his course were paid less than the scale rate recommended by the Guild of Medical Secretaries, and none was paid more (6). Receptionists' pay is separately negotiated within each practice and there are wide discrepanies in rates. There is little evidence of receptionists working to improve this situation by combining into unions or local professional associations. At present, there is a lack of forums through which receptionists can meet and become aware of how other receptionists are dealing with similar problems. CHCs could possibly stimulate this through organising meetings on specific topics of relevance to receptionists, which would also encourage liaison between receptionists, reducing their general isolation from each other.

Research studies on receptionists in general practice all point to the critical importance of good communication between doctors and their receptionists. In some practices this occurs on an informal daily basis, but in other practices involvement in a minimum of a monthly practice meeting is essential, so that receptionists really are accepted as part of the practice team and can have their concerns listened to and where appropriate acted on. They are often the ones who know most about what improvements are needed, for example in how the appointment system works. This might reduce the number of patients who are understandably irate when told that the earliest available appointment is in five days time!

References

1. *Complaints against doctors*, by R Klein with A Howlett. Charles Knight, 1973.
2. *Changes in the structure of general practice: The patient's viewpoint*, by S Arber and L Sawyer. Unpublished report to the DHSS. 1979.
3. *Changes in general pactice: Do patients benefit?* by S Arber and L Sawyer. British Medical Journal, 21 November 1981, pages 1367-1370.
4. *The medical secretary's and receptionist's handbook*, by M Drury. Bailliere Tindall, Fourth Edition, 1981.
5. *The medical secretary: Her views and attitudes*, by D A Alexander. Journal of the Royal College of General Practitioners, June 1981, pages 368-371.
6. *A broader training for medical receptionists*, by P M D Anderson, S Anderson and D A Lander. Journal of the Royal College of General Practitioners, August 1980, pages 490-494.

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Testing the water

The use of a panel

by Martyn Smith, Secretary, West Birmingham CHC

To represent their communities, CHCs need to acknowledge public opinion. When the CHC view differs from public opinion, members should be aware of this and be convinced of their reasons for differing. A frequent justification for such decisions is that public opinion is uninformed, and the CHC represents the best available informed public opinion. We are dissatisfied with such arguments, and in 1978 we started to establish a source of informed public opinion by setting up a "panel".

The aim is to maintain regular contact with a representative group of 200-300 residents, matched as far as possible by age, sex and area of residence with the district population, and to question this group when seeking public opinions. The argument is that by receiving CHC papers and taking an interest in health matters, this group becomes unrepresentative only to the extent of being better informed. This is a relatively cheap method of assessing informed public opinion, and the group also acts as an informal "grapevine" within the district, which knows quite a lot about the CHC and its work and can refer grumbles and problems to the office.

We recruit panel members mainly by door-to-door delivery of leaflets. The alternatives are working through voluntary organisations, which under-represents the relatively isolated members of the community, and door-to-door canvassing, which would be expensive. Replies to our leaflets come in by Freepost.

Initial recruiting was phased over a year, and later phases were restricted to under-represented geographical areas within the district. Additional recruiting is needed at least annually to maintain the panel. Members move or die and have to be replaced. Others stop responding to questionnaires, so the panel has to be "weeded" at intervals to ensure that the response is representative. The recruiting leaflets, which are combined with a newsletter, encourage applications for membership from people who would improve the demographic balance of the panel. In this way, we have had to turn down only a very few applications.

Panel members receive the policy papers going to the monthly CHC meetings. They are invited to attend or submit comments, but it is made clear that this is not a duty, and we rarely get more than a couple along. In the last two years, members of the panel have been asked to deal with ten questionnaires on a wide variety of subjects, some initiated by a CHC interest and others by NHS planning issues. Secondary care, primary care and matters only peripheral to the NHS have all been covered.

Questionnaires are circulated with the monthly papers and returned by Freepost. One advantage of the method is that any supplementary questions can be raised with the same people, and if necessary ambiguities can be clarified. We try to avoid sending any relevant information with a questionnaire. Even just mentioning a subject accentuates its importance to the respondent and distorts the results. A paper circulated a few months earlier is less intrusive, becoming a part of general background knowledge.

The panel system has its limitations. It does not purport to be based on random sampling. Because it relies on volunteers prepared to become informed about the NHS, the sample is to some extent self-selected. This is an accepted limitation rather than an error of the system. People totally illiterate in English are unrepresented (an attempt to recruit such members paired with helpers who would communicate with the CHC brought no response from voluntary organisations). "Mobile" people are less likely to join the panel and more likely to move away, and are increasingly under-represented. The articulate middle class is over-represented. These problems can be reduced, though not eliminated, by selective recruitment of replacements. We feel that the age/sex/area matching described is all we can reasonably attempt.

Experience is teaching us another limitation, namely that some subjects are more appropriate for panel research than others. Response rates to questionnaires differ markedly. Primary care services generate a generally good response, and so do questionnaires on subjects peripheral to the NHS, but only a small number of people have information on and views about subjects such as hearing aids and mental handicap.

We find our panel useful for giving a broad indication of what members now accept as informed public opinion. But it is only a broad view, and we consider the results significant only when an opinion is very strongly apparent. Above all, the exercise helps us to concentrate more detailed CHC work on the problem areas highlighted by panel opinion.

Book reviews

Self help in the inner city

by Barry Knight and Ruth Hayes, London Voluntary Service Council, £3.50 (available from MacDonald and Evans Distribution Service, Estover Road, Plymouth PL6 7P7).

A useful addition to the fairly small body of literature on the evaluation of community initiatives. Disappointing that the researchers chose to use pseudonyms for the four London boroughs and smaller areas within them which they studied. The researchers found that the statutory social services were seen by clients as unacceptable and ineffective, and point out that, while people felt there was less stigma attached to seeking help from community groups, many of the groups studied re-create the "privileged worker/poor client" relationship. Their broad conclusion is that community initiatives are currently marginal to inner city communities — too small in scale, coverage and intensity — but that self-help should be a key feature of any strategy to revitalise the inner city. The measures which they suggest to facilitate self-help include: adequate, secure, accessible funding; employment of non-professional, local workers; less bureaucracy and more social activities in groups.

Susie Parsons, Secretary, Kensington, Chelsea and Westminster NW CHC

Delegation in general practice

by Ann Bowling, Tavistock, £10.50

This immensely readable little book gives an insight into GPs' delegation to nurses, which should help CHCs understand some traditional attitudes of doctors and their apparent sensitivity about their independence. Indications are given that the modern GP lacks a clearly defined role in medicine, being asked to refer "interesting" patients for specialist advice and to delegate certain clinical duties to practice nurses. The importance of the GP as a personal, first contact, is stressed, as is the doctor's independence and autonomy, which is being eroded by the involvement of nurses and social workers in certain aspects of his role. The nursing profession is establishing its own identity aside from medicine, and this may deter nurses from accepting medical tasks delegated by doctors. Conversely, delegation of clinical work may enhance nurses' job satisfaction. The role of nurse-practitioners in the USA is discussed, and on economic grounds experimentation here is suggested. The future role of the GP may include more preventive medicine, and more involvement in the emotional aspects of illness.

Fiona Drake, Secretary, South East Cumbria CHC

Books received

Training for general practice by D J Pereira Gray (Macdonald and Evans £9.95, ISBN 0 7121 2004 1)

Get help: A guide for social workers to the management of illness in the community by Primrose Halliburton and Kate Quelch (Tavistock £2.95, ISBN 0 422 77570 3)

Parliament

Hospital complaints

The DHSS is preparing an explanatory leaflet about procedures for complaining about hospital services, and CHCs will get supplies to give to the public on request. But the Government "does not see it as part of the role of CHCs to give the procedure general publicity" (Dr Roger Thomas, Carmarthen, 8 December).

Ophthalmic services

During 1981/82 the average cost of a pair of spectacle lenses, including dispensing fee, was £12.70, and from 1 April the new maximum charge will be £30 (David Atkinson, Bournemouth East, 8 December).
The increase in the maximum charge for a lens will be 81% (Terry Davis, Stechford, 7 December).
NHS frames account for 50% of all new frames supplied (Michael Shersby, Hillingdon Uxbridge, 23 December).
Twenty years ago there were 23 different NHS frames for adults and six for children. Now the figures are 12 and five. Dr Vaughan has been reviewing the range of NHS frames, with the optical profession and industry, and hopes that "some improvement can be made fairly soon" (Austin Mitchell, Grimsby, 23 December).

Dental therapists

The New Cross training school for dental therapists will close in summer 1983, but there will continue to be an "important role" for dental therapists in the NHS, and dental schools around the country will be asked to train small numbers of therapists "to meet local demand" (Adjournment Debate, 21 January).
Closure of the New Cross school will save £0.9m pa at current prices (Nigel Spearing, Newham South, 24 November).
The school is the only one at present training dental therapists in the UK (Dr Roger Thomas, Carmarthen, 27 November).

War planning protests

Four CHCs have protested to the DHSS about the creation of regional "home defence planning" posts — Bexley, North Camden, Islington and Walsall (Doug Hoyle, Warrington, 3 December).

Management costs squeeze

In 1979/80 in England, 5.14% of NHS resources were spent on management. Over the three years beginning next month, this expenditure must be reduced by 10%, with regional cuts ranging from 3.14% (Mersey) to 18.09% (SW Thames) (John Hunt, Bromley Ravensbourne, 23 December).

Open FPC meetings

When family practitioner committees become independent health authorities they will be subject to the Public Bodies (Admission to Meetings) Act 1960, and so will be required to admit the public and press to the non-confidential parts of their meetings (Dafydd Wigley, Caernarvon, 11 December).

Night visits by GPs

Since November 1981 patients visited by GPs at night have not been required to verify the visit by signing form FP81. Authenticity of forms is now subject to random checks by FPCs (Laurie Pavitt, Brent South, 23 December).

Scanner

Family care

Some 66,000 mentally handicapped adults live at home with their families, and for these people "community care" still tends to mean "family care". The Campaign for Mentally Handicapped People's new report *Living for the present* includes a series of interviews with older parents, and makes recommendations for those responsible for the planning and development of services for mentally handicapped people and their families. £2.25 inc post from CMH, 16 Fitzroy Square, London W1P 5HQ.

Design guidance

A wide range of fresh design guidance on NHS buildings is now emerging from the DHSS. The Department's Works Group has just published two pamphlets on mental health buildings, *Residential facilities for mentally handicapped children* and *Health service residential accommodation for severely mentally handicapped people: How to make the most of current design guidance.* Copies of both have been sent direct to CHCs.
A new generation of Health Building Notes, aimed at producing "guidance which is adaptable to local needs and circumstances and at the same

time encourages economy in capital and running costs", has also been launched. HBN 37 *Hospital accommodation for elderly people* (HMSO £3.75) is the first building guidance to be issued by the DHSS on this subject. HBN 38 *Accommodation for adult acute day patients* and HBN 39 *Ophthalmic clinic* have been issued in draft form with circular HN(81)33. Revised cost guidelines for health buildings have been issued with circular HN(82)1.

Health projects and volunteering

The National Council for Voluntary Organisations' *Directory of community health initiatives* describes over 40 community health projects, around the country, many set up by CHCs. £1.40 inc post from the NCVO, 26 Bedford Square, London WC1B 3HU.
Pioneering community mental health services, from the Mental Health Foundation, discusses experimental projects the MHF has supported, ranging from an emergency night shelter for homeless young people to a babysitting service for parents of handicapped children. £1 inc post from MHF, 8 Hallam Street, London W1N 6DH.
The Volunteer Centre has published a package of three reports exploring the potential of disabled people to contribute to the community through voluntary work. £1.90 inc post from 29 Lower King's Road, Berkhamstead, Herts.

Health circulars

HC(82)1: Deals with the setting up of professional advisory committees —medical, dental, nursing and midwifery, pharmaceutical and optical — to advise the new DHAs.
WHC(82)2: Sets out the Welsh arrangements for medical advisory machinery, for medical membership of DHAs and for medical representation at unit level.

CHC Directory: Changes

Changes to the CHC Directory are published on this page in each issue of *CHC NEWS*. Please let us know if your entry needs updating. Single copies of the directory are available free — send an A4-size self-addressed envelope and 25p in stamps.

Page 2: South West Durham CHC Chairman: John Boustead
Page 3: Beverley CHC Secretary (Action) should read Secretary (Acting)
Page 7: Tower Hamlets CHC Chairman: Dr Richard Smith
Page 8: Waltham Forest CHC Chairman: Margaret Wheeler
Page 8: Hastings CHC Chairman: Mrs M Clarke
Page 9: Lewisham CHC Chairman: Barbara Every
Page 9: North West Surrey CHC Chairman: Mrs M Arnold
Page 9: Guy's CHC Mary Sheridan House, St Thomas's Street, London SE1.
Page 11: Aylesbury and Milton Keynes CHC Chairman: Miss N M Sale
Page 13: Dudley CHC Chairman: Dr Deans Evans
Page 13: South East Staffs CHC 4 Bakers Lane, Lichfield. Tel: Lichfield 51030. Chairman: Alan McDonald
Page 15: Rochdale CHC Chairman: Mrs M J Geoghegan

News from CHCs

☐ The **Association of CHCs** has released details of three cases in which regional health authorities are attempting to obstruct the legitimate work of CHCs. On page one of this issue, ACHCEW's secretary Mike Gerrard says he detects a regional "clamp-down" on CHCs, and speculates that regional chairmen have been asked by the DHSS to keep an eye open for CHC behaviour which deviates from the present Government's criteria.

☐ The most bizarre instance of RHA interference involves **Salford CHC's** series of public meetings on women and health, reported on this page last month. The CHC wrote to the North Western RHA's legal department, asking about legal requirements for running a crêche during the meetings, only to receive a reply suggesting that the NHS Act 1977 does not empower CHCs to run health courses. Further correspondence elicited the remark that "health education falls within the scope of health care rather than within the scope of the representation of the local community's interests". The CHC points out that running meetings and courses is commonplace amongst CHCs, and that other CHCs which have run courses specifically on women's health issues include **Bexley, Brent, Cardiff, City and Hackney** and **Leeds Western.** Furthermore, the Government's own handbook on NHS policies and priorities *Care in action* states clearly that CHCs "can help to transmit the preventive message to the public". Meanwhile the meetings have been continuing, with about forty members of the public attending each week.

☐ The second case concerns a complaint about a GP, in which a member of **Cambridge CHC** acted as the "patient's friend". Presumably because the FPC service committee hearing was so unsatisfactory — the GP refused to produce the medical records — the DHSS ordered that the case be reheard before a barrister. In such repeat hearings both parties are entitled to legal representation, and the CHC member was understandably reluctant to tangle with a medical defence society barrister. The CHC's request to be allowed to pay for the patient to be legally represented was turned down flat by the RHA, with no offer of help from its own legal department. The result of the second hearing is not yet known, but if necessary CHC members have agreed to have a "whip round" to raise the £200 or so that will be needed.

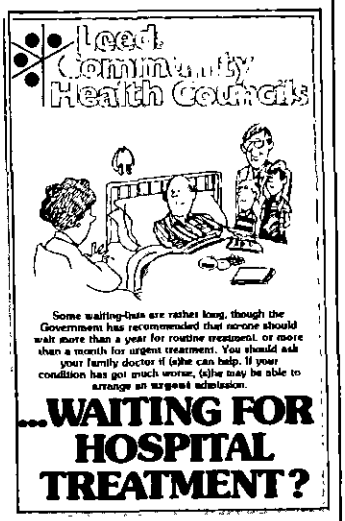
☐ The third case is a more overtly political battle between **Brent CHC** and the North West Thames RHA. It began when Brent offered the use of its premises to a local political group, for a meeting on the theme of "Troops out of Northern Ireland". The RHA warned that NHS premises "may not be used for any purposes other than those clearly connected with health care", and the CHC subsequently agreed to restrict the use of its office by community groups to "those meeting to discuss health and health care issues — as defined by our council". But this did not satisfy the RHA, which then demanded advance notice of all outside use of the premises, "to avoid any misunderstanding over the relevance to health care issues of matters to be discussed at future group meetings". The CHC sees this as an infringement of its autonomy, and does not intend to comply. The RHA is also complaining about Brent's new leaflet on prescription charges, mentioned on this page last month. Three of the leaflet's four pages discuss patient's rights, but the fourth launches a bitter attack on Government spending policies —contrasting cuts and shortages in the NHS with increases in defence spending. A letter from regional chairman Dame Betty Paterson says: "It is not the function of health service authorities to publish comments of a political nature on Government decisions, and ... it is quite unacceptable for public funds to be spent in this way ... I seek your assurance that information leaflets issued by your council in the future will be free of political comment". Brent rejects the notion that "politics" can be kept out of representing a community's interests.

☐ *Health Minister Dr Gerard Vaughan has agreed to address the next annual general meeting of the* **Association of CHCs** *— accepting an invitation originally extended to Social Services Secretary Norman Fowler. The two-day AGM, will be held in Coventry on 24 and 25 June.*

☐ **Medway CHC** is fighting a decision to centralise radiotherapy services in the region, closing the local unit at St Williams. The CHC claims that RHA officers have underestimated the difficulties for cancer patients travelling to Pembury, the unit proposed to take over services, and to prove the point arranged a trial ambulance run with volunteer "patients". In favourable weather conditions the round trip took four hours and forty minutes excluding treatment time. Patients too queasy after therapy to face the ordeal would have to opt for in-patient treatment, and the CHC estimates that this would mean 40 extra beds and 20 hostel places at Pembury.

☐ SE Thames RHA's centralisation policy upset **King's CHC** too, but they have just won the battle to save their radiotherapy unit at King's College Hospital, after 9000 people signed a petition in protest at the closure proposal.

☐ **Lewisham CHC** found support from consultants when it produced a proposal to establish a short-term care and assessment unit for physically handicapped children. Paediatricians agreed that the unit would pull together services scattered throughout the district, ease the burden on parents, and provide a centre of expertise for the treatment of children with mobility problems. After a successful public meeting held by the CHC the health district has set up a working party to plan for the unit.



☐ *How long should you have to wait for an appointment, and what should you do if your condition gets worse?* **Leeds CHC's** *free leaflet answers these questions and others, and explains that waiting lists are not always as bad as people think.*

☐ The controversial "dismissed employees" clause in the recent DHSS circular on CHCs was included at the specific request of the **North Western Regional Association of CHCs.** It wrote to the Secretary of State complaining that the sacked secretary of **Rochdale CHC,** Tom Hughes, had been returned to the CHC as a member by Rochdale borough council. The letter was sent after a meeting of the association at which 12 of the region's 18 CHCs voted unanimously to condemn the borough council's action. The **Society of CHC Secretaries** wrote to the Secretary of State along the same lines.

Other CHC publications

☐ Travelling to health: A guide to voluntary transport schemes **(Aylesbury and Milton Keynes CHC),** If your are nursing an elderly person at home ... advice leaflet **(Cambridge CHC),** A guide to services in Cornwall for families with a handicapped child **(Cornwall CHC),** Needs of the disabled in Haringey **(Haringey CHC),** Voluntary visiting services **(Lancaster CHC),** 1974-1981 A review **(St Thomas' CHC),** Report on a survey of parents of mentally handicapped children **(South Tyneside CHC).**