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Association of Community Health Councils for England and Wales
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CHC/RHA RELATIONS

Following correspondence with Wessex RHA last summer over the difficulties some CHCs had in finding subscriptions to ACHCEW, Tony Smythe circulated all RHAs on 8 July. He reminded them that membership of the Association was purely voluntary but that annual subscription income was our main source of funding. Most CHCs agreed with the principle of having an Association and currently our membership is 175, a drop from 205 in 1983. However, while a small number of CHCS had decided that ACHCEW did not sufficiently fulfil their needs, others had left because they could not afford the subscription; in some cases because their general budget did not cover the expense and in others because certain RHAs were reluctant to allow specific allocations from their budgets.

Other pressures are now beginning to emerge with additional responsibilities, notably the new relationship with FPCs. There has been no recognition on the part of any RHA as to the resource implications involved. The DHSS has recognised the problem but rejected the idea of offering guidance to RHAs. In order to plan ACHCEW's national activities and services, therefore, we need to know details of policies and procedures in relation to these matters, particularly in the light of Griffiths. Two other areas for concern were salaries, conditions and training opportunities for CHC staff and the relationship between CHCs and RHAs in relation to policy and consultation.

This evoked a deafening silence, so a second letter was sent on 30 October and, so far, eleven RHAs have responded. Given lack of space, we can only give a brief account of the results:

Yorkshire RHA: Saw little need for additional financial resources for CHCs. CHCs in its region had a history of underspending, although three had marginal overspending. CHCs met ACHCEW subs. from "all other expenses" on their budgets. In the past CHCs known to have some difficulty were allotted a

further £100 but this was when the sub. was £150. Therefore, the RHA saw no reason to increase the cash allocation although some further adjustment might be needed in 1986/87 to take into account different subs. bands. As most CHCs had observer status at FPCs previously, the RHA saw no need for extra resources for this. Regarding staff training, the RHA recently devolved the approval of non medical study leave to the appropriate budget holder and budgetary provision existed.

Merseyside RHA: Funds basic training for new CHC Secretaries and includes in-training for Authority members and CHC members too. There are a number of organised study days and events. The job description for posts of CHC Secretary in Merseyside RHA is the same now as when the posts were initially graded in 1974 and "the responsibilities attached to these posts are no different now than in 1974." To argue that there should be "a separate career structure for CHC Secretaries seems the same as saying there should be one for Medical Records Officers." (We had not suggested this.) Career improvement should be by moving into other spheres of administration. As CHCs have always liaised with FPCs, the RHA could see no need for additional funding. CHCs subscriptions appeared as part of their budget submissions and, as such, were subject to normal cash limits, the final budget going to the Regional Chairmen for approval.

Wessex RHA: No Wessex CHC has said there was a need for additional resources to cope with additional FPC representation. Any additional funds to CHCs could only be made available at the expense of other areas of health care. Wessex RHA's priority was for improving resources allocated to direct patient care. CHC staff salaries were graded by the Whitley Council and this was their responsibility. Wessex RHA is not aware of any criticisms from CHCs about lack of training. If there is significant cost in respect of training CHC staff member, the expense is met from a centrally held RHA training budget.

S.W. Regional Health Authority: Realises that the new system regarding FPCs will probably add to responsibilities of CHCs but admits it has not given any consideration to the resource implication of this. Nor are there any proposals to do so. "It is likely that it (the RHA) would take the view that, as FPCs have open ended budgets, they should be better placed to contribute to funds of the CHCs. It was appreciated that this raised a new issue for the funding of CHCs but the RHA would wait for a national lead. If CHCs are not satisfied with staff gradings this should be pursued through Whitley Council channels. The Authority holds a central budget to cover training for new CHC members. The location and cost of CHC premises is under review and Cornwall has moved into new premises bought by the RHA. Plymouth and Torbay are moving shortly and alternative accommodation is being sought for Gloucester. In recent years offices have been substantially upgraded and this demonstrates the RHA's concern on this particular issue. While taking on board the point that additional work required additional funding, financial pressure means that the costs of administration need reducing in order to spend more on patient services. Increases for CHCs would add to administrative costs and, therefore, it is unlikely that any additional funding will be made available.
S.W. Thames RHA: CHCs budgets are allowed under very broad

headings and CHCs have autonomy on how that money is spent. After discussion on the new responsibilities regarding FPCs, opinion is divided within this RHA whether there really is an increased workload. At present there is no policy within the RHA and it is for CHCs to determine their relationships with FPCs but there seems little chance of extra resources at present. The RHA is actively looking at ways of improving training opportunities for CHC staff but it is in the hands of the Whitley Council on grading and salaries.

S.E. Thames RHA: Feels the DHSS itself is cynical in bringing in new FPC regulations with no thought given to their implications. The RHA does not agree there should be funding available to allow those CHCs not in membership to join or rejoin ACHCEW. CHC salary scales are a national issue and, anyway, the RHA would want an "objective grounds" for making a regrading case after "careful analysis".

N.E. Thames RHA: It is left to CHCs to decide what is value for money and there is no evidence at this stage that the new relationship with FPCs will require an increase in budgets. A request for regrading all CHC Secretaries in the region is under consideration although they are in line with other Secretaries nationwide. CHC staff have the same access as other RHA staff to in-house training courses but specific CHC training must be paid for by the CHC. The Regional General Manager has met all CHC Secretaries to discuss their role in future regional policy and he is keen to develop a more regular form of communication.

East Anglia RHA: Each CHC is invited to submit annual estimates for its allocation and the RHA accepts subscription to ACHCEW as a bona fide expense. So far no CHC has asked for extra funding regarding the change in status of FPCs and the RHA would need evidence to be convinced this was necessary. The question of grading and salaries of CHC Secretaries has been brought up but all are correctly graded under Whitley Council grades. CHC budgets cover attendance at courses by staff members and the RHA knows of no case where a request has been refused for a specific training course. The RHA has recently reminded DHAs of the need for proper consultation with CHCs and the RHA Chairman and Executive meet CHC Chairmen and Secretaries from time to time for discussion. The next topic will be 'consumerism'.

Oxford RHA: It is up to a CHC to decide whether or not to join ACHCEW and this is not dependent on finance. As FPCs have their own funding, FPCs should fund any extra resources needed by CHCs for any further work involved. CHCs are no different from any other health authority in experiencing financial difficulties and the RHA has made considerable efforts to assist them including the allocation of development money. There is a continuing dialogue between the RHA and CHCs on training needs and assistance is provided where necessary. The Local Association of CHC Secretaries is currently discussing pay and conditions of service and will be seeing Regional Officers shortly. Should CHCs, either individually or collectively, come forward with a case for additional staff or specific funding, this will be considered.

West Midlands RHA: Staffing grades and salaries are set by Whitley but CHCs have flexibility as to how staff is appointed and can use YOP or MSC too. Staff are encouraged to take part in training schemes and financial support is available - some CHC Secretaries have taken university degrees sponsored by the RHA. Career opportunities most likely mean a sideways move at some stage. There is a good relationship between CHCs and the RHA who meet bi-monthly. As well as normal funding for CHCs, there is a contingency reserve to meet individual applications for funding large items of equipment which a CHC can't meet from its own budget or to refurbish premises and a similar sum is held in a Research account and a CHC can submit an application for funding for a specific survey. This is considered by a committee which includes CHC members and Secretaries and a Research Adviser from Birmingham University. (The full reply was the most positive received).

In brief, it appears that all RHAs fall back on Whitley when it comes to discussing grading and salaries and that some also use the need to put resources towards direct patient care as a main reason for not finding more funds for CHCs. No RHA is convinced of the need for extra resources for the new FPC status. Most RHAs are sympathetic towards funding for training courses and some make allowance for ACHCEW subscriptions. Correspondence can be made available to CHC members in the appropriate regions.

ACHCEW's argument for adequate and extra resources for extra work is basically sound but it cannot be denied that underspending in some cases, the success of some CHCs in obtaining "soft money" from outside the NHS (e.g. MSC grants), the refusal of some RHAs to authorise extra staff even when paid for within budget, and the unwillingness of some CHCs to supply information, complicates efforts to get a more coherent approach to funding from RHAs and the DHSS. ACHCEW's own position in being able to make accurate budgetary forecasts for core income based on voluntary subscriptions remains, in the circumstances, parlous.

Are CHCs purely part of NHS administration or something more to do with, if not patient care, then patient support and patient participation?

The consumers strike back

A little publicised but interesting statement was made in the House of Commons on 11th November (in the form of a long Parliamentary Question) from Sir Fergus Montgomery, Conservative MP for Altrincham and Sale about a proposal put forward by the RHA chairman to entirely abolish the Trafford Health Authority. He criticised the chairman and the authority in downright terms over its "inept, cavalier and inappropriate use of the consultation process which has caused a great deal of anxiety among my constituents." The report on the proposal was published on 11th October and the decision itself was to be taken on 22nd October. Sir Fergus was, he says, bombarded with telephone calls and letters from angry constituents; several delegations came to see him made up of both medical personnel and members of the public. "Because of the ham-handedness of those in charge of the RHA, unnecessary alarm and aggravation was caused." The criteria

selected by the RHA to judge the relative merits of the various options on whether or not to abolish the Trafford HA were, says the MP "misapplied, misconstrued or ignored." Claims that cost saving would result were not backed up, the claim that patients would benefit could not be substantiated and there was no answer to questions on how the change would benefit the people of Trafford. He quotes a member of the DHA as saying: "It is incredible that the health of the people of Trafford depends on such inept, perfunctory and arrogant decision making." The proposal would have meant 2,900 people employed by the DHA would have lost their jobs without advance warning to representatives of that authority, a matter of only six days before a decision was due. It had not apparently occurred to anyone at the RHA that even staff needed to be consulted. The outcome, however, was a happy one. In spite of very heavy attempts by the chairman to push his plan through on 22nd October, he was outvoted by the other members of the RHA.

Hansard 11.11.1985 cols. 401-403.

Mindless Cut

TRANX stands for the National Tranquilliser Advisory Council. It was started by a woman given tranquillising drugs when she was a battered wife who became an addict for 17 years. TRANX now has a network of self-help groups. Its aim is to help people come off these drugs and nobody disputes the good work it does. But it is likely to fold in 1986 for lack of funds.

This information should be seen in context. It is estimated that there are around 50,000 heroin addicts. Yet 3.5 million people are at risk from tranquilliser addiction. According to TRANX 35 per cent of users take them for longer than six months, they are medically useless within a comparatively short period, three times more women than men are prescribed them, withdrawal symptoms - which are severe - can last up to nine months and there is virtually no state aid for victims or even recognition that there is a problem.

In spite of all that doctors are now supposed to know about tranquillisers, they still prescribe them in huge quantities. 40 million prescriptions for them were issued in 1980 at a cost to the NHS of £30M. However, at least some drugs do now appear on the restricted list and it is no longer possible for a G.P. to give an NHS prescription for Valium at £24.02 per 1000 rather than its generic equivalent, diazepam, at £1.75. Yet patients still spend years on tranquillisers, endlessly picking up repeat prescriptions without seeing a doctor.

According to TRANX, many doctors still do not believe they are addictive. Women are handed them more often than men in part because of the attitude among some doctors that most "women's complaints" are caused by neurosis. Now, they are increasingly prescribed for the unemployed. They are handed out as an answer to everything from marriage breakdown to bad housing. Withdrawal symptoms include stomach cramps, eye defects, breathlessness, loss of use of the legs, dizziness, nausea, panic attacks and mental problems such as agrophobia. A leaflet from MIND says: "Remember that anxiety is usually a healthy response to things

that threaten your health or well being."
(On a personal note Judith Cook writes "Some years back as a single parent with four children I was out of work following a car crash and I also had severe housing problems. Visiting my doctor with my son who had an ear infection, the doctor asked me why I was looking so tired and washed out. I told him I had a lot of problems and he immediately reached for his prescription pad. When I enquired why, he said he would give me "something to make me feel better". I told him that unless he could write a prescription for a job, housing I could afford nearby, and finance for a removal, there seemed little point as all a drug would do would be to make me less likely to find my way out of the mess. I've never forgotten it").

Prison Medical Service

The Social Services Committee of the House of Commons has invited ACHCEW to submit evidence on this subject. The Clerk to the Committee, mentioned that it had already received assistance from several (3) CHCs. In his reply, Tony Smythe noted that the Committee has heard from the two CHCs which had managed to negotiate visits on an informal basis to local prisons to look at the services provided. But other CHCs who have tried to do this have been unsuccessful. "The lack of a formal role for CHCs in respect of the PMS, their lack of resources to fulfil their formal responsibilities in relation to DHAs and FPCs, the inhibitions and lack of information consequent on the operation of the Official Secrets Act, all militate against the acquisition of detailed information and experience. All I can say on behalf of CHCs is that some, with prisons in their districts, are aware on an anecdotal basis of problems and inadequacies. This awareness and concern would not constitute evidence."

Therefore, ACHCEW argued that, if the principles of consumers representation, proper complaints procedures and public accountability are accepted within the context of the NHS, and, as the appropriate machinery exists through CHCs, there was a powerful argument for extending the same principles and practices to prisoners and their representatives in respect of the PMS. "When considering the NHS, we talk a good deal about the equivalence of influence and the constant need to redress the balance of power between the users and the providers of health services. If anything the need is more glaringly obvious in the prison situation because of the inevitable disadvantages experience by prisoners..." ACHCEW made a plea for CHCs to play a role in monitoring the PMS (along with the additional resources necessary) and concluded: "We are definitely not clear on who or what is responsible for monitoring, evaluating and processing complaints and maintaining standards. Unless an appropriate mechanism is brought into existence, we fear that the quality of the PMS will be constantly challenged and that the maintenance of acceptable and comparable standards will not be achieved."

It's Pathetic

If you think last year's Annual Report on the Health Service in England & Wales with regard to what was said about CHCs, was pretty awful, this year's "mention" - if so it can be called - is absolutely pathetic. We are given about 80 words merely

detailing that CHCs are statutory bodies with a duty to "represent the interests in the health service of the public in their districts" and how they can answer individual queries. And that's it - all of it.

Hinkley B

In the last issue we mentioned the accident at Hinkley B nuclear power station on 25.10.1985 which closed the plant down for 16 days at an estimated cost of £4M. Although an expert had advised us that there was bound to have been a release of radioactivity, the C.E.G.B. denied this categorically. It took four questions in the House of Commons for MP Paddy Ashdown to be told that had been a release of radioactivity but it was "within permitted safety limits". On November 22 there was a second accident. On November 29 a third, described by an ex-researcher at the United Kingdom Atomic Energy Authority as the worst nuclear accident in Britain since the 1957 Windscale Fire. 5000 workers had to be evacuated when the pipe carrying carbon dioxide coolant around the reactor core fractured, venting 24 tons of radioactive gas into the building. 15 tons were filtered before being released into the atmosphere, the other eight went straight into the chimney and out. Again we are told it was within permitted safety limits. Paddy Ashdown says that as the C.E.G.B. lied to him and others about the first release of radioactivity, how can we believe assurances there is no hazard to health from this latest accident? He is calling for a full scale public inquiry. Although the "plume" of radioactivity travelled across Somerset and then was blown by south westerly winds up the Thames Valley, no warning of any kind was considered necessary by the C.E.G.B. nor did they undertake any monitoring of milk, etc., or if they did, they won't say. 500 employees were given potassium iodine tablets for counteracting any possible ill effects from Iodine 131 as a precautionary measure. The C.E.G.B. states that the sickness and vomitting experienced by the men were side effects of the tablets and not due to radioactive contamination.

As it looks in the media

The Government has published its response to the Social Services Committee's report on Community Care with special reference to the adult mentally ill and mentally handicapped people. The Committee warned Norman Fowler in February last year: "Any fool can close a long stay hospital: it takes more time and trouble to do it properly and compassionately." The response of Barney Hayhoe is that the government confirms the priority attached to developing an integrated network of mainly local community care services and welcomes the support of the Committee for the community care philosophy. Much has been done, is being done and remains to be done, he says. However it is instructive to read how two different newspaper correspondents read between the lines. David Hencke of The Guardian (22.11.1985) under a heading "handicapped may get more integration cash says that the government may provide assistance to more than 100,000 handicapped and disturbed people moved from hospital to the community. The government has pledged no hospital patient shall be discharged until appropriate services are available for them and that expenditure in this field will be kept under review and monitored. But Sarah Thompson in The Daily Telegraph (2.11.1985)

under the heading "No extra aid for mentally sick" states that the community care programme will prove more costly than old fashioned institutions, according to the DHSS, and that there is no promise of any extra funding at all. In fact various recommendations made by the Social Services Committeee have been turned down. Who is right? Time will tell. The Guardian does point out that the government is withdrawing financial support from all experimental drying out and rehabilitation centres for drunken offenders.
Report available from HMSO Comnd. No. 9674 Price £4.70.

Independence for the Disabled

Two London "Centres for Independent Living" have been set up to help the disabled. They are both staffed by a Development Worker, Education & Publicity Worker and an Administration/Finance worker. All staff are themselves disabled and well versed in the needs of disabled people. They will act as advice centres to explain what rights disabled people have and to discuss ways of assisting the disabled to lead more independent lives based on what they want for themselves. Details from: Jane Nation, 65A St. Augustine's Road, London NW1 (01) 482/3414 or Dick Harris, 32 Lenton Terrace, Fonthill Road, London N4 3JJ (01) 263/3178.

Quality of Care in G.P. Practice

Last month we drew attention to the talk given by Professor Ian Stanley on this subject in Wolverhampton. He has now sent us the full text of his paper. A couple of quotes are worth picking out this time too. "Consumerism is not the mindless doctor-bashing beloved of investigative journalists and modelled on the Ralph Nadar antics of the 50s and 60s against multi-national companies. It is a constructive, participatory process in which the user helps to define the qualities (or properties) of a service like General Practice." The support of CHCs is very necessary to "weld consumers into an effective element in primary care. CHCs must have more resources... the support I am proposing would require additional expenditure but these additional costs are trivial in relation to the budgets of FPCs and DHAs."

News from Scotland

The Association of Scottish Local Health Councils asks, in its newsletter, if "we are alone in finding this a particularly hectic year?" (Reply from ACHCEW: "No"). "Is the answer staff "burn out" in the ASLHC office or a real increase in pressure? "It is getting harder to respond promptly or sometimes even to respond at all to all the Executive Committee decisions and requests for information" says the Association. Our Scottish colleagues do a splendid job on a shoestring and the Association iscirculating its members detailing just how little money there is for what it has to do, and asking them to raise the issue with their MPs, pointing out how many constituents are represented by LHCs.

ASLHC, together with the Scottish Consumer Council, has been negotiating for the last 18 months with the medical profession over the production of a guide to GP services. The Scottish

Consumer Council has allocated funds to carry out a project in Edinburgh to test the feasibility of producing such a guide/directory but negotiations with the medical profession have been difficult and confusing, with varied responses. The medical profession, while accepting the need for more information to be made available to the public, has been unenthusiastic about the idea of non-medical groups producing such a directory. A detailed questionnaire on the subject to all GPs, seeking factual information was, therefore, rejected by the GP. Sub Committee who advised local GPs not to complete it. ASLHC and the SCC still hope to produce a directory with help from the medical profession but, if this is just not forthcoming, consideration is being given to producing a less detailed directory which will be tested by patients and GPs.

AIDS

Most CHCs will now be aware that the Government is providing an additional £6.3M to combat AIDS. Of this £1.8M will be for the development and use of a test for the AIDS virus. There will also be a special allocation to the three Thames Regions and Haemophilic Centres as well as additional money for voluntary organisations and the training of counsellers.

By the end of October, 241 people had contracted the disease of whom 134 have died. Three quarters of the cases are in the London area.
Ref: 85/336.

Christmas Crackers

1. Dr. Patrick Wood chairman of the Fellowship for Freedom in Medicine told the Royal Society of Medicine at its AGM on 28 November that he was in favour of the Royal College of GPs producing a discussion document on quality in General Practice. But hold hard, he doesn't like their criteria or the means by which such quality might be assessed. Bringing in a third party would be a terrible infringement of freedom. "Solicitors and accountants don't have people peeping in their drawers" he challenged, in words that might have been better chosen... The only real incentive is financial so doctors should be rewarded by their clients, i.e. their patients, paying 'directly'". He asks the profession not to "tie themselves in the bondage of performance review..." Drawers, bondage, what next? The mind boggles.

2. Sir Edward du Cann, MP for Taunton, on learning there had been another and more serious accident at Hinkley Point nuclear power station, the third in five weeks: "I have total confidence in the Central Electricity Generating Board. The sooner we have a third nuclear power station at Hinkley Point the better." (The Guardian) 29.11.1985.

AROUND THE CHCs

Cambridge CHC, which has had considerable media coverage over its views on the private medium-secure mental home at Kneesworth, has paid it a visit, although this has been denied by AMI in Social Work Today. ACHCEW was invited to visit on 21.2.86 and

accepted on condition that the invite also included local CHC representatives. In the meantime, the CHC is considering the outcome of the recent Cambridge Health Authority meeting when Kneesworth was discussed. The registration is granted in respect of 49 adults only and will at no time exceed ten per cent of all patients for whom the Home is registered; all informal patients, their nearest relatives and sponsoring authorities will be sent an information sheet detailing the rights of all such patients; the register of patients will include their legal status on admission; there will be a Visiting Committee whose terms of reference will be to "maintain contact with the local community". Among many points raised by the CHC was that the HA had been required to register a facility within its boundary using Guidelines designed for small charitable homes, not large international conglomerates where the first priority is the needs of investors, not patients. Also, although required to inspect and register Kneesworth, the HA had said no Cambridge patients would be sent there and members found it difficult to reconcile this with the decision to register the home especially as the HA said the District followed different treatment regimes to those at Kneesworth. The Visiting Committee's members would be "selected" by the owners of the hospital... One member of the CHC has been invited to join the committee as a private person but it was stressed that the Visiting Committee had little value as an independent monitoring body, selected as it was by the company. The CHC wants to see an independent body with an HA member involved. The CHC also expressed anxiety on the ethics of private psychiatric care. The HA has agreed to approach the DHSS for clarification on a number of points.

On another subject, in view of all the publicity given to patients being able to "shop around" for smaller waiting lists, Cambridge CHC has informed the local press that it is reasonable for patients to expect adequate services near home and that, in his Annual Report for 1983/84, the Health Service Commissioner, investigating problems arising from waiting lists, stated that health authorities must reach an acceptable standard in the management of waiting lists and failure to do so represented "maladministration". Where facilities within the patient's own area meant a long wait, the Commissioner stated it was up to the DHA to make enquiries to find out whether the necessary operation could be carried out elsewhere. In one case "they neither did this nor reasssured their patient that everything had been done to help him." The significance of this judgement cannot be underestimated, says the CHC. The onus must not (their italics) be put on patients or CHCs to do this, although, in reality, this is what often happens.

St. Helens & Knowsley CHC conducted a survey at the Whiston Hospital Maternity Unit which appears to have produced two good results. The CHC has made a number of reports over a long period of time highlighting the unacceptable waiting times in the Ante-Natal Clinic and, at the last meeting of the DHA, they were fully considered and it was finally agreed to approve the appointment of a fourth consultant obstetrician as soon as funds allow. Typical comments from mothers were "I travelled from Gatewood, leaving home on the 12.10 train for a 1.15 appointment and I arrived home at 6.p.m. Surprise, surprise I had extremely high

blood pressure." "My appointment time was 2.30.p.m., it was 5.0.p.m. when I went in to see the doctor." "After waiting two and a half hours I left without being seen." The second point, made by some of the women, was lack of seating in bus shelters near the hospital. After the CHC took the matter up with the Merseyside Passenger Transport Executive Users' Advisory Committee, it submitted the CHC's request to the local Transport Authority which has agreed not only to put seats in the bus shelter outside the Maternity Unit but outside all other major hospitals in the Merseyside Region!

Airedale CHC has taken up the question of non-essential food additives with Norman Fowler. It calls on him to instruct food manufacturers not to use them, colourings and flavourings, in the production of medicines and foodstuffs. Secretary John Godward says "there is mounting evidence to prove that some additives produce medical conditions, particularly in children, such as hyperactivity, asthma, eczema, migraine, arthritis, glue ear, irritable bowels and, sometimes, mental illness." It is essential, he says, to get the message across to government and public that the removal of such additives will improve health. Note: in the USA such full details of such additives have to be printed on labels and many allowed in Britain are now banned in America. A reply from the Minister is awaited.

Harrogate CHC is also waiting for a reply from the DHSS, this time on delays in the transfer of GP Medical Records. Following widespread criticism of such delays, the DHSS said it would be monitoring progress made in reducing them. Harrogate has asked if the DHSS intends to hold a follow-up survey or has asked the Society of FPCs to do so - "presumably some time next year."

South Birmingham CHC is also looking for what it calls "Bouquets as well as Brickbats" and it will be making a special effort in the coming year to find out about the praise and good practice in the health service. Too often the CHC is seen only as a body that criticises services and this is often necessary to get them improved but "we should also like to be thought of as a body that complements the Health Authority for good practice and we particularly want to encourage services or systems which consider and respect people as individuals and which are readily available to those who need them."

North West Herts CHC, like Cambrdige, is continuing with a battle. This, as detailed in Community Health News No.10, is about consultation and the proposed closure of one of three large mental handicap hospitals. The CHC has now received "clarification" from the RHA but the CHC points out that it still leaves a number of unanswered questions and some confusion. It states the RHA is under no legal obligation to consult on a change of management proposal but later says that funds released by the closure of the hospital will be used for new community facilities. This surely requires consultation. It also states that a joint planning group will be set up to look into the future of all three hospitals but there is no mention of either CHC or local authority involvement, nor is there any mention of any N.W. Herts H.A. involvement at a meeting to discuss the issue "and this seems quite incomprehensible when it is supposedly this Health District which is to take over the integrated management

"and this seems quite incomprehensible when it is supposedly this Health District which is to take over the integrated management of the service."

Manchester CHCs have launched a campaign to stop the closure of the NHS part of the Manchester Foot Hospital despite ever growing waiting lists. The Hospital offers a unique foot care service and the CHCs are asking people and interested bodies to write to the CHCs with their views and to protest to the Chairman of the North West RHA and to their MPs, local councillors and the MEPs.

Torbay CHC has been finding out the views within its area on the need for a Well Women Clinic, to be based in existing clinic facilities at Newton Abbot, the geographical centre of the district. Interest has been sufficient for the CHC to ask the HA to provide a 12 months trial Clinic providing screening procedures and counselling for women, by women.

Central Manchester CHC has updated its information on AIDS. So far 225 people in this country have contracted AIDS and the early pattern continues: 93 per cent are homosexual and most of the others come within the categories of drug abusers, haemophiliacs or people from West Africa, but the spread of those with the antibody positive virus HLTVIII is continuing at a rapid rate. A sobering figure is that it is now estimated that between 60% and 90% of haemophiliacs currently have the virus. Those CHCs who want an update should contact Central Manchester.

Hounslow & Spelthorne CHC is very concerned that local orthopaedic surgeons may be keeping waiting lists for joint replacement operations long, to prove the point they need more beds. Isobel Brooks, chair of the CHC, made the accusation to the local media after discovering that very few patients were being transferred to areas with shorter waiting lists. Even the RHA has questioned why the area has such a low uptake of the funding available for such transfers. While the CHC backs the orthopaedic surgeons' attempts to get more beds and agrees they are drastically needed, it cannot support the surgeons in keeping such long waiting lists. It advises patients on the lists to approach their GPs again and ask to see another consultant who could perform the operation earlier and it also urges GPs to shop around and find surgeons with shorter lists.

The East Yorkshire CHCs' seminar on "Caring for the Carers", held in Cottingham last month was very successful. Secretary Margaret Godson writes that its aims were to explain the concept of care in the community, to consider the needs of those who will be caring to ensure their health won't break down and to bring together the managers of services to identify problems, along with voluntary organisations involved. The main impact, says Ms. Godson came in the afternoon when three carers spoke of their own personal experiences of distress and suffering when services that should have been available were not. The histories concerned a husband looking after a wife with multiple sclerosis, a man who had nursed a 94 year old mother with senile dementia and the mother of two severely mentally handicapped children who has been told after her first child was born that "lightening couldn"t strike twice." She finally managed to get a play

group with suitable facilities, established after she had written to Jimmy Young. After his broadcast "suddenly all the facilities appeared." The atmosphere, says Ms. Godson, was electric and you could have heard a pin drop. The carers succeeded magnificently in getting their human needs, both emotional and otherwise, over to the professionals and others present. Much discussion went on in workshops over the problems of community care. "As a CHC we shall be looking towards the spring when it is intended to hold a meeting with all appropriate officers of the various services to discuss services for the district's patients and carers. Believing, as I am sure many of us do, that if support is inadequate now, as transition from hospital to community takes place, chaos could result for some". The CHC has received many letters of congratualation regarding both the content and usefulness of the day.

Northumberland CHC takes up an issue made in CHN No. 10 in a reply made by John Patten on notification particularly regarding closures. The CHC was involved with the proposed closures of three ambulance stations and objected to them, putting forward a counter proposal which was duly referred to Ministers. The Minister decided in favour of the RHA decision but the first the CHC chairman knew of this was when a local reporter rang up asking for her reaction to it. The RHA subsequently apologised for failing to inform the CHC but the CHC told the RHA that members were much concerned as to the reasons for the Minister's decision. The response from the RHA was that they could not give the CHC the reasons behind the decision as they did not know them themselves.... Subsequently the CHC asked the Minister as part of a letter on another topic. A reply is still awaited.

South Birmingham CHC has been approached by the Secretary of the Perthes Society to help improve knowledge of the condition and its effective treatment. Treatment for the condition which affects the hips of children who have the disease can be extremely effective and avoid the necessity for hips replacement operations in middle life. South Birmingham feels other CHCs might like to know about the Society which will be pleased to pass on information about its work and the disease. For details write to Mrs. G. Draper, 49 Great Stone Road, Northfield, Birmingham B31 2LR. Tel: 021 4774415.

Exeter CHC has been looking at GP practices which produce leaflets or booklets on services available, other than a basic card giving the names of the doctors in practice and the surgery time. The CHC would like to encourage and support the use of practice leaflets which would bring benefits to both patients and doctors and avoid some unnecessary difficulties. From the information received Exeter has drawn up a draft leaflet which includes services such as well baby clinics, childrens' hearing tests, immunisation times, cervical smear clinics, medical examinations, etc. It also includes details of home visits, medicines, repeat prescriptions, the role of the practice nurse, minor injuries, referrals and details of the midwife and community nurses attached to the practice. It would seem to be a very good idea. Secretary Tony Day has been in touch with his FPC which, it appears, is thinking on similar lines. The FPC and CHC will, therefore, be having discussions on the subject and it

is hoped that a joint initiative will emerge.

AROUND THE HOUSE OF COMMONS

As we have noted before, very often interesting discussions on health matters in the House of Commons do not get reported in the media as they are not considered newsworthy. During the debate on the Queen's Speech many MPs expressed concern and anxiety over the proposed reforms of the social security system and this was by no means confined to Opposition benches. One issue brought up by Mr. Michael McNair-Wilson, Conservative MP for Newbury, was that of 'no-fault compensation'. He asked the Minister to consider "whether a social security system that pays attention to the needs of the disabled, but not to those who are victims of medical accident, has a major defect." There was still time, he said, for something to be added to the White Paper. He detailed the history of attempts to improve the situation including cases such as that of Peter Kelly who suffered cardiac arrest during a routine appendectomy which resulted in brain damage. His family had to wait 12 years for compensation which finally amounted to £400,000, paid this year. "For twelve years his family had had to care for him without the additional resources which were presumably part of the compensation that he received." Sadly his case is not unique. As the law stands, said Mr. McNair-Wilson, the case has to be decided on whether there is negligence or an error of judgement. This is of less interest to the patient who has been injured. Nor are those involved and those who try and help victims including MPs given the information they need. Asking how it might be possible to get the information, make doctors more accountable and find a better way of compensation without resorting to court action, he asked for a "no fault compensation scheme", and he suggested the Government look into schemes operating in Sweden and New Zealand with a view to learning from them. In doing so he pointed out that the 80,000 doctors in the NHS and 10,000 in private practice contributed £336 per head per annum to one or other of the medical protection societies, which provided these bodies with an income of £3M per year! "Thus the situation arises in which the patients, who are also the taxpayers, are contributing money to the medical profession to defend itself against possible claims for negligence by those same patients."
Hansard 11 November 1985. Col. 333 to 338.

Better Living for People with Mental Handicap is the title of a Report on a seminar held on this subject on 27 June last by N.W. Herts CHC. So many people have expressed interest in how the seminar can be followed up that the CHC is holding a follow-up meeting on 16 January 1986 at the Better Living Centre, St. Peter's Street, St. Albans. Copies of the report and further details from H.W. Herts CHC.

Medway CHC has carried out a survey of Family Planning Services in its area which is being widely circulated throughout the district. It is the first comprehensive study of the service in the Medway Health District and includes a list of all services provided, a look at nationaly regional and local policies, a brief review of recent research literature and surveys all clinics, from the consumer's viewpoint. Questions arising highlight many of today's crucial NHS problems - health

authority, G.P. services, preventative versus curative medicine, the allocation of finite sources, the whole subject of women's attitudes to the treatment provided for them in the NHS versus the attitudes of people providing the treatment. The paper, says Medway CHC, is part of its campaign to ensure a full and informed debate on aspects of health care and is also aimed at persuading the HA, in spite of financial difficulties, not to follow the example of others and cut services but to take the opportunity to look creatively at what can be provided. It is a very good survey and those interested in seeing what it revealed should contact Medway CHC for a copy.

GLACHC has published its Annual Report. It makes gloomy reading and emphasizes that the priority groups in London have not benefited at all from the funds supposed to have been released for their benefit while massive cuts in the acute sector continue to place an unfair burden on local communities who care for the frail, chronically ill and vulnerable. "The pace of change in the pattern of health service provision is now gathering a momentum that alarms many CHCs in London" says Naomi Honigsbaum. "Most Districts are predicting drastic cutbacks and high reductions in the acute sector in 1986." Copies from GLACHC. (c/o Islington CHC).

PUBLICATIONS

Ten out of ten for the Health Education Council's The Big Kill, a statistical analysis of smoking habits. It suggests that 77,774 people die in England and Wales each year from smoking-related diseases at a treatment cost to the NHS of over £111,000,000. The Council is calling for political action to restrict tobacco promotion and cut smoking in public places. The Big Kill analyses smoking-related death and disease according to Westminster and European constituencies, local government districts and health authority districts and regions. The national figures show that patients with smoking-related diseases take up an annual total of 1,463,400 hospital bed days at a cost of £111,325,000. All MPs, local government leaders and health authority personnel are being circulated with the section of the 15-volume study specifically related to their region.

Hull CHC took up with the HEC the question of why ACHCEW was provided with the data but not individual CHCs "who should not be dependent upon seeking information of this type at second hand with the possibilities of delays over which we have no control." The HEC has replied saying that the expenditure had to be kept within a heavily committed budget and that it had been decided not to send whole volumes to the CHCs, on the assumption they would have close contact with those who did received them. The HEC did not take up the point, also made by Hull, that ACHCEW had inadequate resources to circulate all CHCs with the detailed data saying that the HEC had assumed all CHCs "would be able to talk directly to ACHCEW who received the complete set."

Copies of the complete set of volumes cost £35. Individual, regional volumes which will probably be of more interest to CHCs cost £3 each. Both available from Public Affairs Division, Health Education Council, 78 New Oxford Street, London WC1A 1AH.

Samantha Goes to School - The Battle for Mainstream Education by Tom Hulley tells the story of his 11-year old severely handicapped daughter and her experiences while going to an ordinary infant and junior school for the last six years. Samantha was born normal but, following a severe illness, she suffered brain damage. It is a story of immense hope and courage and is very moving as he tells how he and his wife, with the help of others, brought their little daughter back from a state of nothingnesstowhat she is now, "a smashing person and a lovely character." It is a heartfelt plea for such children to be educated in a normal environment. It is available from CMH, 5 Kentings, Comberton, Cambs. CB3 7DT. Price £2.50.

The 10th edition of the Disability Alliance Handbook has just been published. It is based on the experience of the Alliance's welfare rights service and it is invaluable as it passes on the benefit of that experience in an easily understandable form. Two-thirdsof disabled people live in, or are onthe margins, of poverty. Disability itself inevitably leads to extra costs, says the Alliance, yet many thousands of people fail to claim the help to which they are legally entitled. A most useful aid for CHCs. It is available from the Disability Alliance, 25 Denmark Street, London WC2H 8NJ. Price £2.40 inc. p. & p.

Pete Townshend,formerly of 'The Who', and an ardent anti-drugs campaigner has launched a new Directory of organisations concerned with drug abuse. It is intended both to inform people wishing to donate money to existing drugs organisations and also as a reference for drugs misusers and their families to know which organisations are available to them. The Directory of Organisations Concerned with Drugs Abuse is available from the Charities Aid Foundation, 40 Pembury Road, Tonbridge, Kent TN9 2JD. Price £2.95 plus 35 pence p. & p.

Eating for a Healthier Heart is a report published by Bradford University highlighting steps taken by health authorities to formulate practical policies to implement nutritional advice. The aim of local food and health policies, says the report's authors,"is for the NHS to set an example which canbe followed in other local authority sectors, the wider community and the private workplace."
It is available from Food Policy Research, School of Biomedical Sciences, University of Bradford, Bradford BD7 1DP. Price £5. inc. p. & p.

The Western Health and Social Services Board have sent us a copy of their very informative Handbook for Members of District Committees. Although not directly relevant to CHCs in that it deals with the situation in Northern Ireland, it must be a useful aid to those who are members of such committees. Possibly there might be similar handbooks for members of health bodies and local authorities over here. It is available from Board Headquarters, Western Health and Society Services Board, 15 Gransha Park, Clooney Road, Londonderry BT47 1TG.

Law in the Health Service by Brian Capstick, published by NAHA, could be of use to CHCs too. It details in particular patient complaints and litigation, - how to get information, the role of

the medical defence organisations, assessment for personal injuries etc. but does not address itself to the concept raised by McNair-Wilson MP. (mentioned elsewhere in this bulletin) of the need for "no fault compensation". It is obtainable from NAHA at £5.95 a copy (£4.95 for members).

The Friends of the Earth London Road Safety Alert has published a Road Safety Information Pack which analyses where, why and how accidents happen and suggests remedies. These include slower speeds on residential roads, better pedestrian facilities, better enforcement and tougher drink driving sentences and action to stop dangerous and illegal parking. It is available from F o E, 377 City Road, London EC1V 1NA.

There has been extensive media coverage already of the College of Health's Guide to Hospital Waiting Lists 1985. Obviously useful, it is aimed at the patient as, rightly, it says if you are in need of hospital treatment or an operation then for you, the need is urgent. Copies are available from the College of Health, 18 Victoria Park Square, London E2 9PF. Price £2.50 (members £1.50). The College is also offering a telephone service for information on AIDS on (01) 980 4848 along with 12 tapes on AIDS-related topics including a very frank one called "Safer Sex". Callers can ask to hear any of the tapes of their choice.

People in trouble often turn to radio and television as channels of communication for their problems which, with their limited resources, need to know how best they can organise themselves to meet these needs. The National Consumer Council has drawn up a set of Guidelines after extensive consultation with the BBC and IBA along with a number of voluntary bodies. Copies can be obtained from the NCC at 18 Queen Anne's Gate, London SW1H 9AA.

Unemployment and Health is a resource pack produced by two Glasgow Health Education Officers aimed at raising the awareness of health issues and providing information and suggestions for action on health for groups of unemployed people. It is written in clear, straightforward language, has lots of references in every section and is illustrated. It is available from the Greater Glasgow Health Board, 13 Woodside Place, Glasgow C3 7QW. Price £12.50 inc. p. & p.

Ethnic Minorities and Social Work Training is the self-explanatory title of a Paper published by the Central Council for Education and Training in Social Work and is available from Derbyshire House, St. Chad's Street, London WC1H 8AD. Price £3.00.

Race, Health and Welfare: Afro-Caribbean and South Asian People in Central Bristol has been published by the Department of Sociology, University of Bristol and is available from them at 12 Woodland Road, Bristol BS8 1QU. Price £5.00.

Children in Care in England & Wales is a report by the Secretaries of State for Social Services and Wales on the numbers of children in care. Launching it, Ray Whitney said that he felt that, for most children whose parents are unable to look after them, fostering is the best option and almost half the number of children in the care of local authorities are now living with

families. The total number of children in care has continued to decline significantly. In March 1983 the total was 86,000 compared with 101,200 in 1977. The majority of children have been in care for over a year. Since the Report was published before the result of the Jasmine Beckford Inquiry, it will be interesting to see if these figures now begin to rise again. The Report is available from DHSS Leaflets, PO Box 21, Stanmore, Middx. HA1 1AY. Price £2.80.

The Health Education Journal now has a new look. As well as papers and articles by leading researchers, practitioners and theoreticians, it includes research digests, opinion articles, book reviews and many other special features. It is available quarterly for only £3.00 a year from 78 New Oxford Street, London WC1A 1AH.

Burn and Scald Accidents to Children is published by the Child Accident Prevention Trust and is useful in that it deals with the most common accidents in the home - for example when a small child grabs a kettle flex which is hanging over the edge of a worktop. Deaths from burns and scalds are second only to road accidents as a cause of accidental death in childhood and each year nearly 100 children die, over 5,000 are admitted to hospital and about 30,000 are treated in A and E departments with burn injuries. The book is available from bookshops. Price £3.95 or £4.45 by post from Harper & Row, Estover Road, Plymouth PL6 ZPZ.

Smoking among Secondary School Children in 1984 is the result of an enquiry carried out for the DHSS by the Office of Population Censuses and Surveys. It makes dismal reading. Young people are taking up smoking in large numbers while the adult smoking population is going down. It is shocking to note that 11 - 16 year olds are smoking between £70M and £90M worth of cigarettes each year and there has been no reduction in childhood smoking for three years. In fact smoking among 14-15 year old girls is increasing rapidly. Childhood smoking also appears to run in families. Copies of the Report are obtainable from HMSO. Price £10.00.

Family Practitioner Committees: A Guide for Members is self explanatory but might well be of interest to CHCs. It was produced under the auspices of the NHS Training Authority and was prepared by Keith Barnard of the Nuffield Centre for Health Service Studies. Supplies are limited but there should be one for each CHC Secretary. If you have not received yours contact the DHSS, Eileen House, 80-94 Newington Causeway, SE1 6EF ref. DA(85)36.

Interestingly, the Birmingham FPC has sent us a copy of its report for the period April 1982 to March 1985 which gives an insight into the work and philosophy of the FPC and also lists complaints against various practitioners. It shows how hard it is for a patient to have a complaint upheld.

The Plain English Awards 1985 winners have now had their entries published. Good practice includes a number of very different publications from the Health Education Council's award winning Pregnancy Book to the Southdown Bus Timetable. Also published are the 'Golden Bull Awards'. The DHSS often tends to feature

in this section but this year's wooden spoons go the Grampian Regional Council for an incomprehensible document on student grants, the North West Electricity Board, the Leeds Permanent Bulding Society and - as no such competition would be complete without an entry from the civil service - the Inland Revenue. Details from Plain English Campaign, Vernon House, Whaley Bridge, Stockport, SK12 7HP.

Attitudes to Down's Syndrome An investigation of attitudes to mental handicap in urban and rural Yorkshire, by Janice C. Sinson, published by the Mental Health Foundation, is interesting but there must be serious reservations about such a document which states categorically that the investigation "proved conclusively" that there was a marked difference in attitude between urban and rural communities when many CHCs may not find this to be the case from their own experience. Also depressing was the conclusion that most mothers were against education integration for Down's children. Copies from Mental Health Foundation, 8 Hallam Street, London W1N 6DH.

The GLC has produced a draft Code of Practice for local authorities on positive discrimination towards the disabled. They welcome comments. Copies can be obtained from Raewyn Stone, Head of Disability Resource Team, County Hall, London SE1.

INFORMATION WANTED

A computerised call and recall facility for cervical cytology should be available in Walsall within the next year. Discussions are taking place on the best way to tell women the extended service is available and to encourage them to use it. Walsall CHC would like to know if Councils have come across leaflets, posters, videos or other items they feel were particularly effective in advertising such a service? Any ideas, warnings or pitfalls would also be welcome.

Calderdale Well Woman Centre would like to hear from any other Well Woman services around the country as they are trying to compile a list of Well Women Services. They receive lots of phone requests asking if there are such services in other areas. Contact Sylvia Barker, Harrison House, 10 Harrison Road, Halifax HX1 2AF. Tel: Halifax 60397.

East Birmingham CHC would like to know if any other CHCs have experience of assisting sufferers (and their families) with dystonia. Any advice or information available would be much appreciated.

COMING EVENTS

Age Concern is running the following workshops and seminars:

Bereavement Workshop 14.1.1986. Cost £10.
Management of Continence 11-12.2.1986. Cost £55.
Reality Orientation 11-12.2.1986. Cost £55.
Hospital after-care Schemes 5-7.2.1986. Cost £55.
Coping with handicap 20-21.2.1986. Cost £55.

Details and application forms from: Age Concern, 60 Pitcairn Road, Mitcham, Surrey, CR4 3LL. 01.640.5431.

Unhealthy Housing: A Diagnosis is the title of a conference being organised by the Institution of Environmental Health Officers to look into increasing fears that housing may once again become a threat to community health. Details of the conference are, for some reason best known to the organisation, embargoed and being kept under wraps until 15th January! Anyone interested after that date should contact them at Chadwick House, Rushworth Street, London SE1 0QT for preliminary papers. It is hardly a question of breaking the official Secrets Act if we say the conference is late on in 1986.

CHILDREN STILL IN MENTAL HANDICAP HOSPITALS (from EXODUS).

The latest DHSS statistics show that there were 656 children living in mental handicap hospitals or NHS units of 25 or more beds in December 1984. There were 12,000 admissions in 1984. These figures are now available for each health district and each hospital. This allows CHCs and others to challenge their health authorities and local authorities as to why there are still children in their hospitals, even though it is now widely recognised that such hospitals are totally inappropriate for them. Hospital is the wrong place for short stay care as much as it is for long stay.

Local and health authorities need to work closely together to ensure that those children remaining in long stay mental handicap hospitals are moved into genuine integrated community settings.

If your DHA has a mental handicap hospital you can assist this process by:

1) Asking if each child has been jointly assessed and reviewed by the responsible local education and social services department as well as the health authority. If not press for this to occur. If they have, press for the implementation of the reviews.

2) Ask the DHA and SSDs what plans exist to tranfer the remaining children either to foster families, their own families with appropriate support or to small ordinary integrated houses. This applies to SSDs of the child's family origin as much as to the one in whose area the hospital is located.

3) If no plans exist with reasonable timetables, press for these to be drawn up.

4) If your authority does not have an effective JCPT sub-group concerned with services for children with mental handicap - insist that one be established.

5) Get your DHA to set dates for the closure of its childrens' wards in its mental handicap hospitals.

6) Ask the DHA for age profiles of the children in its mental

handicap hospital and the age profiles of those who are aged 16-19 years.

7) Ask your DHA for a record of admission dates to its mental handicap hospital for children of 16 years and younger including short stay admissions and for the length of each stay.

8) Find out what is the normal course of events if:

(i) a mentally handicapped child living in the community becomes ill.

(ii) a mentally handicapped child living in long stay hospital becomes ill - are they sent to the general hospital?

9) Do your local and health authorities provide adequate and flexible short term relief for families with mentally handicapped children other than hospital replacements.

10) Has your district got adequate levels of community mental handicap teams.

11) What training is being introduced for staff who will be transferring from hospitals to community care locations and services?

We can act together to ensure that all local and health authorities fulfil their responsibilities to children with mental handicaps and end once and for all the social scandal of placing them short or long term in mental handicap hospitals. Hospitals are for the sick and ill and for them alone. The answers to the 11 points above will help CHCs to push on the childrens' behalf.

AGM RESOLUTIONS

Replies are still coming in from the DHSS as below:-

Black Report - Resolution 11

The Working Party on Inequalities in Health recommended that resources should be shifted towards community care and improvement in the provision of primary care services. "Care in Action"(1981), which set out the Government's general strategy for developing health service facilities, said "It has been a major policy objective for many years to foster and develop community care for the main client groups". Your Association will be aware that joint finance can now be used for education and housing for the disabled and may be used over an extended period to transfer patients from long-stay hospitals to community care, and health authorities can make a lump-sum payment or continuing grants to local authorities or voluntary organisations for such patients for as long as necessary under the Care in the Community initiative. The Helping the Community to Care programme is making a total of 10.5 million pounds available to help volunteers, families and others to care for people needing support in the community, for example, the elderly who leave hospital. The Government is considering what further action

should be taken to carry forward the recommendations of the Harding and Acheson Reports in the primary health care field. However, the pattern of service locally is largely a matter for the health local authorities concerned to decide.

The Government is unable to accept the recommendation of a special health and social development programme in ten selected areas because the money would have to be taken out of the NHS funds available for distribution to health authorities and the resources are already being distributed in relation to objectively assessed health care needs, using the Resource Allocation Working Party formula.

To sum up, many of the recommendations of these Working Groups would be immensely expensive, and the Government is not convinced that expenditure on the scale envisaged would necessarily be effective, even if it could be afforded. However, a good deal of progress is being made in areas covered by the Working Groups' recommendations where these do not involve vast additional expenditure.

The Government agrees that community care services should be properly planned and in place before a long-stay patient is moved out of hospital care. Community care is not necessarily a cheap option and will in many cases be more expensive than existing hospital care. Much depends on the level of disability.

Apart from the arrangements already referred to, the amount allocated to health authorities for the support of community care developments planned jointly with local authorities has increased by over 50% in real terms since 1978-79 and the joint finance allocation this year will be £105 million, up 5% on last year. Spending on personal social services with money transferred from health authorities has always been outside the arrangements for controlling local authority expenditure. In addition year on year increases in a local authority's spending on individual community care projects to which the health authority is also making a contribution are disregarded when liability for grant hold-back is calculated.

Demographic and similar pressures which affect the personal social services are reflected in the indicative provision for local authority services given in the Government's expenditure plans. It is however for the authorities themselves to decide how to spend their resources. In general the development of community care has to be within planned resources and many authorities have shown that they are able to protect services for the most vulnerable in our society. What is most important is that health authorities and local authorities work together along with voluntary organisations to plan the services for those who most need them to make sure that the best use is made of the resources that are available.

CHC MEMBERSHIP OF JCCs - (Resolution 28).

The Government has no plans to extend membership of JCCs to include CHCs. The Government recognises that CHCs have an important part to play in assessing from the NHS consumer viewpoint the effectiveness of collaboration between health and

viewpoint the effectiveness of collaboration between health and local authorities and voluntary organisations in influencing the services provided. We believe they can best do this by establishing good relationships with the authorities locally.

Resolution 31.2

"That the financial allocations to DHAs guarantee the full cost of national pay award and the actual level of inflation in prices".

Such a guarantee would, I am afraid, be incompatible with the way in which public expenditure is now handled.

Prior to the publication of the 1982 White Paper public expenditure was indeed planned on a volume basis; that is, plans were expressed in constant prices which were uplifted in line with subsequent pay and price movements. However,a major shift took place in 1982 when cash planning and the use of cash figures in public expenditure plans was introduced. It is the finance available that now determines the level of services provided. And the figures published each year in public expenditure plans are realistic estimates of the cash which will be spent.

Cash planning involves the use of assumptions for a range of indicators such as inflation and exchange rates. Adjustments to allocations are not made where pay and price movements fail to match the forecasts derived in this way. Higher than expected costs must be absorbed within the agreed cash plans. Lower increases result in a bonus. Under these arrangements health authorities together with the rest of the public sector are faced with the task of ensuring optimum levels of service provision from within the resources available to them. This is being achieved not only by increased allocations from central government - spending in 1986/87 will rise by 6.7% - but by increased efficiency. Authorities' cost improvement programmes are set to realise £150m in 1985/86 alone. The prospects for future years look equally good.

Resolution 22 - Choice of Women Doctors

It is already Government policy that women should as far as possible be able to obtain treatment from women doctors. With special reference to women in ethnic communities, a letter was sentin Januaryl985 by the Chief Medical Officer to general practitioners concerning the "Asian Mother and Baby Project" (CMO(85)2). In this letter it was recommended that women with strong objections to examination by a male doctor, particularly on moral or religious grounds should, where possible, be referred to a female gynaecologist/obstetrician for ante-natal care. This letter was also sent to Health Authorities.

The proportion of women medical students has been increasing for many years and reached 44% in the latest intake. Women now constitute about 25% of the total active medical workforce in England and Wales, and some 23% of hospital doctors and 20% of general practitioners. There can, of course, be no question of directing doctors of either sex to particular medical careers, and some specialties (for instance, Surgery) demand a full-time

commitment to medicine which some women doctors are unable to make. However, the Department is concerned that there should be no arbitrary difficulties in the way of women doctors wishing to enter any speciality and is currently funding a research study on factors which influence doctors to make the fullest possible contribution to medicine is underlined by the provisions for part-time training, part-time career posts, and a "Doctors and Dentists Retainer Scheme" which enables doctors with substantial domestic commitments to keep in touch with medical practice.

Resolution 29 - Hospital Complaints Procedures

The Government has given a commitment that there will be wide consultation on the form the Directions under the Act should take and that consultation will involve organisations representing the consumer view, including CHCs and your Association.

Resolution 30 - FPCs & CHCs

As you know the funding of CHCs is a matter for RHAs in England. As a result of the new formal relationship with FPCs CHCs should have been reviewing and if necessary re-ordering the priority they attach to various tasks to ensure that they are acting in accordance with their statutory obligations. It is open to each CHC to ask the RHA to review its financial allocation but the RHAs decision will necessarily be taken in the light of the Region's available resources and overall priorities. Because of the average size of CHC budgets the Government has not expected rigid cost-saving measures to be enforced on CHCs nevertheless CHCs cannot be exempted from the need to ensure that they are acting efficiently and cost-effectively in their allocation of priorities and working methods. The Government would not wish to intervene in the resource allocation process unless there were sufficiently widespread evidence of major problems.

Resolution 15 - Care of the Elderly

The recently published 1985 Annual report on the Health Service in England clearly shows that the steady increase in services for elderly people has kept pace with the growth in the elderly population.

NHS expenditure specifically for their care has risen by some 20% in real terms since 1978 so that today 42% of all NHS expenditure is being used to care for the 15.3% of the population that are elderly.

In service terms the numbers of elderly people being treated as inpatients in geriatric units alone has increased by 47% since 1978 and throughout all hospitals the elderly occupy over half of all available beds.

In the community about 40% of the total of the £105 million available this year for joint NHS and local authority projects is aimed at elderly care.

There are now more Doctors and District Nurses available to provide primary care and local authorities have increased the numbers of home helps and meals provided at home.