



# the columns

## correspondence

### Remember patients' views

Sir: The Government is said to be strongly committed to the principle of partnership between the NHS and patients (Stuart, 1999). A recent Government document, *Patient and Public Involvement in the New NHS* (NHS Executive, 1999) emphasises the importance of 'patient partnership' as central to the work of the NHS Executive. Hence an increasing amount of emphasis is being placed upon managers and clinicians to involve patients in the planning of the delivery of services. Little work has been done in this area. We would like to share the findings of a study of the preferred choice of psychiatric patients regarding the site for out-patient clinics, and the factors that influenced their choice.

Previously, in-patient psychiatric services for the Borough of Solihull were provided at Hollymoor Hospital, a traditional psychiatric hospital, approximately 15 miles from the centre of Solihull. Out-patient services were provided at Lyndon Clinic, a resource centre within the locality. When Hollymoor Hospital closed, in-patient services were transferred to the purpose-built Solihull Hospital, a District General Hospital. At this stage there was an opportunity to transfer out-patient clinics to the new hospital.

A questionnaire was designed to determine patients' preferences regarding the site for out-patient clinics – Lyndon Clinic or Solihull Hospital – and also the factors that influenced their choice. The questionnaires were distributed by the receptionist to 100 consecutive attendees at Lyndon Clinic and the patients were asked to complete and return them anonymously. The response rate was 100%. Data were analysed using the Chi-squared test.

Of 100 responses, 69 subjects had visited the new hospital, and only these data were analysed further. Of the 69, 51 (74%) preferred that the out-patient clinics be held at Lyndon Clinic, 11 (16%) preferred that the clinics be transferred to Solihull Hospital and 7 (10%) had no preference.

Parking and the availability of a convenient bus route were the only significant factors in determining patients' preference for the site of the clinic. Surprisingly, the

quality of the reception, waiting area, the décor and the presence of catering facilities did not influence the choice of the site.

Many hospitals are large, centrally located establishments and often have poor provision for car-parking, which may lead to unnecessary increased levels of anxiety in patients. We invite comments from others on experience in this area and recommend that managers examine and consider these factors when planning services.

NHSEXECUTIVE (1999) *Patient and Public Involvement in the New NHS*. Leeds: NHS Executive.

STUART, G. (1999) Government wants patient partnership to be integral part of NHS. *British Medical Journal*, **319**, 788.

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### Learning disability teams and mental health trusts

Sir: As O'Hara discusses (*Psychiatric Bulletin*, October 2000, **24**, 368–369), there are interesting times ahead for community teams for adults with learning disabilities (CTLD). Such teams provide a range of services of which mental health is only one component. CTLDs reside within community, rather than mental health, trusts, with important consequences. O'Hara highlights two of these: perpetuation of a model of separate health services for people with learning disabilities and difficulties implementing key areas of health care policy such as the Care Programme Approach. Partitioning CTLDs between mental health and primary care trusts would help to delineate their specialist mental health component. It would also help to achieve the ideological goal of 'mainstreaming' while respecting the need for specialist psychiatry.

However, I am concerned about how CTLDs will be received by mental health trusts. Perhaps the single biggest priority of a general mental health trust is to

maintain general psychiatric services and when limited resources are available specialist teams cannot always take their worth for granted. Without mention in the National Service Framework, newly relocated CTLDs may find themselves particularly vulnerable and will need to work especially hard to earn status and support. This may be an uphill task where learning disability specialists have little or no significant general psychiatry experience at higher training level and risk being perceived by some colleagues (themselves with no useful training in learning disability) as professional outsiders.

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### New BNF maximum recommended dose for haloperidol

The maximum recommended dose for haloperidol has been reduced from 100 mg (rarely 120 mg) to 30 mg a day for oral therapy and from 60 mg to 18 mg a day for intramuscular administration in the latest edition of the *British National Formulary (BNF 40)*; British Medical Association & Royal Pharmaceutical Society, 2000). This dosage change has not been widely publicised; we only became aware of it through a message posted on the UK Psychiatric Pharmacists' website by a pharmacist, Margaret Rotchell. It appears that the changes to the maximum recommended dosage of Serenace (manufactured by Norton Healthcare) were made to the drug's licence back in September 1998 but have not been brought to the attention of doctors and pharmacists.

The dosage change has implications for patients who are receiving haloperidol on a Form 38 or 39, as the dosage they are receiving may no longer be 'within BNF limits' and therefore may not be covered by these forms. Inevitably, more patients will now be considered as being on 'high dose' antipsychotic therapy and should be the subject of physical monitoring (Thompson, 1994). Strictly speaking, these patients should be made aware that they



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are now on high dose therapy and this may affect their consent to treatment.

BRITISH MEDICAL ASSOCIATION & ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN (2000) *British National Formulary*. London & Wallingford: BMJ & Pharmaceutical Press.

THOMPSON, C. (1994) The use of high-dose antipsychotic medication. *British Journal of Psychiatry*, **164**, 448–458.

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## New mental health information strategy

Sir: Elphick (*Psychiatric Bulletin*, November 2000, **24**, 426–428) stated a true picture of the difficulties in bringing health information strategies into the forefront of psychiatry. He reiterated that more clinicians need more informatics training (NHS Executive, 1999). Unless the clinicians play a part in the frontline developments we will never have a good operational system. With these ideas in mind I would like to inform like-minded clinicians that there are opportunities to be trained. I am currently on a Diploma in Medical Informatics course which the forward thinking Royal College of Surgeons in Edinburgh have started in October 2000. This involves 12 modules (at about 75 hours per module) starting from an introduction to 'information' and leading to proficiencies in databases, telemedicine, electronic health records and other computer and web-related medical topics. You need a computer and connection to the internet. Apart from the initial weekend in Edinburgh and a final week in Edinburgh (2–5 years later) you can do everything else on-line. The course is challenging and lateral thinking is a useful advantage as

concepts are quite wide-ranging in the introductory module.

I suggest a look on the Royal College of Surgeon's website (<http://www.rcsed.ac.uk>) for further information.

NHS EXECUTIVE (1999) *Learning to Manage Health Education: A Theme for Clinical*

*Education*. Enabling People Programme. Bristol: NHS Executive South and West.

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## Shakespeare and beef

Sir: Given the current topicality of concerns about the safety or otherwise of beef, both in this country and in continental Europe, I was most interested to note the following exchange between Sir Andrew Aguecheek and Sir Toby Belch in Shakespeare's *Twelfth Night* (Act I, Scene III):

Sir Toby: O knight, thou lack'st a cup of canary! When did I see thee so put down?

Sir Andrew: Never in your life, I think; unless you see canary put me down. Methinks sometimes I have no more wit than a Christian or an ordinary man has; but I am a great eater of beef, and I believe that does harm to my wit.

Sir Toby: No question.

I have always been an admirer of Shakespeare's descriptions of medical and psychiatric conditions, but can it be that in this case, as in so many others, he has once again exhibited remarkable prescience?

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## Managers' hearings and patients' rights

Sir: I read Gregory's opinion (*Psychiatric Bulletin*, October 2000, **24**, 366–367) and Kennedy's humorous editorial reply (*Psychiatric Bulletin*, October 2000, **24**, 361–362) with interest. As a practising clinician and long time medical member of the mental health review tribunal I would like to make the following points.

Manager's tribunals have no discretionary powers. They must decide on the legality of the section, continue if it is legal, discharge if it is not. Kennedy is right that discharges by managers are rare, I believe the national figure is less than 1% but there is a wide variation, with some trusts having a figure above 20%. If there are a significant number of illegal sections this is a cause for enquiry. I suspect the truth is that a minority of managers overstep their remit.

Issues of medication, side-effects, polypharmacy, prescribing within *British National Formulary* limits and consent to treatment (Gregory) are all matters that managers should concern themselves with. They should ensure that their trust has policies and procedures in place to monitor these matters. They have no part in a manager's appeal.

Kennedy is right to raise the matter of legal representation at managers' appeals. This has crept into practice and should be stopped or else the panel must have legal expertise in all cases. Lawyers rehearse their questions for a future tribunal – this runs contrary to the British legal system and is akin to the American system of pre-disclosure of testimony.

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## the college

### Annual Census of Psychiatric Staffing 1999

Occasional Paper OP50  
£7.50. 74 pp.

This eighth annual census undertaken by the Royal College of Psychiatrists relates to psychiatric staffing in England, Scotland, Wales and Northern Ireland as at 30 September 1999. For the first time the assumptions made in producing the census are clearly given.

The College has confidence that the census provides the most accurate picture we have of psychiatric staffing in the UK.

This is vital information as we work towards producing an effective response to the National Service Framework for Mental Health and the NHS National Plan, and their respective workforce expansion requirements. The data collected in the census have a direct bearing on the College negotiations with the NHS Executive with respect to the number of national training numbers that remain within the speciality, or are added or withdrawn from its pool.

### Comment

There has been an overall increase in consultant posts with growth rates

varying from 4.6%, England, 7.4%, Scotland, under 1% in Wales and a slight reduction in Northern Ireland by 5%. There is considerable regional variation. The North West and Mersey have over 20% vacant posts, compared with 17% in Yorkshire, but under 8% in East Anglia, Oxford, Wessex and all of Scotland except the West. Compared with last year, the vacancy rate generally is coming down despite the creation of new posts. There is also variation between specialities. In child and adolescent psychiatry recruitment is improving in most areas except Scotland. The same is true of forensic psychiatry where 16% of posts in Scotland are vacant, but empty posts are reducing everywhere else. Learning