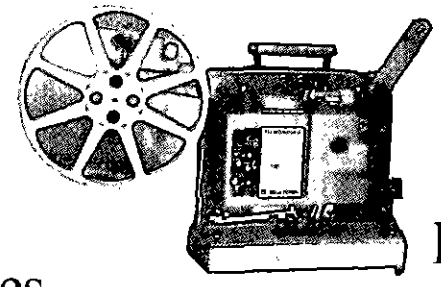
CHC NEWS

For Community Health Councils

April 1977 No. 18



COMPLAINTS the inside stories

Two reports giving details of cases investigated by the Health Service Commissioner are now available*, and both give chilling insights into just how badly things can sometimes go wrong within the NHS.

The commissioner's second report, for August to November 1976, was published last month. In it are anonymous details of 38 investigations carried out in England and two in Scotland. Eighteen of the complaints were upheld in whole or part, and the remainder were found to be unjustified. In the first report, covering April to July, 31 out of 47 complaints were upheld.

Though his powers are strictly investigatory and his approach to establishing the facts is suitably cautious, commissioner Sir Idwal Pugh uses strong language where appropriate. He describes as "deplorable" a case in which a patient was kept waiting 5½ hours in an accident and emergency department before being seen by a doctor.

The hospital's administrator complained that the patient's son-in-law had behaved disruptively on the day in question, but the commissioner comments: "I do not know how the Authority expect people to behave if their close relatives are left untreated and in pain for 5½ hours. It seems strange to me that the Authority should have concentrated on this aspect of the matter rather than on the manifest deficiency of their service".

Equally disturbing is the case of the "unnecessarily outspoken" registrar, who within earshot of a complainant referred to her as "the lowest form of animal life". She had asked that her mother, a terminal cancer patient, should not be discharged because of her deteriorating condition. In the event her mother died in hospital two days later.

Another decision criticises a consultant for sterilising a woman without her consent. The operation had been authorised by the woman's father, and had been performed at the same time as an abortion. The woman had epilepsy and an "immature personality disorder", but was 23 years old and in full-time employment. She remained unaware of the sterilisation until three years later, when she visited her GP thinking she might be pregnant.

Since the sterilisation was not essential for the woman's health, the commissioner ruled that the consultant's decision had not arisen solely out of clinical judgment and so was not exempt from his criticism.

Complaints sometimes remain unresolved because there are "irreconcilable differences" between the various sides of the story, and no way of establishing the truth. In one of these cases the parents of a one-year-old girl in-patient claim they made repeated but unsuccessful requests for a doctor over a period of about ten hours, because of their child's apparently worsening condition. The baby eventually had a cardiac arrest and resuscitation attempts failed. The commissioner notes that he is unable to establish the truth in this case because of "the inadequacy of the hospital's investigation" at the time.

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ACTION ON COURT

FIT FOR THE FUTURE

Tremendous interest has been shown in the Court Report on child health services *(Fit for the Future)*. Members of the Court committee have been speaking at meetings around the country and CHCs are discussing the report in different ways.

SW Herts CHC invited about 35 people from a wide range of local statutory and voluntary bodies to a meeting on 8 March. Discussion centred mainly on those proposals for which comments have been requested by the DHSS and the evening provided an excellent opportunity for people from different disciplines to explain their views and learn from others in the light of local knowledge and experience. Comments were made on the possible dangers of over specialisation (eg. the proposed general paediatric practitioners and child health visitors), the problems of different catchment areas for schools and GPs; the advisability of basing mental handicap teams on districts; that mental handicap services should be seen primarily as educational and social; that more services should come out into the community and consultants should be more willing to see patients and parents in their homes or schools in addition to in clinics or hospitals.

At the other end of the scale, Frenchay CHC is organising a one-day national seminar in Bristol on May 7th to which CHCs and local PTAs and voluntary organisations are being invited. Professor Donald Court and three other members of the Committee (Mrs Gorell Barnes, Mrs Glenys Carter and Mrs Jean Davis) will be speaking in the morning as well as Professor Ron Davie of Cardiff University and Professor Neville Butler of Bristol University. The afternoon session will look at child health services from the consumer's point of view. It is hoped afterwards to issue a booklet summarising the conference.

Blackburn CHC is hoping to arrange a similar type of day conference for CHCs in the northern regions.

YOUR LETTERS

PUBLICITY IDEAS

Eve Mervyn-Smith, Acting Secretary, SW Surrey CHC

How do we reach the people who need us most? In my experience the only poster that penetrates is the Child Benefit Scheme, and press reports on CHC activities may be noted in relation to a particular happening, but individuals do not seem to say "maybe they could help me" or not enough of them. Ideas please — mine so far: *Talks by CHC Secretaries:* young wives and mums, schools, colleges, voluntary organisations of all kinds, women's institutes, health visitors, community nurses, mothers union. *Gravevine:* members of CHCs, members of AHA who represent a wide selection of The People (?!), voluntary organisations e.g. the Red Cross by libraries in hospitals, WRVS via meals on wheels in the community, health visitors, community nurses and GPs (I hope, I hope). *Paper:* Maybe annual reports if they can be disguised as booklets worth reading, attractive cheap bookmarks given to school children who hopefully take textbooks home. *Media:* flash on TV, plug on Women's Hour and such programmes as "The Archers" and "Waggoners Walk". Maybe someone can suggest a sobriquet easy and attractive to remember and which would avoid confusion with the community health services.

PRESCRIBING PROBLEMS

Dr D A Webb, Bristol

I read with interest the comment on GPs' prescribing by a CHC member *(CHC NEWS 16).* Perhaps I should declare my "interests": a CHC member representing a voluntary organisation, medically qualified, but not in general practice.

I feel your correspondent should consider other aspects of the problem. The so-called proprietary brands generally incorporate additional features to the basic preparation. This may be slow release — giving more sustained blood levels of the drug, reduced side effects increased palatability, etc.

The article following GPs' prescribing concerns drug collection schemes. Many patients gather these collections of drugs because they find the preparation unacceptable. If I prescribe for my family, I consider first the drug of choice and then the most acceptable form of this drug. It would seem to me that the doctors of Oxford are quite sympathetic to the needs of their patients. Concerning prescribing excessive quantities, this is often done to save patients a too frequent 20p charge for regular prescriptions.

SPINAL INJURIES

Stephen Bradshaw, Development Officer, Spinal Injuries Association, 126 Albert Street, London NW1

The Spinal Injuries Association, a charity which helps paraplegics and tetraplegics, has just submitted evidence to the Royal Commission on the NHS. We feel it is important for your readers to be aware of our main recommendations.

There are seven Spinal Injuries Units (SIUs) in England and Wales, and the total number of SIU beds is falling despite the rising incidence of spinal injuries. We recommend two new units and the expansion of small units to 40-60 beds, each unit with two full-time consultants. Associated with SIUs should be retraining facilities and "rehabilitation houses", where patients can learn how to live independently before their discharge. Hospitals should run counselling services for the newly-paralysed, and there is an imperative need for swifter transfers between general hospitals and SIUs. Standards of care are deteriorating because of a shortage of spinal nurses and doctors. Little recognition is given to nurses in this specialised field, although a certificate of competence can be obtained. A career structure for doctors, leading to the posts of Spinal Doctor and Consultant in Spinal Injury, is needed. In the community, the provision of home adaptations should be streamlined and more residential accommodation should be provided. Support systems must be developed so that the illness of a spouse or helper does not necessitate readmission. Spinal injury patients depend on wheelchairs, and artificial limb and appliance centres do not provide a round-the-clock, seven-days-a-week repair service. Either there should be a repair service of this kind, or every spinal injury patient should have a spare wheelchair.

Finally, and as a matter of priority, an adviser on spinal cord injuries should be appointed to keep the DHSS informed about the state of spinal injury treatment and rehabilitation in this country.

RACE AND HEALTH

Graham Hoult, Secretary Leeds East CHC

Only last month my CHC was concerned with a problem that slots into the points raised in the article "Race and Health" *(CHC NEWS 16).* We had received complaints from the Community Relations Board that children of negroid extraction were being subjected to blood tests at school dental clinics. CHC members were concerned about inadequate information being available on the need for this preventive measure, and on the disease itself (there is the risk of collapse due to oxygen starvation of the brain in patients with sickle cell anaemia trait who are given anaesthetics).

A special sub group of the Council was set up and it has passed recommendations to the AHA and the Health Education Council to introduce a wider social awareness in this field. We have also alerted the family practitioner committee and the local dental committee to the need for further and improved communications between practitioners and immigrant families.

I am sure this issue is in no way peculiar to Leeds and would be interested to know if CHCs in other areas of high immigrant population are encountering similar experiences.

BENYON'S ABORTION BILL

Jane Roe, Co-ordinator, Committee in Defence of the 1967 Abortion Act.

I hope that all CHCs will study carefully the Abortion (Amendment) Bill which obtained its second reading in the House of Commons by a majority of 38 in February. This is a complex Bill, the cumulative effect of which will hinder women in obtaining early abortion; seriously restrict the clinical freedom of doctors; cripple the work of the two main charitable organisations (BPAS and PAS London), and will destroy confidentiality and the individual's right to privacy by allowing police access to patients' records.

It is simply not true that this Bill merely implements the recommendations of the Lane Committee and the Select Committee on Abortion. Seven of its 13 clauses go far beyond Lane and in two instances even beyond the recommendations of the Select Committee. Because of its complicated and controversial nature, the Bill is unlikely to emerge from the committee stage until it is too late to complete the rest of its passage through Parliament unless given extra time. It is important therefore for CHCs who want to keep the 1967 Abortion Act intact to write to the Leader of the House of Commons, the Rt. Hon. Michael Foot MP, urging the government NOT to allow the Bill extra time. For further information write to me at 27 Mortimer Street, London W1.

TRAINING FOR RECEPTIONISTS

A. Plumley, General Secretary, Association of Medical Secretaries, Tavistock House South, London WC1.

Your readers may like to know that since 1968 training programmes for receptionists have been available. At the present moment, 300 peope are studying for the Association's Certificate in Medical Reception and 2,500 for the Diploma in Medical Secretarial Studies. Training can be taken by both the school leaver and the older person, and by way of full-time course or a part-time one at a College of Further Education.

The Association is the national examining body recognised by the DHSS and the Department of Education and Science. It is also represented on a working party which is exploring ways and means of making training even more available for receptionists and preparing textbooks.

We welcome all letters from our readers but request that they be kept short so that as many as possible can be included. We reserve the right to cut any contributions for reasons of space, and particularly those over 150 words.

AUDIO-VISUAL MEDIA FOR CHCs

By Ian Townsend, Educational Media Adviser, NHS Learning Resources Unit

Communicating with people? Its easy if you have the time, the patience, and there aren't too many of them. But as life gets more hectic, more people want to hear your message, personal communication becomes more difficult. In an attempt to improve matters, many people have taken to using audio-visual media to present their messages.

Audio-visual media? For us the term usually means one of three things — video, film, or tape-slide presentations.

The great advantage of using media presentations is that once they are made, they can be shown to interested parties on demand — at any time of the day or night, and under almost any conditions. They don't get tired of repeating the same message, they are always fresh and new! In fact, media presentations can save money and time, freeing you for other activities.

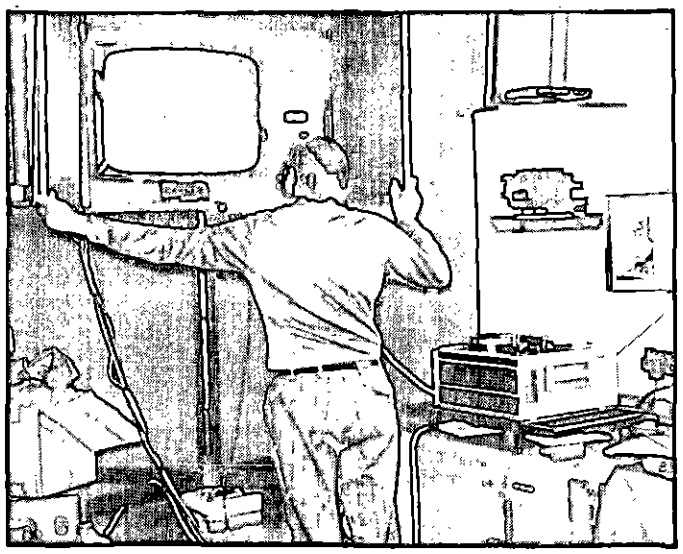
What I'd like to do here is to look at each of these media briefly in turn, and describe some of their advantages and disadvantages. Where possible, I'll try to indicate where you can go for further information.

First then, "video" — a generic term covering a range of basically similar recording processes. Images and sound are captured on a special recording tape, and can then be played back at your leisure. The 'message' is made with a camera, microphone, and video recorder, and is potentially capable of being recorded in colour or black-and-white (see ref 8a and 8b).

The great advantage of video is its immediacy — there is no wait while the material is being processed: you can see the effect of what you have done right away, the result is a moving image — which is very attractive. Although the equipment costs are fairly high, material costs are relatively low, as the videotape can be reused. Also, there are no processing charges, and hence, no postage to pay!

With videocassette machines, programmes can be left playing while you're not there, but they do need someone present to rewind and restart each playback. The main disadvantage of video is the time element needed to get an acceptable result — and the fact that unless you are prepared to spend a lot of money on colour equipment, you are limited to black and white. A further difficulty (unless you have the right sort of equipment) is that video programmes present a problem for updating (see ref 6a).

The second AV medium is film. I wouldn't really recommend this to anyone for in-house production unless they have had some experience of film-making — in either 8mm or 16mm. Short 8mm loops *can* be made which are shown very easily in a loop projector, 16mm films need to be shown on a "proper" film projector. However, unless you have lots of money to employ a professional film-making team (ref 1), video will probably suit you better than film. Film does have the advantage of greater portability of the 'message-making' equipment (unless you've got a portable video kit!) and the programme length is not prescribed by tape length, but you do have the disadvantage of processing time and costs to bear, the fact that the software is not reusable, and practical projection difficulties (ref 3).



The third AV medium I want to describe is the tape-slide presentation. This is probably the most commonly used type, and certainly it is one which almost anyone can make. What does it consist of? Essentially it is a series of projected visual messages (35mm slides) from one or more projectors, related to an audiotape soundtrack which can be electronically synchronised to produce automatic ('no-hands') slide changes.

How do you go about making a tape-slide sequence? Have a look at my series of articles published last year (refs 6b, 6c, 6d). If you want information on equipment, try

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CHCs AND THE USE OF VIDEO

Bob Faulkner, Secretary Manchester Central CHC

For the last 14 months my CHC has been campaigning on behalf of the local homeless and rootless population in Manchester in the hope of gaining for them an adequate primary medical care service.

The problem is larger than it may at first appear and is principally concentrated in the area of the inner city; the single homeless population in Manchester has been estimated at 2000 — possibly more. Their health problems have been well documented in a variety of publications. Many suffer from a variety of diseases, particularly those of the respiratory system, and in Manchester there have been instances of active TB cases present for a long period of time amongst large numbers of hostel residents in a confined space. In the absence of any adequate primary care service their health may continually worsen until eventually they present themselves at a casualty department as a last resort. In collaboration with Manchester University Department of General Practice we have been pressing for a combined research/GP appointment to assess the extent of need to provide primary care services. The Medical Practices Committee refused an additional GP appointment although sufficient money had been made available for this.

Just before Christmas, I was put in touch with a community video film unit set up under the Job Creation Programme in Manchester who agreed to make a half-hour programme concerned with the medical problems faced by the single homeless and the services which *they* feel they most need.

The film was completed at the end of March and we hope to show it to the Area Health Authority, Local Medical Committee, Manchester University, Family Practitioner Committee, CHAR, and any other interested bodies. It has the advantage of communicating visually a health and social problem with

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Medical Appeals Tribunals

Some CHCs may have been approached for help and advice by people who are dissatisfied with the amount of social security benefits they receive. It may therefore be helpful to know about the procedure that exists for contesting given levels of disablement benefit in cases involving industrial accidents and diseases, and also awards of the mobility allowance.

DISABLEMENT BENEFIT

People claiming this payment are first interviewed by a DHSS local insurance officer. If the officer decides that the non-medical conditions for benefit have been met, the claimant will be examined by a *medical board* of 2 doctors, usually GPs, who will assess the extent of disablement. Claims are considered at 55 centres throughout Britain, and boards can make home or hospital visits where necessary. The doctors' decision is binding on insurance officers. Boards may make provisional assessments when they find it impossible to determine how much or how quickly a claimant's condition will worsen. Boards' decisions are monitored by the DHSS's regional offices.

If a claimant is dissatisfied with a board's decision, he or she can appeal to a *medical appeals tribunal* (although claimants who have had provisional assessments made within the last 2 years may not). The tribunal has 3 members: an experienced lawyer in the chair and two medical members of consultant status. Claimants can be represented by a friend, a legally qualified person or an official of their trade union. The tribunal hears evidence from the claimant or his representative, and from any witnesses. Hearings are, normally, open to the public. A medical examination may be held during the hearing, in private where necessary. The tribunal sends detailed written notice of its decisions, and there is no further right of appeal on medical grounds, although an appeal can be made on a point of law to the National Insurance Commissioner. Decisions of boards and tribunals can, however, be reviewed at any time by a medical board if important fresh evidence becomes available or if a claimant's condition has worsened unexpectedly. If the Secretary of State is dissatisfied with any medical board decisions he can refer the case directly to a tribunal. There are 12 medical appeals tribunals in Britain and they hear cases in different towns and may make home visits if necessary.

MOBILITY ALLOWANCE

The mobility allowance was introduced in January 1976 to help in providing greater mobility for those who are unable or virtually unable to walk. Claimants are first examined by a local GP, the "examining medical practitioner", who where necessary can make home visits. The insurance officer may decide the case on the GP's advice or may refer it to a medical board. If the officer disallows the claim, claimants have the right of appeal to a board, and the procedure is then as has been described above.

Constitution and Procedure of Medical Appeals Tribunals. Form B1 258 L. HMSO. January 1976.

MEDIA

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the EFVA catalogue (ref 5) or the 1977 AV Directory & Buyers Guide (ref 2), or Edric AV (ref 4).

For me, the advantages of the tape-slide overweigh the disadvantages (you can't have a moving image, there are processing costs and postage to pay, etc): this would be my first choice. The software is relatively cheap, it is easy to produce a really good 'professional' result, it can be updated very easily, and, with care, the presentation can be made almost fully self-operating, repeating itself for hours on end!

If you find yourself interested in using one of these three presentational devices, but feel you need a little help, what can you do? Well, you can always try the 'Teaching Media', 'Educational Technology', 'AV Media' (or whatever else it is called) department of your local university, polytechnic, school of art or further education, or college of education. Very often, staff will be only too pleased to help you, and may welcome some "real" projects their students could become involved in. Some colleges run AV courses which you could attend (see reference to the National Audio Visual Aids Centre in 7, or any of the journals mentioned there). Perhaps groups of CHC staff could join together to produce cooperative packages? The possibilities are endless. If you would like information on the work of the NHS Learning Resources Unit, please write to me at 55 Broomgrove Road, Sheffield S10 2NA for an information pack.

REFERENCES

1 "Programmes — the basic requirements" Audio Visual, February 1976, 34-39.
2 "AV Directory & Buyers Guide" Audio Visual, PO Box 109, Croydon CR9 9BT.
3 "Overcoming the Problems of 16mm Projection" by B. Donohoe, Visual Education, January 1977, 11-13.
4 "Catalogue" Edric Films Ltd, 34-36 Oak End Way, Gerrards Cross, Bucks.
5 "Equipment for Audio-Visual Aids and Price Guide" NAVAC, 245 Belsize Road, London NW6 4BI.
6a "Educational Television Explained" by I. Townsend, Nursing Mirror, 1 July 1976 67-68.
6b "Producing a Tape-Slide Package: Part 1" by I. Townsend, Visual Education, February 1976, 17-19.
6c "Producing a Tape-Slide Package: Part 2" by I. Townsend, Visual Education, March 1976, 23-27.
6d "Producing a Tape-Slide Package: Part 3" by I. Townsend, Visual Education, April 1976, 23-24.
7 "Educational Media Information Services" by I. Townsend, Nursing Mirror, 3 February 1977, 64-65.
8a "Video Tape Recorders Surveyed: Part 3: CCTV reel-reel VTRs", Video and AV Review, June 1976, 30-33.
8b "Video Tape Recorders Surveyed: Part 4: Cassette and Cartridge VTRs", Video and AV Review, June 1976, 34-41.

VIDEO

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an impact which is difficult to achieve in any other way.

In this case the film (which will be backed up by a written research document) includes interviews with virtually every interested party since a one-sided advocacy stance would be unlikely to produce the desired result. We feel the local GPs in particular have appreciated the opportunity to "have their say".

Most University departments have video units: planning departments, training and education sections of local industry have them, and the latter also give training courses on how to use video. The British Film Institute will occasionally fund projects, the Metropolitan Police have literally hundreds of video units, and there is a video users association in London. Polytechnics may well be interested in joint community projects which could help to train their students. Unfortunately, some of the above tend to be rather protective of their video equipment and you may have no luck but a little CHC pressure (on the basis that many video units are bought by the ratepayer) could work wonders. If you would like to see this example of the use of video give me a call on 061-832 8183 and I would be very pleased to arrange something for CHC secretaries or members.

PERSONAL VIEW

Strength for the Community

Forty years ago Albert Einstein wrote: "It is of great importance that the general public be given opportunities to experience consciously and intelligently the efforts and results of scientific research. It is not sufficient that each result be taken up, elaborated, and applied by a few specialists in the field. Restricting the body of knowledge to a small group deadens the philosophical spirit of the people and leads to spiritual poverty."

In Britain we have followed the long term trend towards an information-dependent society which, of necessity, has placed a high premium on education, knowledge, information, intellectual and professional elitism, and specialisation. All these are marshalled within our bureaucratic institutions of which the National Health Service is the most pervasive since it touches upon the lives of us all.

As Community Health Councils become more entrenched in the health care system, particularly through participation in planning, and as the lay members of Area Health Authorities become more active in management and at the same time more responsive and accountable to their constituencies, we may begin to see an end to secretiveness and functional lying that bedevils policy making and administration of the health service. But even when community people are admitted to policy making and become involved in planning and monitoring of services they are at a disadvantage in dealing with matters such as professional opinions and practices, and the assessment of technological innovations. Each new technology creates a new ignorance. It is most difficult for a lay person or for that matter a professional working in another discipline — to discern whether one proposal is based on recent analysis, unequivocal evidence, and a broad spectrum of experience, or whether another

By Julian Knox former Secretary of Islington CHC

is only supported by an unchallenged acceptance of conventional wisdom, or because it is generally regarded as a "good thing".

I am not proposing an exclusion of scientific or professional judgement from the processes of evaluation and decision making about innovations, but rather that a way must be found both for community representatives to understand and utilise the processes of technology assessment, and to effectively introduce community criteria of need and choice to the policy process.

We need a *community methodology* which will give us a balanced and comprehensive appraisal of the nature, significance, status and merit of innovation, in order to establish whether it is desirable, undesirable or uncertain so that its impact may be predicted with a reasonable degree of probability.

Participation in the work of health care planning teams and other official working groups is a new activity for CHCs, and in order to be effective they must rapidly gain substantive knowledge of both the health care system and of the communities they are helping to plan for. The training process will be demanding and over sustained periods of time. We will have to become adepts at posing the right questions and exploiting expertise, often from outside the NHS. We must develop ways of presenting information to both planners and our communities in reliable and continuing forms, and at the same time continue to press for changes in the planning process so that it may become more amenable to community inputs. In order to assess specific technologies we can begin to try out such approaches as the establishment of panel investigations or hearings.

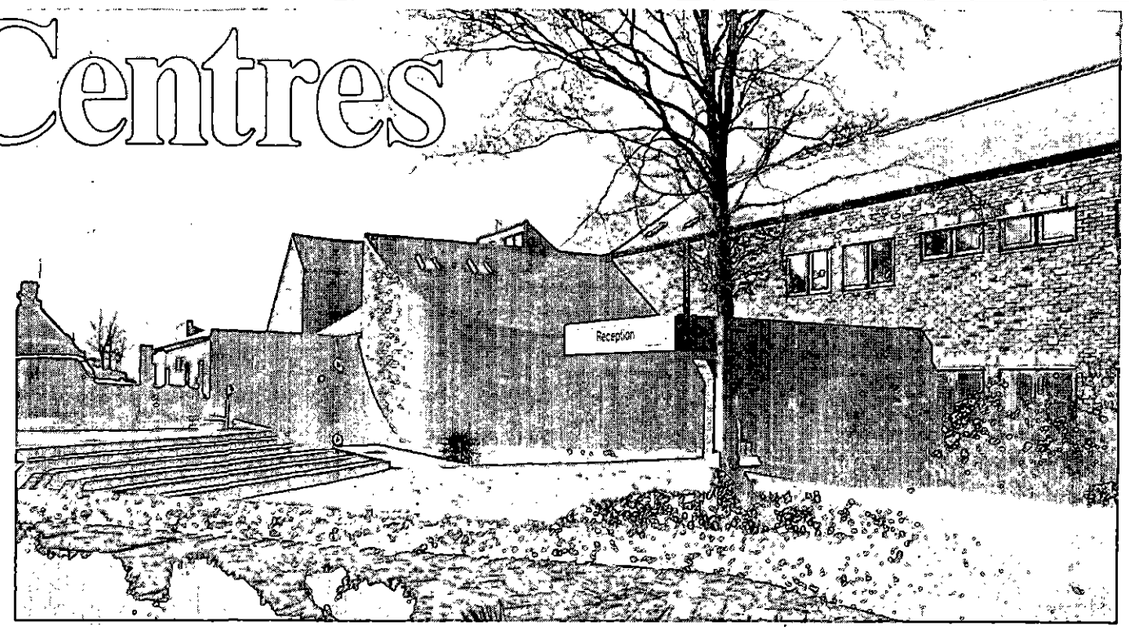
CHCs and AHA members are beginning to test what will be the next major step in the history of the NHS — that of true democratic control. A major force in achieving this will be the extent to which we have succeeded in mobilising the resources and energies of the people as a source of insight, information, experience and wisdom.

News from CHCs

- Liverpool's 1,000 single homeless people need more medical care than the average person but get less, according to a report prepared for the city's Central and Southern CHC. The 88-page report "Primary medical care and the single homeless in Liverpool" has been widely distributed, and attracted considerable publicity. Less than 40% of Liverpool's single homeless were found to be registered with GPs, and nearly 27% of homeless people treated at the city's Royal Infirmary casualty department should have been dealt with by a GP.
- All hospitals should be classed as teaching hospitals so that doctors are trained to meet the specific problems of the areas where they will eventually work. This is proposed by Merthyr and Cynon Valley CHC in evidence to the Royal Commission on the NHS. Merthyr also recommends the setting up of informal GP/CHC committees serviced by CHC secretaries, who can then act as a direct link between patients and doctors.
- Kensington, Chelsea and Westminster South CHC has surveyed 60 local GPs to support its campaign for a new day-care abortion unit. Of the sixty, 32 said that NHS provision was inadequate. Forty-four supported the CHC's plan for a local day-care unit.
- A letter from Brent CHC, encouraging local applications for the post of Brent and Harrow AHA chairman, has been published in seven local north London papers. The post falls vacant in July, and the DHSS has promised to consider all nominations when appointing. Harrow CHC has supported Brent's initiative, and both councils are fowarding suitable applications to the Secretary of State.
- Ceredigion CHC has organised a patient "adoption" scheme for long-stay geriatric hospital patients who get no visitors. A list of volunteers willing to visit a specific patient regularly has been compiled by the CHC, in conjunction with the Aberystwyth Council of Churches. Some 14 elderly patients are now being visited.
- The Isle of Wight CHC is campaigning with its local branch of the Spina Bifida Association for regular paediatric neurology sessions on the island. The association is surveying its members about the difficulties they face in taking their children to Southampton for regular assessment sessions.
- Bolton CHC has published a 30-page report of its study day on drug abuse, held last October. The report contains expert talks on drug dependence, self-poisoning, drugs and the police and drugs in schools, and 1,000 copies have been distributed locally. The CHC is setting up a drug abuse working party, which will have close links with local schools, parents and welfare services.
- The Leicestershire FPC has agreed that secretaries of the county's three CHCs can act as a "patient's friend" at any hearing of a service committee investigating a complaint. This followed advice from the DHSS that a secretary in such a situation would not be acting as a paid advocate. Secretaries will be acting solely on behalf of the complainant, and so must not report back details of hearings to their councils.
- For details of new chairmen and secretaries, see directory changes section on back page.

Health Centres

MARY AITCHISON secretary of Frenchay CHC



The chaos of reorganisation of both the health service and local government has meant that the health centre priorities and programmes have had to be re-established. Regrettably, the divorce of health care at primary level from local authorities found some area health authorities devoid of experience in the field of valuation, land purchasing and planning. Frenchay Community Health Council may not be alone in "Mounting Health Guard" action on consequent critical situations.

When members of Frenchay CHC read in the local press that the Bristol City Housing Committee had taken a decision to build flats on a site designated as a health centre, a special meeting was called to plan action. Only five days before the press report we had received a statement from the Frenchay District Management Team saying that the DMT recommended top priority for the health centre scheme at 100 Fishponds Road, Eastville; that provision be made in the capital programme and that the Bristol City Council be asked to continue to reserve this site for a health centre.

The Bristol City Council had submitted the scheme to the DHSS in April 1973 after the approval of the then Executive Council (FPC) and doctors. The scheme had only been postponed because of lack of capital funds. The CHC was concerned at the existing grossly inadequate general practitioner services. One doctor's premises were stated to be "rat infested". The pending retirement of a GP brought problems when replacement by a younger doctor was proving impossible. Ancillary care was urgently needed for this health deprived and under-privileged neighbourhood as health centres in adjacent catchment areas were already stretched beyond their capacity.

The Eastville health centre was also part of an overall development which included an elderly people's club, residential home for the blind and workshop for the handicapped. The loss of this site would deprive the disabled of easy access to health facilities. The City Council's proposal to build one-bedroom flats on the health centre site was considered to exacerbate the problem of lack of pimary health facilities.

The CHC drew up a plan of campaign by approaching the Area Health Authority and urging it to make strong representations to Bristol City Council asking that the site of the health centre be retained. The CHC also asked to meet the AHA to discuss the critical situation. Letters were sent to local MPs and to the Chairman of Bristol City Council. To stress our concern, one CHC member met the MPs at the House of Commons. We gained the support of the DMT, Family Practitioner Committee and GPs.

The Chairman of the city's Housing Committee stated that "it has been decided to insist that if designated sites such as this could not be developed within a reasonable period, they would be taken over by the Housing Committee for residential development". The Housing Committee then offered an alternative site which was accepted by the Area Health Authority. Investigation of the site by the CHC, however, highlighted not only access and gradient problems, but that only one third of the land was in the ownership of the Bristol City Council. Owners of the other properties on this site expressed strong resistance to sell. It was apparent that if the designated site were lost, many years would elapse before a health centre was provided in this area, with the possibility of less doctors remaining to serve the population.

Press reports of the CHC's concern aroused public action. Within three days a petition signed by 1,300 local residents was sent to us for presentation to Bristol City Council. The petitioners asked that the site for the health centre should be retained. The action of the CHC was backed by the DMT, FPC, MP and local doctors. Approaches by the CHC to the AHA to effect a meeting and discuss the crisis were not accepted. We regretted this as the AHA believed that the DMT, FPC and GPs accepted the alternative site offered by Bristol City Council — which was contrary to the views expressed in correspondence sent by these bodies to us.

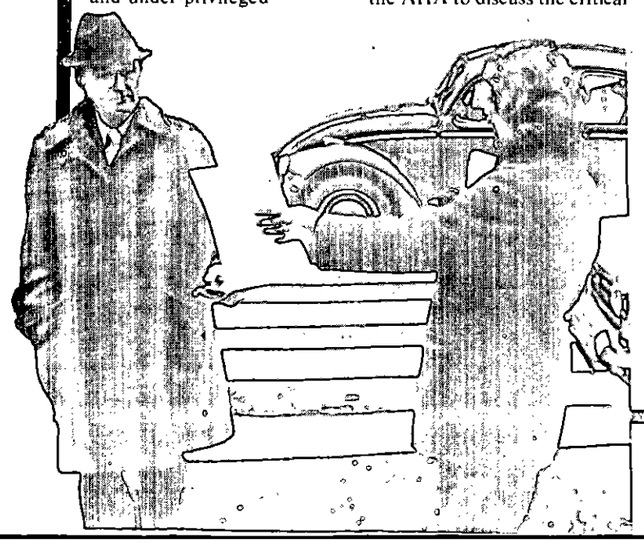
The Housing Committee agreed to meet us.

The discourse was difficult and frank, but an assurance was eventually given that if the City Council could be given a guarantee that a health centre could be started in 1977/78 the site would be retained. The time factor in negotiating this guarantee became critical. Further setbacks arose when the local MP received a reply from the Minister for Health stating that he had been informed that the situation had been carefully considered by the Area Health Authority, Family Practitioner Committee, District Management Team and local doctors who all agreed that the alternative site was a reasonable one.

The CHC wrote to the Minister submitting the letters from the DMT and local doctors confirming their distress at the loss of the site and stating their disapproval of the proposed alternative site. Continuing persistence on our part to meet the AHA finally resulted in a meeting with the FPC, DMT and GPs present. The evidence presented by the CHC, supported by the other bodies, convinced the AHA that immediate action be taken to save the health centre site. The AHA agreed to act at once to purchase the land at 100 Fishponds Road for the health centre and to give urgent attention to the listing of its priorities for 1977/78 by October, giving the health centre top priority.

We were given the assurance that if the site was retained, the AHA would make every effort to have the health centre included in the programme for 1977/78. The DHSS replied to us stating that Bristol City Council had been advised that the scheme had a very good chance of inclusion in the 1977/78 programme and so was being asked to retain this site for the health centre. The City Council agreed to this request.

The latest development is that the AHA has received a letter from the Regional Health Authority saying that the outline project policy has been approved in respect of the Eastville health centre and that planning could now proceed to the "ready to go to tender" stage. That we were able to give this information to the Residential Home for the Blind, who wrote asking when the health centre would be started, justifies the determined action of the community health council.



First proposals for a nationwide provision of health centres were made in the *Dawson Report* in 1920. Two kinds were envisaged: primary centres to be staffed by GPs, and secondary centres to be staffed by specialists to deal with more complicated cases. During the next 20 years the idea was adopted in principle by a number of organisations such as the Labour Party and TUC but the only health centre built was in Peckham, London in the 30s. The two questions on which there was conflict were the size and functions of the proposed health centres and, even more crucial, who should control and administer them.

The White Paper of 1944 *(A National Health Service)* announced the Government's intention to provide a number of health centres on an experimental basis with a view to more widespread development if trials were successful.

However, the National Health Service Act 1946 placed a specific duty on local health authorities to provide and maintain health centres and in February 1947 the Ministry of Health issued a circular requesting that building plans should be submitted. By December 1947 the conflicts had not been resolved and the country was facing an economic crisis and February's circular was cancelled. On the 'appointed day' (5 July 1948) 27 premises were taken over to be used as health centres and by 1963 only a further 18 had been built. By the 1960s the concept of community care was accepted and this enhanced the priority of health centres so that by 1971 there were 307 in operation, from which 1625 doctors were practising.

The last circular issued by the DHSS on this subject (HRC(74)21) was in March 1974 and described arrangements for the transfer of responsibilities for health centres to the new health authorities. A 'comprehensive' circular on health centres is expected soon from the DHSS.

HEALTH CENTRES READING LIST

Interim report of the committee on the future of the medical and allied services (Dawson Report), Cmnd. 693, HMSO, 1920.

Segregated health care: the origins and design of health centres, by Brian Brookes, Built Environment, October 1973.

A bibliography on health centres in the UK, by Gail Baker and John Bevan, Update Publications Ltd, 33 Alfred Place, London WC1, 1973.

As above: supplement for 1973 and addendum to the original bibliography, Health Services Research Unit, University of Kent at Canterbury, 1974.

Health centres, published by Health and Social Services Journal, 27 Furnival Street, London EC4, 1974, £1.00.

Health centres: the next step, Socialist Medical Association, 14 Bristol Street, Birmingham 5, 25p.

British health centres directory 1973, by Brian Brookes, published by King Edward's Hospital Fund for London, 1973, £2.00.

EDITORIAL

At a time when so many confusing statements about NHS policy and finance are being issued, there is great difficulty in working out exactly what path the health service is following. The RAWP report "Sharing Resources for Health in England" was issued in September 1976 as a consultative document. On 21 December 1976 the Secretary of State announced that although he accepted the broad principles of the report, his decision on the precise method to be used to bring a policy of resource redistribution into effect would be taken in relation to 1978/79 and subsequent years. In other words, we do not yet know for sure whether the formula devised in the RAWP report for assessing "need" will be used at all, or whether it will have to be modified. Furthermore, there is uncertainty about the use of the formula in calculating allocations *within* regions in the areas and districts.

In the meantime the allocations to regions for 1977/78 were announced on 2 March 1977. The problem is to unravel on the one hand those elements that reflect the national policy of allocating NHS money more fairly in geographical terms, and on the other hand the elements that relate to the real differential priorities for health care groups within the population of each region. But for CHCs the main concern must be what happens at district (or single-district area) level. The crucial thing to watch in the coming months is whether the districts adhere to their stated plans for improving aspects of the service, and whether they react in an honest and rational way to the shortages of time and money that may arise. Unless CHCs are vigilant there must be a danger that hard-pressed staff may make expedient decisions which could work against the future interests of the health service itself.

CHC NEWS

APRIL 1977 **No. 18**

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CHC NEWS
126 Albert Street,
London NW1 7NF
01 267 6111

CHC NEWS is distributed each month free of charge to members and secretaries of Community Health Councils in England and Wales. It is also available to subscribers at £2.50 per annum (or special discount rate if five or more copies of each issue are ordered). Special and overseas rates on application.

Published by King Edward's Hospital Fund for London and printed by The Chesham Press Ltd., 16 Germain Street, Chesham. HP5 1LJ.

BOOK REVIEWS

THE ROLE OF MEDICINE
by Thomas McKeown, (Nuffield Provincial Hospitals Trust, 1976, £3.25).

This book is full of useful information and ideas. It can be regarded as a manifesto for the health service, a programme for future medical education, a dissertation on the importance of community medicine, and much else besides. Professor McKeown provides evidence to show what a mistake it is to believe that improvements in physical health over recent generations are due to the efforts of our medical services. He shows how the major causes of sickness and death have hardly been influenced by medical intervention — rather they have been determined by nutrition, environmental conditions and the control of population growth. He argues for a rethinking of the goals of health services so that the role of community medicine is strengthened and that a more coordinated approach to the hazards of occupational and domestic environments is achieved. A more concerted attack on the risks associated with medical intervention and treatment, together with a radical revision of the training of doctors is also called for. Professor McKeown demonstrates the importance of setting a realistic time span for achieving these changes. He warns us away from plans which are designed primarily to please the electoral ambitions of short-sighted policy makers. Several of these points will already be familiar to CHCs, but the particular value of the book is to provide clearly-reasoned factual arguments to back up the claims that are made.

PRESCRIBING IN GENERAL PRACTICE
(Available from Royal College of General Practitioners, 14 Princes Gate, London SW7, £3.00.)

This is a series of papers some of which are based upon the work and prescriptions over a period of time of 859 doctors, but some of the papers are much wider ranging. They tackle subjects like prescribing by ancillary staff, prescribing costs and the relationship between pharmacist, GP and public. We are not given just the figures so beloved of our statisticians. We are given stimulating studies of general practice with reference to its workloads, appointment systems and off duty rotas. There is too an interesting consideration of the problems of pharmacists, not only as they relate to the public but also as they affect doctors. One member of each community health council should read this booklet and set up discussion on it.

William Ashworth (Chairman, Burnley, Pendle & Rossendale CHC)

HEALTH AND ILLNESS
A New Society Social Studies Reader (35p inc post from King's Reach Tower, Stamford Street, London SE1 9LS)

This is a collection of 14 articles which appeared in New Society magazine in 1973-75. The subject matter ranges from community medicine, mental subnormality, attitudes of gynaecologists, VD and drugs to problems in the USA and Italy. Presented in a readable form the articles are useful and thought-provoking introductions or descriptions of topics we all need to know more about.

Another selection of New Society articles in this series is called THE ORIGINS OF THE SOCIAL SERVICES (30p). It delves into the backgrounds and explains some of the reasoning behind developments in housing, public health, social security and education.

HELP STARTS HERE
Voluntary Council for Handicapped Children, 8 Wakley Street, London EC1V 7QE. 01-278 9441

This brief pocket-sized booklet is aimed at parents whose children have special needs. Using a question-and-answer format it gives information on a wide range of services and aids for handicapped children and explains how to go about getting information and help — CHCs are mentioned as one of the main sources. At present the booklet is avilable free from the above address but when present stocks run out a charge may have to be made.

THE SANITARY IDEA

Asa Briggs, Provost of Worcester College, Oxford

There were many Victorian gospels. One of the most powerful was that of "the sanitary idea". As Charles Dickens put it "searching sanitary reform must precede all other social remedies". Improved public health, it was believed, was not simply a matter of devising machinery — better water supplies; networks of drains and sewers, commissions of experts. It was a matter of mobilising human energies and purposes to "beat what had hitherto been accepted as Fate". Lives could be saved, waste eliminated. Another Victorian writer, Charles Kingsley, author of *Water Babies*, put it this way: "I see one work to be done ere I die, in which Nature must be counter-acted lest she prove a curse and a destroyer, not a blessing and a mother; and that is Sanitary Reform."

For many years the best-known and the most controversial of sanitary reformers was Edwin Chadwick, born in 1800 in industrial Lancashire. He became a disciple of Jeremy Bentham, the great reformer who believed that all institutions should serve the greatest happiness of the greatest number. Bentham left Chadwick a ring containing his effigy and a lock of his hair along with law books and a small legacy. Chadwick believed in individualism as the mainspring of a developing industrial economy, but he also believed — following Bentham — in the need for social control. His first public work concerned the new poor law of 1834 but very quickly he realised the close interconnections between poverty and disease and through the Poor Law Commission tried to stimulate interest in public health questions. His report *The Sanitary Condition of the Labouring Population of Great Britain* (1842) was a classic document. Six years later, after fierce struggles,

Edwin Chadwick

Chadwick played a major part in securing the first general public health act in the statute book.

Chadwick reconciled individualism and social control in this way: "It costs more money to create disease than to prevent it; and there is not a single structural arrangement chargeable with the production of disease which is not also in itself an extravagance."

The General Board of Health, set up by the 1848 Act, was not a success. It met with bitter resistance locally and nationally. Chadwick was partly to blame. He had no tact and he was unwilling to recognise how necessary it was to involve doctors as well as administrators and engineers in the battle for improved public health. *The Times* which had asked in 1848 "if this Bill will not do, what will?" was declaring itself ready by 1854 to take a chance of "cholera and the rest" rather than be "bullied into health".

Chadwick was dismissed from public office with the rest of the Board in 1854. He lived on, however, as Florence Nightingale was to do, into a new age. In 1889 — very belatedly — he was knighted: a year later, he died. His achievements belong to the early years of sanitary reform when public health was a clarion call for the few. By 1890 it had all been systematised. And by then there were other social gospels to propound.

RURAL HEALTH

Roughly 135 of the CHCs in England and Wales cover rural areas, where lack of adequate transport compounds all the major health care problems. Deficiencies in public transport cause most distress to 'at risk' groups such as the elderly and the handicapped, most of whom have no access to private cars.

Northumberland CHC has made a study of travel problems in its largely rural area and identified problems for out-patients and for visitors to in-patients, particularly disabled visitors. In some parts of the county transport services are so inadequate that people cannot get back home on the same day, but it is worth noting that many school buses carry fare-paying passengers. Northampton CHC's area includes nine villages without any bus service at all. Norwich CHC has taken up problems of staff travel with its RHA and it transpires that there are provisions for payments in order to recruit or retain staff in poorly serviced areas but these are subject to fairly strict conditions.

The number of GPs based in the smaller villages has been decreasing steadily over the years. Encouragement of group practices and health centres makes the problems greater because more patients then have further to travel to reach their GPs. Northampton CHC has suggested that there should be a minibus service to ferry patients to and from group practice surgeries and in Oxfordshire a free transport service is arranged to and from a Health Centre. In Hinckley, Leicestershire consideration is being given to a proposal for a mobile unit to cater for GPs, health visitors, family planning and infant welfare clinics. Policies of centralising many services in the more populated areas can have particularly adverse effects on those rural areas which are on the fringes of conurbations.

Many villages don't have chemists and a number of CHCs are suggesting collection and delivery services. Frenchay CHC has now got one going but found that their main obstacle was finding a suitable collection point.

Elderly people are sometimes the most vulnerable members of rural communities and Norwich CHC carried out an extensive survey into needs and problems in North Norfolk. This found gaps in the meals on wheels services and the CHC have suggested that hospital kitchens could take over the cooking during periods when school kitchens are closed. Another suggestion is a need for more flexibility in the home help service with more opportunities to use neighbours. The CHC also discovered that the WRVS ran a voluntary village taxi service.

Holiday areas are prone to some very special problems. In some cases the influx of holidaymakers can increase the population of a small town or village by ten times whereas provision of health services is geared to the permanent population. Many pensioners retire to holiday areas which causes an unnatural balance of population.

The Ramblers Association feels that in some areas the transport situation is worse than it was 50 years ago. In fact, between 1960 and 1975 the number of passenger railway stations went down from 4877 to 2376 in the UK. One useful development came in 1967 with the introduction of the first post-bus. By October 1976, 112 were operating, 30 in England and Wales and the remainder in Scotland. Organisations interested in getting a local post-bus service should contact their local head postmaster.

CHCs in large areas have their own problems of organisation and both Northumberland and Oxfordshire have set up geographical groups. Norwich CHC have found a very useful publicity spin-off to their survey and subsequently CHC members gave talks to a large number of local organisations.

District Boundaries

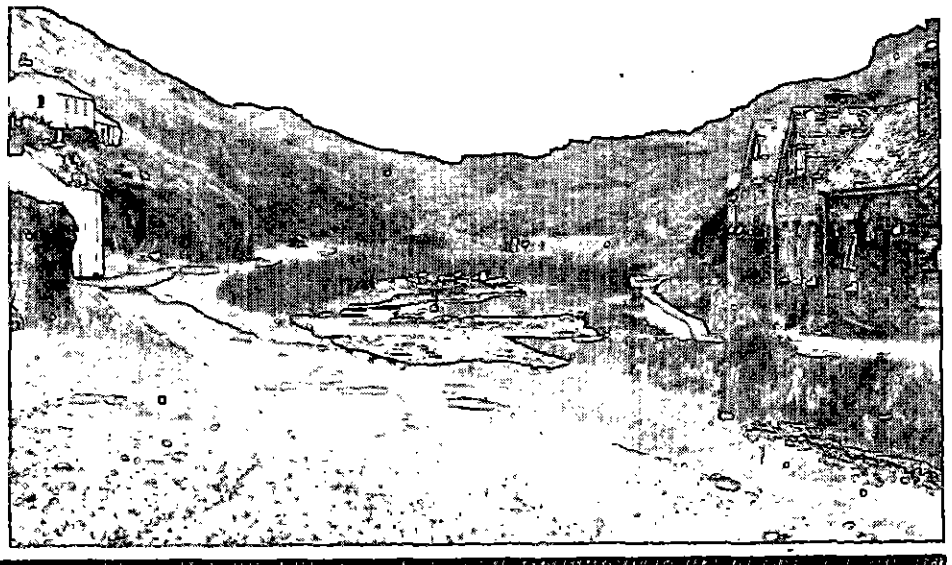
The one point on which both critics and friends of the NHS are agreed is that there are too many levels of administration. While successive Secretaries of State have agreed that it is too soon to have another reorganisation, the DHSS has now given approval to one district merger and several others seem 'on the cards'.

In Liverpool, DHSS approval has been given to merge the two districts subject to further consultations with the staff involved. The new district will have a population of just under ½m and the AHA's argument is that the city should be administered as one unit. A large new teaching hospital is due to open at the end of 1978 and the future of another seven hospitals in the city is now in doubt. A further two hospitals inside the city boundaries are administered by Sefton AHA. Consultation began on the proposals in mid-1976 and both CHCs gave approval subject to reservations concerning remoteness of facilities from patients. A new management structure is still being worked out and no date has yet been fixed for the merger.

On the Wirral (two districts with populations of 256,000 and 116,000) an official consultation document was issued in February 1976 on the proposed merger and following representations from the CHCs and other local bodies a final decision is expected in the next month or so. A large new DGH is being built in the middle of the area and the future of 18 other hospitals is under consideration. The CHC is proposing the establishment of three urban community hospitals. Since first proposals were made posts have been frozen at district level, and staff morale has been severely affected by uncertainties about the future.

Sheffield has three districts and a joint

Continued on page 10



HEALTH VISITING

Mary McClymont and Liana Buob, Dept. of Health Studies, Stevenage College

Health visitors can offer planned personalised care over a wide range of health needs including health education and social advice. This confidential, continuing, nonstigmatising service can be offered in clinics or surgeries, in residential accommodation or hospital units or, most often, in the privacy of the client's own home.

Many people think of health visitors as being concerned mainly with mothers and young children, perhaps occasionally working with the elderly and/or disabled but, of course, the health visitor is a family visitor with a remit to care for all age groups. Because of low ratios it is true that at the present time almost two-thirds of their time is spent with children and their families, but even from within this range of activity other household members are contacted and helped on a wide range of topics. Examples of the items which health visitors are equipped to discuss and offer counsel on include the care of adolescent children or ageing relatives, menopausal difficulties, family tensions, housing difficulties and social security benefits, as well as the whole range of health fears or symptoms which may be causing anxiety.

Some health visitors are now running slimmers clubs, advisory sessions and group clinics for those endeavouring to give up smoking, planned exercise programmes and sometimes, a range of supporting groups for those dealing with special health problems such as coping with diabetes or post-mastectomy care.

In many localities health visitors, in cooperation with GPs, district nurses and health education officers, are providing screening programmes and health checks for those aged 35 to 65. Such screening may include sight, hearing, blood pressure, ECG readings, weight and height, urine testing to detect diabetes or kidney infections, testing lung capacity to reduce the risk of chronic respiratory diseases and checks of posture and foot health. For women there are also cervical cytology tests and breast examinations. Where age-sex registers are available these health checks can be more readily arranged.

Members of CHCs can do much to support and help health visitors achieve a greater impact in the field of positive health care in middle life, not only by encouraging FPCs to adopt the use of age-sex registers, nor just by encouraging clinic and practice audits, but also by drawing public attention to the facilities health visitors can offer and encouraging their use. In some instances, where caseloads are higher than the recommended ratio of one health visitor to 3500 population, it may be necessary for priority to be given to young children, the disabled and chronically sick, but good preventive care in middle life is likely to reduce the burden of ill health in the younger elderly.

The Government has said *(Priorities in the Health & Personal Social Services)* that they are aiming for an annual increase of 6% in both the health visiting and district nursing services until the ratio of 1 to 3000 population is reached.

A health visitor has a minimum of three years' training in general nursing followed by obstetric or midwifery preparation plus a one-year specialised course in preventive and social health. Channelling those with the needed professional skills and personality traits into health visiting and providing them with adequate supporting ancillary staff so that they are not deploying their special skills on unnecessary clerical and administrative tasks will enable the community to receive greater cost benefit of improved health and quality of life.

Complaints

Continued from page 1

There are many situations which the commissioner cannot investigate — such as decisions depending solely on clinical judgment, and cases in which a complainant can reasonably be expected to seek a remedy through the courts. In particular, the commissioner cannot investigate complaints about family practitioners, though he can investigate the way in which FPCs handle such complaints. The reports suggest that the present commissioner is stretching his terms of reference to the full.

Although the commissioner has no powers to enforce changes, it is encouraging to note that investigations often result in proposals from health authorities for improving their procedures, and in apologies and attempts at reconciliation.

*First Report of the Health Service Commissioner, Session 1976-77, HMSO, £2.25; Second Report, £2.50.

District Boundaries

Continued from page 9

working group of staff and AHA members has been working out a new two-district structure since mid-1975. A new DGH had been planned for the South district, but expenditure cuts caused cancellation of the project and the AHA maintains that districts must have DGHs. The AHA has pledged that there will be no redundancies but in the time taken to consult and implement decisions two district administrators and other administrative staff have left, so it appears that the pledge will be implemented by natural wastage.

Weston-super-Mare health district has a resident population of only 95,000 which is swelled each summer by large numbers of holiday makers. In June 1976 the AHA denied there were any plans to merge the district with Bristol, yet in October they issued a consultation document proposing a merger. This has met with vigorous opposition by local people.

The CHC feels that previous inadequate provision cannot be used as an excuse for lack of proper provision in the future.

In none of these cases has the future of the relevant CHCs been formally discussed. Regions have advised that the merger of districts does not necessarily mean the merger or closure of CHCs. (There are two 2-CHC districts in England and five in Wales.) It is noticeable that little attention appears to have been paid to this aspect at Regional and Area levels.

Districts were not mentioned by name in the NHS Reorganisation Act although they were described in the 'Grey Book' (*Management Arrangements for the Reorganised NHS*, 1972) as the basic operation unit of the integrated health service. Any changes in their boundaries have to have the approval of the Secretary of State. The boundaries were to be fixed according to three main criteria: the number of primary care teams (of GPs and local authority social workers); existing patient-flow patterns even where these cut across existing local authority boundaries; the existence of a district general hospital (DGH) or a group of hospitals providing a district service. The optimum population was seen as 250,000. 222 districts were set up in England and Wales of which 42 had a population below 150,000 and 110 had populations between 150,000 and 249,000.

The questions that therefore need to be asked are: Are the 'Grey Book' criteria the right ones? If so, are they being followed? If not, what alternatives can be put forward? CHCs will want to ensure that the priority is patient care rather than administrative convenience, while bearing in mind that these are interlinked and not necessarily alternatives. The crux of the matter is whether delivery of health services to the population will be enhanced by specific changes in administrative boundaries.

Underlying these questions is the basic principle of *who* should be involved in making the decisions about provision and delivery of health services — administrators? the medical profession? the public?

HEALTH & SAFETY AT WORK

The Health and Safety at Work Act 1974 is the culmination of decades of dissatisfaction with existing occupational health and safety law. When the Robens committee reported its two-year study in June 1972, it told a sorry tale. Each year 1000 people were being killed at work and half a million were reported injured. Reported industrial accidents and diseases were claiming 23 million working days per annum, at an annual cost of £200m.

Five government departments were controlling seven separate inspectorates policing 31 Acts of Parliament and over 500 minor pieces of legislation relating to health and safety in and around the workplace. Even so, many employees remained completely without protection. The law was looking increasingly outmoded and the inspectorates were becoming swamped with new and more complex types of hazard.

Robens proposed a fresh approach, based around a "single centre of initiative" which would unify the inspectorates and have day-to-day autonomy from government departments. This new body would operate a comprehensive, new enabling Act, translating its general principles into specifics by way of statutory regulations, and wherever possible by voluntary standards and codes of practice. The Robens proposals were adopted by the Conservative government in a Bill published in January 1974, and following the February election a similar Bill was reintroduced by the new Labour government. The main difference was that this new version provided for the appointment of employees' safety representatives by trades unions, or alternatively for their direct election by the workforce. Employers could also be obliged to set up safety committees, when requested to do so by safety representatives. These committees would keep under review the measures taken by an employer to ensure employees' health and safety at work.

To control the work of the new unified inspectorate, a Health and Safety Commission was set up on 1 October 1974. This consists of a chairman and 9 members appointed after consultations with the TUC, local authority associations and professional bodies. Implementation of the Commission's policies is controlled by the Health and Safety Executive. The Act itself became law on 1 April 1975, and the Commission is gradually introducing new regulations and approved codes of practice. Existing legislation — covering for example, factories, offices, shops, railway premises, mines and quarries — will remain in force until it is superseded. The new codes of practice will have a special legal status — they will not be statutory requirements, but they may be used in courts as evidence.

Health and safety inspectors — factory inspectors, alkali inspectors, etc. — can issue prohibition notices to halt activities which they consider are creating a risk of serious personal injury. This procedure can be applied when a new and potentially hazardous process is about to start up. Inspectors can also issue improvement notices, requiring an employer to stop breaking the law within a specified time. Eventually it is hoped that inspectors will be able to adopt the role of outside advisers to the workplace safety representatives. The Commission has powers to compel disclosure of information relating to health and safety, and where necessary inspectors may pass on information to employees or their representatives. To protect the general public, employers can also be required to give information about health and safety hazards to people who are not employees but may be affected by work activities.

The Act extends protection to eight million workers not covered by earlier legislation, including the self-employed and "home-workers". People providing medical, dental and nursing services in or outside hospitals, and all medical and supporting staff employed by AHAs are amongst those now covered for the first time. The Commission has just completed a pilot study of work hazards in the NW Thames Region, out of which should come general guidance relating to health workers and premises. Meanwhile, health sector inspections are being made when requested by management or the workforce. The TUC had originally expected the regulations implementing the provisions for health and safety representatives and committees would be introduced by mid-1975, but last year the government announced that this would be postponed because of public expenditure restrictions. This annoyed both the Commission and the TUC which sees the Act as an important part of the social contract. The decision was abruptly reversed in February this year, during the build-up to talks about the next phase of pay restraint, and the government now says that the regulations will come into force on 1 October 1978. Safety representatives will then be empowered to make 3-monthly inspections of plant and premises, to inspect immediately following accidents and dangerous occurrences, to investigate complaints, to consult with health and safety inspectors and to make representations to management.

Parliamentary Questions

STATEMENT ON CHCs

Mr Ennals was requested by Michael Morris MP to make a statement about CHCs. He said: "What I have seen so far of the work of community health councils encourages me to think that this experiment in providing a voice for consumer interests is proving successful; and I am confident that the councils will continue to develop their important and valuable role of representing the interests of the public in the operation of the NHS."

In reply to Gwilym Roberts MP the Secretary of State said he had no plans at present for extending the legal powers of CHCs.

PUBLICITY FOR CHCs

Ken Weetch MP asked that the Central Office of Information be involved in helping to publicise CHCs, but Roland Moyle replied that this was better achieved locally. He was willing to consider what help central government facilities could provide, and he thought this would be taken up by the proposed national association of CHCs.

SURVEYS OF THE DISABLED

The numbers of disabled persons on the registers of local authorities has risen from 405,000 in 1970 to 854,000 in 1976, said Alf Morris in response to questions from Lynda Chalker MP. He added that it was even more necessary during a period of economic restraint for local authorities to identify the handicapped in their areas so as to ensure that limited resources were directed to those most in need.

ANALGESICS

53 CHCs in England and Wales have written to support a ban on self-service or self-selection of analgesics, and 7 have opposed the ban, said Mr Moyle in reply to a question from Sir Bernard Braine MP.

VOLUNTARY ORGANISATIONS

The DHSS will be giving grants totalling £5m to voluntary organisations in 1977/78 — an increase of £1.85m over the previous year. In reply to a question from Ivan Lawrence MP, Mr Moyle added that local authorities had powers to support voluntary effort locally, and he hoped they would bear this in mind when allocating their own resources.

SMOKING

The government intends to introduce legislation in the next session to bring smoking products containing tobacco substitutes and additives within the Medicines Act 1968. Roland Moyle was replying to a question on this from Robert McCrindle MP.

NOTES.....

NURSING ETHICS
The Royal College of Nursing has issued a code of conduct discussing the moral standards that nurses should apply in their work. It advises that nurses are "morally obliged to question medical instructions which they believe will cause the patient harm or unnecessary distress", though such an issue should be raised during case conferences. In their private lives nurses should support the moral values of their profession, and this may require protest against "social and political conditions which are detrimental to human wellbeing", says the code. Threats to the safety of patients such as unnecessary treatments, hazardous experiments and the withdrawal of services during industrial disputes should be "actively opposed" by the profession. The RCN has also published a booklet titled "Ethics related to research in nursing", giving guidance to nurses involved in research using human subjects.

WELSH CHCs' EVIDENCE TO ROYAL COMMISSION
The Association of Welsh CHCs has proposed the integration of health and local authority services, in its evidence to the Royal Commission on the NHS. The association's majority view is that integration could best be achieved by "bringing the health service within the framework of local government, even though this may be in conflict with the view of the medical profession in general". Reorganisation "should be based on district rather than county level", says the association. It also suggests that existing English arrangements for joint financing between the health service and local authorities should be extended to Wales.

ASBESTOS HAZARDS
An interim statement on asbestos hazards has been issued by the Health and Safety Commission's Advisory Committee on Asbestos. It deals with the health risks of inhaling asbestos dust, and recommends precautions. A technical guidance note on hygiene and measurement of dust concentrations has been published by the Health and Safety Executive.
Asbestos; health hazards and precautions, 10p from HMSO; Asbestos: hygiene standards and measurement of airborne dust concentrations, from HSE, Baynards House, Chepstow Place, London W2.

SELF-HELP GROUPS FOR BACK SUFFERERS
Self-help exercise and diet groups to combat back pain are forming in London and other British cities. Following the Back Pain Association's decision to help set up the groups it has received over 1000 letters, many highly critical of NHS provisions. "Problems of pain and disability are compounded by many doctors' failure to recognise patients' needs for adequate information about their illness and its management", said the BPA's deputy director. BPA, Grundy House, Somerset Road, Teddington, Middlesex: 01-977 1171.

NHS VOCATIONAL TRAINING: HC(FP)(77)1
The NHS (Vocational Training) Act 1976 will make appropriate training experience compulsory for doctors going into general practice in Britain. Date of implementation has not yet been set, and the DHSS is consulting the medical profession and other interested bodies about the types of training which will be required.

EMERGENCY WALLET
The Hertfordshire Association for the Disabled has produced a small plastic wallet suitable for recording personal details relevant in an accident or other emergency. Such information could include current drug treatments, allergies, disabilities, blood groups, addresses of GP, local hospital, next of kin, willingness to be a kidney donor, religion etc. Wallets are 15p each plus post from HAD, 2 Townsend Avenue, St. Albans, Herts.

HEALTH PRIORITY AREAS
Health priority areas — analogous to Educational Priority Areas or Housing Action Areas — should be set up in deprived inner cities and scattered rural communities, says the National Council of Social Service in its evidence to the Royal Commission on the NHS. The council says that CHCs are a "worthwhile experiment in consumer advocacy", but their ability to change the NHS will need to be evaluated.

DISEASE NOTIFICATION: HC(76)57
Viral haemorrhagic fever and Marburg disease have been added to the list of notifiable diseases set out in the Public Health (Infectious Diseases) Regulations 1968. Notified cases of these diseases must now be included by Medical Officers for Environmental Health in their weekly and quarterly returns to the Registrar General. The changes will give MOEHs the full range of control powers under the Public Health Acts in any future outbreaks.

DRUG INTERACTIONS
Situations where common drug treatments and oral contraceptives can interfere with each other's efficacy are listed in a booklet published by the Wyeth company. When cycle irregularities are noticed and one of the listed drugs is being given, additional methods of contraception should be considered. Drug interactions with oral contraceptives, free from Wyeth Laboratories, Huntercombe Lane South, Taplow, Maidenhead, Berks.

HOSPITAL EYE SERVICE CHARGES: HN(77)12
Announces increases in charges for metal spectacle frames and cases prescribed through the hospital service. Increases to patients relate to appliances ordered on or after January 17.

Directory of CHCs

A directory of the names, addresses and telephone numbers of all community health councils in England and Wales is now available, priced 60p. Corrections are published monthly in CHC NEWS. Please notify the Editor of any changes.

Cheques and postal orders should be made payable to "King Edward's Hospital Fund for London" and sent with orders to: CHC NEWS, 126 Albert Street, London NW1. Please note the following changes:

Page 1: North Tees CHC
Secretary: Mr John Grigg

Page 10: South Nottingham CHC
Secretary: Liz Haggard

Page 15: South West Hertfordshire CHC
Chairman: Col. C de Lisle

Page 19: Islington CHC
Secretary: Marcia Saunders

Page 24: West Surrey and *North-East Hampshire CHC*
Address: 230 Farnborough Road, Farnborough, Hants

Page 26: Croydon CHC
Chairman: Mr C J Wood

Page 27: Kingston, Richmond and Esher CHC
Address: 41c Victoria Road, Surbiton KT6 4JN
Telephone: 01-399 8415

Page 28: West Dorset CHC
Secretary: Mr David Russell
Address: Colliton Clinic, Glyde Path Road, Dorchester, Dorset

Page 30: East Berkshire CHC
Address: 30 Windsor Road, Slough, Berks SL1 2EF

Page 31: Oxfordshire CHC
Chairman: Mrs Margaret Campbell

Page 36: North Warwickshire CHC
Chairman: Cllr A H Walker

Page 48: South Gwent CHC
Address: 2 Emlyn Walk, Kingsway Centre, Newport, Gwent NPT 1EW
Telephone: Newport 215666

EXHIBITION STANDS

A set of exhibitions stands is now available on free loan to CHCs.

The kit has 10 poster-sized panels and when assembled, the overall dimensions are 2.3 metres high x 3.0 metres wide (7ft 8in x 10ft).

CHCs wishing to borrow the stands should contact CHC NEWS to make a booking.