CHC NEWS

For Community Health Councils

June 1977 No. 20

Patients Committees gather support

GPs can benefit from the involvement of their patients in decisions about how to provide primary care, a conference in Bristol agreed last month. Over 50 people attended, including doctors and other health workers, members of patients committees, and CHC members and secretaries. Dr Alistair Wilson from the Aberdare Health Centre made the first contribution. *CHC NEWS* readers will be familiar with his work which was covered in issue numbers 3 and 11. He set the theme for the conference: patients committees offer a really positive way to improve primary care.

The next speaker was Dr Tim Paine, a Bristol GP, who explained how the committee worked at his practice in the Whiteladies Health Centre. It is called "The Practice Association" and to start it going he wrote a letter to all his patients in 1973 inviting them to comment on the idea of such a group. He said in the letter that the association could provide an opportunity for discussion, suggestions, comments and criticisms on the way the practice was run and on future plans. He also suggested a register of volunteers could be set up to help with such things as transport for the elderly.

A meeting of interested patients was called and from it a 12-member committee was elected. The community volunteer group was also built up from people in the practice. Both doctors and patients now agree that the association has been able to achieve tangible improvements. Examples are clearer notices in the health centre, a ramp for prams and wheelchairs, a review of the appointments system, the request for a lady doctor to join the practice (which has been met) and a discussion of confidentiality.

Dr Peter Pritchard then described the "Community Participation Group" at his health centre in Berinsfield near Oxford. He started it in 1972 by writing to every local organisation he could identify — parish councils, women's institutes, old people's clubs, youth groups, etc., and asked them to send a representative to a meeting who was also a patient at his practice. Since that first meeting (where the turnout was almost 100%) there have been three meetings each year. Patients have suggested improvements in the services, discussed the roles of the primary health team members, considered self-treatment and sensible use of doctors' services, and generally improved the understanding between patients and health workers. The doctors have consulted their patients about the acceptability of trainees and medical students, and about patients' priorities for primary health services.

The work of a fourth patients committee — at Glyncorrwg in South Wales — was explained by the Rev Stephen Barnes, who is a member. He showed how his patients committee had been able to provide support for doctors who were keen to improve primary care for their patients, and how it was able to help patients with straightforward information about health and illness.

All were agreed that confrontation between patients and doctors would meet with certain failure, and only through trusting cooperation could patients committees succeed. GPs seem bound to feel threatened initially by attempts to share their control over primary care so it is only by gentle persuasion that more patients committees are likely to get off the ground. However, they can be set up in different types of practice — they do not all have to be in health centres, or necessarily have to include all the group practices working at one health centre. The type of organisation can also vary — there is no blueprint, as the examples described have shown.

A second conference is planned for next year, and it is hoped that new patients committees will be established during the intervening time and can be represented there. For people who would like information or advice about setting up a patients committee, the *CHC NEWS* office can put you in touch with members of a steering committee that was elected at the Bristol meeting.

ON THE AIR!

Kent's six CHCs now have their own regular 15-minute local radio programme, focusing on health education and prevention and on local health issues.

It goes out on Radio Medway, on medium wave and VHF, every fourth Thursday at 7.15 pm, with repeats the following day at 10 am. So far the series has featured interviews with CHC chairmen and local health education officers. This month's programme will include an item on summer illnesses such as hay fever, and will give advice on getting vaccinated before holidaying abroad.

Maidstone CHC secretary, June Ayling, is producing and broadcasting the programme, using news items rounded up by her and the other Kent secretaries. She recommends radio as a way of building local interest in CHCs, and has already been booked for a second series of four programmes starting in September.

INSIDE.....

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YOUR LETTERS

CLASS AND HEALTH

Irene Corkery, Member N. Tyneside CHC

I feel there are many reasons why there is a lack of take up of health service provision by working class women *(CHC NEWS 17)*. The 'inverse care law' certainly is one factor. How many public housing estates and low privately rented housing areas have doctors' or dentists' practices within them, let alone family planning, pregnancy counselling or chiropody services? Family commitments constantly having to be carried out in poor housing conditions, financial insecurity and within strict timetables, leave little room for taking action on personal health problems unless they are acute. Many of these women also have to seek paid employment to make ends meet.

Surely one answer would be to bring the facilities to the clients — on housing estates and in factories? Middle class women have access to telephones to make arrangements to suit them; they have enough money to buy a week's shopping in advance; can make easier arrangements for having their children looked after; and transport to get them where they want to go. The need for a mobile service or a multi-purpose house set aside on each large estate for health and counselling services could easily be established by random surveys by CHCs. Unless something is tried, the poor will have to continue to pay more for the provisions to which they are entitled.

RESOURCE ALLOCATION

T E Nodder, Under Secretary, DHSS

In *CHC NEWS 18* you wrote in your Editorial about confusing statements on the Department's policy for resource allocation. May I try to clarify a few key points:

(1) Discussion of the Resource Allocation Working Party (RAWP) Report continues; the Secretary of State has not committed himself to any decision on the precise method of distributing resources for 1978-79 and later years;

(2) distribution of resources for 1977-78 has followed the broad principles of the Report, and represents a further move towards more equitable geographical distribution, while recognising that rapid adjustments are not immediately practicable. Thus the 4 Thames regions receive marginal revenue additions of ¼ per cent or a little more, while the Trent, Northern and North-Western Regions receive additions of approximately 3 per cent. It is acknowledged that no Region will have an easy task in keeping within its cash limits and that reductions in some current services in some places may be necessary.

(3) Health authorities have been asked to develop, jointly between Regions and areas, measures of relative need on the lines recommended in the RAWP report, which can be taken into account where practicable in 1977-78 but more fully in subsequent years in allocating the available resources between districts.

LIBRARY SYSTEM FOR CHC

Shirley McCarthy, Secretary NW Herts CHC

Until now I have tried to list all the information we have received for the benefit of members. However, the volume is now such that this will have to be changed for a reliable library system. I write to ask whether other CHCs have evolved a satisfactory classification and reference system for the bulk of literature we receive as CHCs.

CHILD-PROOF CONTAINERS

Joy Gunter, Secretary Dewsbury CHC

Andrew Gareth Brown died in March 1974 after a bottle of inhalant fluid had been poured over his head. The fluid was poisonous and was absorbed through the skin. Andrew died from brain damage and blockage of the kidney system a few hours afterwards. The inhalant, "Wright's Vapourising Fluid" was clearly labelled "Poison — not to be taken" and "Keep out of the reach of children" and gave instructions to wash off immediately any fluid which came into contact with the skin and call a doctor. The fluid was in a glass bottle with a simple screw top.

CHILDREN IN DRUG MISHAPS

A TOTAL of 172 children were admitted to Coventry hospitals last year after taking drugs by accident. In 100 of the cases the children were under five. These figures ...

Tablet bottles won't be child's play

... CHILD-proof tablet bottles, which are easy for elderly and arthritic patients to open have now been developed. Members of the ...

In March 1977 the identical bottle of fluid could still be purchased: admittedly this was old stock and the manufacturers said they were going to recall it. But still available will be the substitute which is non-caustic and not labelled "Poison" but still bears the same warnings and is in the same type of bottle. If swallowed it could prove fatal, as can household bleach, disinfectants and other medicines.

Now child-proof containers are widely used for painkillers, Dewsbury CHC feels that the next step towards safety would be the extension of their use to include other poisonous substances, e.g. household bleach. We would be grateful if other CHCs would also take this matter up.

ROAD CLOSURES

Gwen Davey, Secretary Newham CHC

Recently a scheme was implemented in Newham which closed several roads and caused a District Midwife on an emergency call great difficulty in getting to her patient. Fortunately, she was accompanied by a Pupil Midwife who was despatched on foot and reached the house in time for the baby's birth, coping alone. However, the situation could have been a near disaster for the mother and her newborn baby.

Although the closure plan had been detailed in the local press, the impact it would have was not appreciated by many people. I was asked by the patient's GP to let the local authority know of the incident and the Department of Engineering and Surveying have now agreed to inform our Family Practitioner Committee and the District Management Team of future closures or changes in road systems so that GPs and District Nursing staff etc. can be circularised.

As GLC road projects also create a similar problem, have any other London CHCs made an approach to them for details of closures inaugurated by them to be similarly circulated?

RESPONSIBILITY FOR THE MENTALLY HANDICAPPED

Irene Quilter, Member Hastings CHC

It is becoming increasingly apparent that future NHS planning for the mentally handicapped cannot be satisfactorily carried out in isolation from other departments, i.e. social services and education. Joint funding and joint planning to use such funds in creating the greatest benefits for the mentally handicapped are imperative, lest their needs become lost in the evasion of responsibility between departments and between areas and districts. Progress must be made towards services provided jointly by health and local authorities in the community. Social workers with a natural interest in the problem, and the benefit of specialised training, should liaise with health visitors, community nurses and representatives of voluntary bodies in providing an improved service for the mentally handicapped and their families. Education and social training should be standardised between departments. In all aspects of care for the mentally handicapped there must be co-ordination and co-operation and CHCs have a responsibility to see it happening NOW.

MEDICAL CARE IN PRISONS

Jean Robinson, The Patients Association

We are greatly concerned about complaints we have received about the quality of medical care in some prisons and particularly about injections of major tranquillising drugs with potentially serious side effects by prison officers without proper medical or nursing qualifications. Unfortunately the prison medical service comes under the Home Office not the DHSS.

We would like to suggest that CHCs with a prison in their district should start asking questions about medical care and we would like prisoners to have the right of complaint to their local CHC.

VACCINATION PROGRAMME

Barrie Taylor, Secretary SW Herts CHC

Like many other CHCs, the SW Herts CHC has recently resolved to support the

government's vaccination programme. However, although accepting the general principles of the programme, which was thought to be a valuable adjunct to preventive medicine, we have requested that the government acknowledges responsibility towards those who may suffer long-term or disabling effects directly attributable to vaccination. We have written to Mr Moyle to this effect, and would hope that other CHCs would support our view.

HYGIENE IN HOSPITAL CATERING

Dilys Palmer, Secretary S. Tyneside CHC

It had come to our attention that conditions in the hospital kitchens were far from satisfactory and staff working under difficult conditions. The CHC Hospital Services Group visited the kitchens with the DHSS *"Handbook on Health Services Catering (Hygiene)"* which was obtained from the RHA, and which listed 66 points on staff practice, cleaning, kitchen equipment, preparation and storage of food, transport of food refuse, infestation, and so on.

The CHC noted the *actual facts* of conditions seen against each of the 66 points made, and after consideration, the report was sent to the Area Health Authority. It urged the AHA to build new kitchens at the General Hospital in phase III and not phase IV as was scheduled. We also felt that this was a matter of some urgency as the kitchens were vulnerable to an outbreak of infection.

£45,000 was included in the next AHA budget for improvement to the hospital kitchens and these are now virtually completed and staff delighted. In view of the recent publicity about environmental health officer's confidential reports on hospital catering, other CHCs may welcome this idea for action they themselves can take.

THE COMPASSIONATE FRIENDS

Mrs Joan Wills, National Secretary, 50 Woodwaye, Watford, Herts.

There is no death so saddening as the death of your beloved child. The Compassionate Friends is an organisation of bereaved parents who have been through their own heartbreak, loneliness and social isolation, and can now offer help to others. We offer no miracle cure, just comfort and the consolation that broken threads can be picked up again. Membership is open to any parents who have suffered a child bereavement and the organisation has no religious affiliations. We are just people helping other people.

The organisation is a registered charity with branches throughout the British Isles. Administrative costs are met through donations and fund raising activities. CHCs may be glad to know of our existence in order to help the public and the professionals with whom they are in contact.

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.

FIRE RISKS IN RESIDENTIAL HOMES

Since December, 1974, two major fatal tragedies at old people's homes near Nottingham and Hull have emphasised the need for better fire precautions in residential homes. Fresh guidance is now available, in a DHSS circular (1) published in April. Its recommendations — and those of a booklet published by the National Corporation for the Care of Old People (2) — would be a good starting point for any CHC interested in the fire safety of homes for the elderly, the physically handicapped, the mentally ill or the mentally handicapped in its district.

The new circular is based on the philosophy of the Fairfield inquiry report (3), which noted that "Excessive expenditure on fire precautions, particularly in existing homes, could result in fewer new homes being built, and some existing homes might have to close if too stringent requirements were imposed on them". Because of restraints on public spending the DHSS says "Further improvements will need to be gradual and long-term, and in most homes any early reductions in fire risks will have to be sought, as far as possible, through measures calling for little or no expenditure".

Homes are run either by local authority social services departments or by voluntary or private organisations. Local authorities, advised by the DHSS, are responsible for registering voluntary and private homes under section 37 of the National Assistance Act 1948, and section 4(f) of the National Assistance (Conduct of Homes) Regulations, 1962, requires "adequate precautions against the risk of fire". The regulations leave it up to individual local authorities to define "adequate".

Local authorities depend for advice on fire safety on their local Fire Authorities, which operate on the basis of guidance (4) from the Home Office Fire Department. The DHSS circular says close collaboration is essential between social services, fire authorities and home managements, but adds that "until the Home Secretary designates residential homes and hostels under the Fire Precautions Act, 1971, the role of the Fire Authority is advisory and the responsibility for deciding on the adequacy of fire precautions remains with the social services authorities."

This discretion is subject only to the powers of the courts under section 10 of the 1971 Act in relation to premises considered to have "excessive fire risks".

So far only hotels and boarding houses are covered by the 1971 Act, and although the intention is to designate homes eventually, designation is not expected to take place in the near future.

Attached to the new circular is additional guidance (5) based on the Fairfield report, which is summarised here:

COMPARTMENTATION. The first stage of evacuating elderly or handicapped people from a building should involve their movement on the same level to a "protected area" — an area separated from the fire by fire-resisting walls and self-closing fire doors. The objective should be to sub-divide each floor into "fire-separated" protected areas containing not more than 10-12 people, though for the time being financial constraints may mean that up to 20 people per protected area will have to be accepted. The DHSS advice notes that "this higher figure will be more acceptable where there is extensive provision of automatic fire detection equipment".

Recent advice from the Home Office Fire Department to chief fire officers (4) agreed that floors with not more than 10 residents do not need to be sub-divided. But it emphasised that where a building has only one staircase this must be protected, irrespective of provision for automatic fire-detection. Where a multi-storey building has been divided into two or more protected areas, each with its own staircase, protection of staircases can be given a lower priority, provided smoke detectors have been installed in virtually every bedroom.

DETECTORS. Smoke detectors are preferred to heat detectors in most situations, since the former react earlier in

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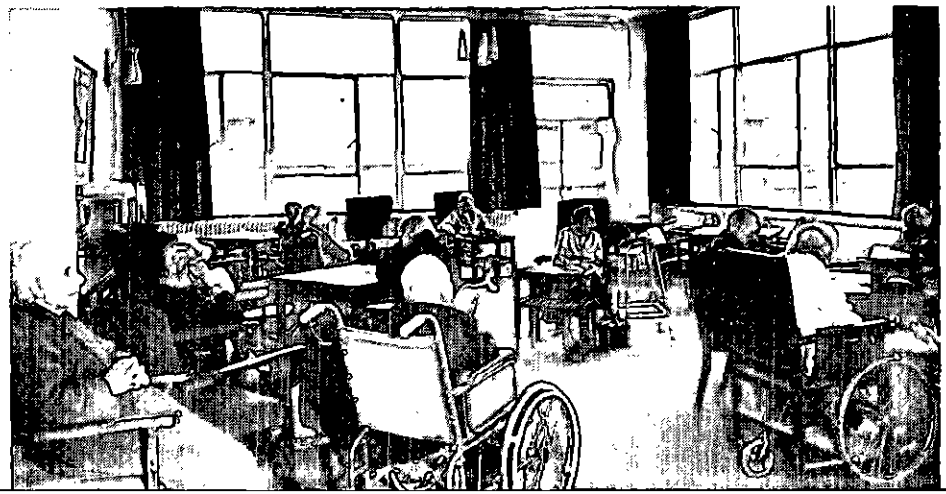

PUBLIC MEETINGS

by John Stevens, Secretary West Berkshire CHC

Some community health councils have either been reluctant to organise public meetings, or have questioned their value and effectiveness. The West Berkshire CHC has taken a positive, enthusiastic attitude and organised a series of public meetings on different health topics.

Topics: Initially a series of six meetings at monthly intervals was arranged, with carefully chosen topics: Women's health clinics, Special problems of the elderly, Dental services, You and your family doctor, Child health services, Health and social services. We have since held meetings on "hot" issues as they arose, taking advantage of current local and national publicity, eg the Court report, and whooping cough vaccination.

The audiences: There were doubts about attracting the public, but in the event the meetings were all very successful in the numbers and types of person attending (average number 60/70). This was achieved by using various methods of publicity. The programme was circulated in advance to many organisations and wherever possible a central point was used, thus reducing cost, eg the county Women's Institute Newsletter. Then for each meeting personal letters of invitation were sent to as many individuals as were known to have a particular interest, including the "professional" workers. In addition, invitations went to all voluntary organisations likely to be interested in the subject.

This was supplemented by paid advertisements in both press and local radio. In addition we gained free advertising by using the local radio, and the council chairman's fortnightly column in the large circulation local evening paper. All methods used were effective, with the largest number attending in response to the letters.

Form of meetings: The meetings themselves were kept as informal as possible, with no speaker but a group of professionals able to give information and comment. After a brief introduction the meeting was given to general discussion. The informal and loose structure proved most successful, since almost all those attending were encouraged to contribute.

Value of meetings: The meetings provided a forum for exchanging information and comment, helped individuals with problems, and the council was able to take up general matters with the health authority or social services department. The meetings often introduced to one another voluntary and professional workers interested in the same subject, who had previously worked in isolation. Social workers have attended each meeting so that the problem of the interface between health and social services was recognised and in many instances overcome.

The meetings helped with general publicity for the council — from the advertisements, articles, and from those attending the meeting who returned to their own organisations with more information about one subject in particular and the CHC in general. If members or secretaries of CHCs talk to different organisations, they usually talk to a group with one particular interest, but by selecting broad topics for meetings representatives of many different organisations are contacted on the same occasion. There is a ripple effect from each meeting.

Publicity after the meetings is also very worthwhile, and the press have given generous coverage to all the meetings. We have also produced notes of the meetings for use as publicity material and to stimulate further comment.

Public meetings have proved worthwhile, and we intend to develop them further by repeating some of the topics in different parts of the health district, with particular reference to local issues. It is essential to select topics of special interest, and to devote time, money and effort into promoting them to carefully chosen individuals and organisations, and to follow up issues raised as effectively as possible.

For in summary, public meetings tell the "public" about us, and so in turn we are responding to them — our public.

OPERATIONAL RESEARCH

by Colin Thunhurst, Member of the British Society for Social Responsibility in Science

Operational research is a technique based on mathematics for studying organisational problems in industry. Recently it has been applied to organisational issues in the public sector, and to health in particular. There has grown up within the operational research (OR) profession a body of opinion criticising the ways in which the OR approach operates. All too often it serves to advance bureaucratic efficiency and the growth of profits and to depersonalise what are intensely human and political issues. People become merely statistical inputs, or symbols to be manipulated, not crucial social actors who should and could control what happens to them. This tendency is already well advanced in OR applications to health care.

Many health studies currently using OR can provide genuine improvements in their own terms. Examples are: the design of systems for outpatient departments or GPs, the scheduling of admissions to hospital, the assignment of nursing staff to cover fluctuating demand, and the planning of menus. At a less tactical level there are studies of the level of staffing necessary to give 'adequate' coverage with emergency anaesthetic services, the 'best' locations for ambulance stations, neighbourhood health clinics, hospitals and so on.

These OR-based tactical efforts show a number of common features. First, they select only one (measurable) effect of the possible actions, and then proceed to 'optimise' it. Usually this means minimum costs, since the benefit is hard to define or measure. Secondly, the measures chosen for optimisation lead to distortions. You can perhaps compute the average journey time for patients to a particular clinic location — but does that mean that the location for which this time is smallest is therefore the 'best'?

OR is also coming to be applied to strategic problems — policy issues such as whether preventive health checks by population screening are worthwhile. Studies like these suffer from a number of extra problems. Many objectives have, firstly, to be defined and measured, and a 'single' performance measure constructed from them. Secondly, the OR models used are so complex and the data requirements so massive that the models can never be properly tested to see if they actually match the real world.

Both tactical and strategic studies have this common feature — they try to by-pass the sweat and tears of political debate by offering an apparently 'objective' argument for the selected policy.

Those of us who are members of the Operational Research and Social Organisation Discussion Group working party on community health councils believe that such studies make the task of CHCs more difficult by making the 'top-down' nature of NHS decision-making seem more inevitable and impregnable. We are sure that the potential power of the OR

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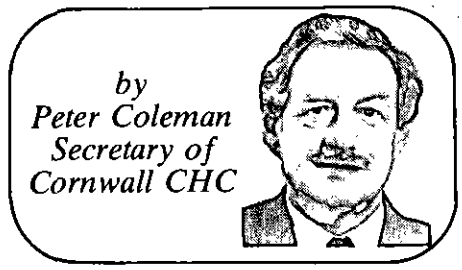
PERSONAL VIEW

This is a personal view based upon the unusual combination of circumstances in Cornwall. A peninsula, 70 miles long, surrounded by the sea except on the border with Devon; population 400,000; a popular tourist and retiring area (which brings two different problems), a single district area health authority and a comparative remoteness, even from Bristol, the headquarters of the regional health authority. Penzance is 184 miles from Bristol! Beyond us are the Isle of Scilly with their own community health council.

This remoteness, the clearly defined boundaries and the nature of the Cornish people engenders a sense of family togetherness within the county, which is shown in the range of voluntary effort.

Daily there is a suggestion in the national press that one of the three tiers in the national health service below the Department should be abolished. Cornwall is one of the few single district areas, and as the hospitals in the easternmost part of the County (7 out of a total of 37) are managed by two of the Devon district management teams, we deal with a single district area health authority, a multi-district area health authority (Devon) and two district management teams. Our relationships with all four authorities are excellent but from our local and regional experience, I am a firm advocate of the single district area being the rule rather than the exception, where practicable; if necessary, by the division of the larger areas.

The advantages — a simpler structure, speedier decisions, public representation at the operational level and, eventually, some saving on administrative costs. The existence of area health authorities controlling only two district management teams is a telling condemnation of the present system.



by Peter Coleman Secretary of Cornwall CHC

This is not an argument for reducing at the same time the number of community health councils, as a reasonable size for area administration may well be too large for a community health council to cover properly. There is already more than one district with two community health councils — Cornwall and the Isles of Scilly AHA is one of them.

The inexorable pressure of the elderly upon community, acute and long stay services is universal but it is particularly heavy in Cornwall because of the continued exodus of young people seeking employment and the influx of retired people who cut themselves adrift from family support. One hesitates to suggest an enlargement of the already overstretched national health service but the provision of accommodation in long-stay hospitals, day hospitals, residential homes, day centres and sheltered housing, together with community nursing and social service support, is so interlocked that there would be considerable advantages to patients if area health authorities were responsible for the provision of all residential accommodation, apart from sheltered housing.

Not only would movement between old person's homes and hospitals be easier but there would be a financial incentive for the national health service to invest in residential homes, which are considerably cheaper to run than hospitals — and more like home. At the moment the national health service and social service departments struggle with their separate problems.

But the patient has only one problem — the frailty of old age.

Community health councils should aspire to being respected but not necessarily to being respectable.

News from CHCs

● Rochdale CHC has carried out an opinion survey to clarify the controversy over the proposed siting of a new health centre in the town of Heywood. An AHA proposal to build the centre at Darnhill, a mile from the town centre, has roused opposition from many Heywood residents. The CHC distributed 3,100 questionnaires to electors, and got a 20% response rate. 58% of respondents thought a new health centre was essential, but 68% opposed its siting at Darnhill, mainly because of public transport problems.

● The West Surrey and NE Hampshire CHC is studying family practitioner services in Aldershot, where there is a health centre, and in Farnborough, where GPs work from group practice premises. Aylesbury and Milton Keynes CHC is also comparing the two types of organisation, to see whether centralisation of surgeries causes transport problems for patients. A questionnaire has been sent to all parish councils and women's institutes in the CHC's district. And Hull CHC has won a fight for adequate bus services in the village of Mappleton. Service changes had made it impossible for villagers to get to their nearest surgery, but the bus company was persuaded to make improvements.

● Kings Lynn, Norwich and Great Yarmouth and Waveney CHCs organised a half-day seminar to discuss the Court report on child health services. Mrs Jean Davis, a member of the Court committee, was the main speaker.

● A half-day conference on "Health and the community" was held in Dalkeith by the Midlothian LHC. Representatives of LHCs, local voluntary organisations and health service workers were invited, and 109 people attended. Discussion centred around dissatisfaction with local services, in particular with the lack of a general hospital in Midlothian.

● Weston CHC has organised a nine-week course of public lectures on the working of the NHS. Lecturers were mainly local NHS workers, and topics included Community and social services, How to run a hospital, Trade unions and the NHS, and Patient power. The course was financed by the Weston Technical College.

● A Lincoln and District Perthes' Disease Action Group has been formed, with help from Lincolnshire North CHC. The CHC decided to help following an article in last November's CHC News, which described a similar project supported by Central Sheffield CHC. Perthes' disease is a bone development disease of children, and about 50 cases were found in the Lincoln area. About 20 families now belong to the group, which aims to provide mutual help, approach relevant authorities and raise funds.

● Derbyshire AHA has agreed to pay a £50 grant to each of four mobile physiotherapy units operating in the North Derbyshire health district. Each unit — consisting of a physiotherapist, a van and equipment — is run by a local voluntary body affiliated to the Mobile Physiotherapy Service Association. North and Central Derbyshire CHCs had asked the AHA to give support as a matter of priority, since the units "provided an invaluable service to the community and saved the NHS considerable expense". Together with the CHCs the AHA will now assess the units' medical value to the community, with a view to increasing the grants in 1978/79.

● CHCs in the south-west of England have found a novel way to cope with communications problems in their region, which stretches from the Scilly Isles to north Gloucestershire. The recent regional conference of CHC members was held on successive Saturdays — in Paignton for the south of the region and in Weston for the north. Format of the two meetings was identical, with speakers from the office of the Health Service Commissioner and workshop groups.

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News from CHCs

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● SW Herts CHC has given two of its voluntary members honorary titles. Mrs Christine Ball has been appointed voluntary project adviser, and Mrs June Ashby is voluntary clerical officer. Doncaster CHC's secretary Mr A. R. Wright has been elected to the Nottinghamshire County Council.

● Only 15 out of 56 Darlington GPs replied to a CHC letter asking whether hospital discharge arrangements were satisfactory. Replies showed some dissatisfaction with the discharge note system and with home-help and meals-on-wheels provision. Most GP respondents were unaware that voluntary agencies may be able to provide a "night sitter" service for distressed terminally ill patients. Darlington's district administration has told the CHC that it would be difficult to provide patients with a form setting out their entitlement to services after discharge, and a CHC working group is now considering whether to do a full discharge survey.

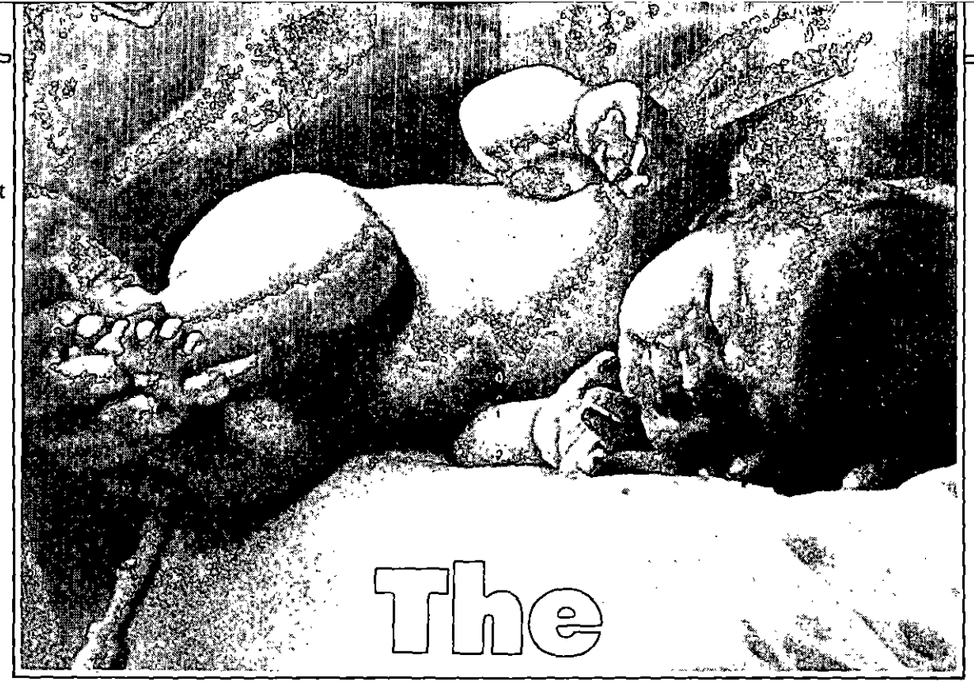
● Roehampton CHC's proposal to interview patients in hospital and again a few days after discharge was turned down by its District Medical Committee, which thought this would cause too much disturbance to patients. The CHC then proposed to send questionnaires to patients a few days after discharge, but the district maintained that this would cause too much disturbance during convalescence. It asked the CHC not to contact people until three months had elapsed. The CHC feels this would invalidate the whole project, since most people would not be able to remember that far back in any detail. It is seeking advice from leading attitude researchers before taking the matter up with its AHA.

● East Herts CHC has embarked on a series of "grassroots" meetings with representatives of parish councils. Topics for discussion include the problems of getting prescriptions dispensed, and care of the elderly. The CHC hopes to build up strong and continuing links with the parishes.

● Bristol CHC has arranged a one-day seminar on "The Function, Planning and Use of Health Centres", to be held at Bristol Polytechnic's School of Art and Design on September 24. Proceedings will include speakers from Bristol University's department of community medicine and the South Western RHA, and will be chaired by Sir Alec Merrison.

● Warrington CHC has arranged for the Warrington New Town Development Corporation to send all its new tenants a letter advising them to register immediately with a GP. The CHC's acute services sub-committee had become concerned that new town residents were not registering until forced to do so by an emergency.

● For details of new chairmen and secretaries, see back page.



The Mystery of COT DEATHS

About 2000 cot deaths occur each year in the UK. In the classic case, a baby aged one week to two years, in reasonably good health, is put to bed at home and is inexplicably found dead the next morning.

Cot death is therefore not a disease in itself, but a convenient label used to categorise deaths which are not understood but exhibit a typical pattern or

Following a cot death parents often experience deep feelings of inadequacy and recrimination.

"syndrome". In the UK cot death represents about 15% of all infant deaths (from birth to one year) and 30 to 40% of post-neonatal deaths (one month to one year). It is thought to be the single biggest category of death in the post-neonatal period.

Since cot deaths are deaths of unknown cause each one must be investigated by the local coroner, to establish the cause of death where possible and to rule out foul play. Normally the coroner arranges for a pathologist to carry out a post mortem, and in about one third of all apparent cot deaths this reveals congenital abnormalities or other disease states sufficient to account for death.

In the remaining cases minor diseases may be detected — particularly respiratory infections — but these are insufficient to explain the death. The death may then be registered as "cot death", or as "Sudden Infant Death Syndrome" (which has now been approved as a registration category by the Registrar General). Either of these terms may be combined with details of the minor diseases detected by the post mortem, or alternatively the minor diseases alone may be mentioned. The exact wording of the death certificate depends on the personal interpretation of the pathologist concerned.

Traditional ideas that cot deaths are caused by suffocation or by inhalation of vomit have been found to explain only a few cases. Recent research has also ruled out the theory that infants can be suffocated by exhaled carbon dioxide gradually accumulating in the bases of their carry-cots. Several research projects are being sponsored by the DHSS and the Foundation for the Study of Infant Deaths, and the current feeling among researchers is that cot deaths are caused by a combination of several different factors, none of which would be fatal alone.

Children are most vulnerable to cot death between two and four months of age. Some researchers believe that the syndrome tends to

It may be possible to identify in advance many children at risk of cot death.

be linked statistically with sleep, with recent minor infections, with a history of neo-natal breathing difficulties, with bottle-feeding, with poor attendance at post-natal clinics, with prematurity and low birth-weight, and with "failure to thrive". There also appear to be statistical links with the winter months, with low social class, with urban living, with crowded housing conditions, with young mothers who already have several children, and with illegitimacy. Cot death is also more common among males and twins.

Several theories which might account for part of the cot death problem are currently being investigated. There is some evidence that over-strong or wrongly constituted baby feeds can cause dehydration, which may make the infant more vulnerable to minor infections. Another theory suggests that there is an "immunological gap" a few months after birth, before the infant fully develops its own immune defences against infection. Allergies, virus infections and breathing abnormalities during sleep are also being looked at as possible aggravating factors.

Some studies have linked cot deaths with parents' inability to recognise disease symptoms, and to make good use of GP and community health services. Relatively minor symptoms which could nevertheless justify a visit or visits to the GP include refusal of feeds, inactivity, weak crying, vomiting, diarrhoea, discharge from a "runny" ear, unusually high or low temperature, and "floppiness" of limbs or body.

To a lesser extent failures on the part of GPs have also been implicated in some cot deaths. Continuing studies led by Professor John Emery, at the Children's Hospital in Sheffield, are suggesting that with careful history-taking of mothers-to-be it may be possible to identify in advance many children at

Some studies have linked cot deaths with parents' inability to recognise disease symptoms.

risk of cot death. Increased support from health visitors might reduce deaths in this group.

Whatever the cause of cot deaths, it is generally accepted that they would be reduced by measures aimed at reducing post-neonatal mortality generally. Such measures would seem to be needed in view of the Court Report's finding that "There has been no significant fall in our post-neonatal mortality rate over the past 15 years".

Cot death is . . . the single biggest category of death in the post-neonatal period.

Comparison of national statistics suggests that while the post-neonatal mortality rate in UK countries has remained fairly constant since 1965, considerable improvements have been made in other countries, including countries which in 1965 already has as good or better figures than the UK.

The Court Report also draws attention to the statistical linkage of low social class with higher post-neonatal mortality (and so with cot death): "A child born into the family of a semi-skilled or unskilled worker is twice as likely to die between the end of the first month and the end of the first year of his life . . . as a child born to parents in social classes I and II".

Another aspect of cot death is the ensuing ordeal for the parents, which may continue right through the next pregnancy until its successful conclusion. This ordeal is not made any easier by the visit of the coroner's officer or a uniformed policeman immediately following the death, nor by the coroner's investigation and the possibility of subsequent press publicity.

Following a cot death parents often experience deep feelings of inadequacy and recrimination, and great care should be taken not to make any remark implying blame or speculating on possible causes of death. GPs and health visitors have a special responsibility to give reassurance and guidance, and sometimes more than one such counselling session will be needed. The biggest psychological barrier for some parents is the lack of any concrete explanation for the death, which can lead to anxieties that their next pregnancy may also end in tragedy.

The Foundation for the Study of Infant Deaths (23 St Peter's Square, London W6, Tel: 01-245 9421) produces a series of useful and straightforward leaflets on cot death and infant care, and can also put people in touch with other parents who have already gone through the experience of a cot death in their family.

EDITORIAL

Does health education work? Is there any way of ensuring value for money spent on it? These must be familiar questions to many CHCs — and probably difficult ones to answer. Within the NHS, health education activity is fairly easy to locate: doctors, dentists and other health workers give advice about health maintenance to patients. Community physicians and health education officers attempt to improve understanding and use of effective health care procedures. From the DHSS, health education activity generally involves giving money to other organisations (e.g. the Health Education Council, ASH, etc.,) and now includes producing a series of publications, of which *Prevention and Health: Everybody's Business* is the first to appear. Yet our major health problems still present a daunting challenge — particularly those relating to tobacco, alcohol, sugar, animal fats and other dietary components, exercise and the ability to detect disease early enough in at-risk groups. A recently published report, by a committee of MPs, called *Preventive Medicine** may help to lead the way. It contains some extremely useful facts and figures, as well as a good deal of common sense. The inconsistencies in government attitudes are well-documented: on the one hand pointing out the increased risk of heart disease in people who consume large amounts of animal fat while, on the other, allowing a subsidy on the price of butter. The government receives £4,000 million per annum from tax and duty on the sales of tobacco and alcohol — which is equivalent to two thirds of the entire cost of the NHS in one year. Is this value for money?

**First Report of the Expenditure Committee, 1976/77, HC169, HMSO, £1.60.*

CHC NEWS

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BOOK REVIEWS

MORAL DILEMMAS IN MEDICINE
by A V Campbell.
Churchill Livingstone, 1975, £1.95

This book has been written mainly for nurses to help them understand better some of the moral problems they may come across in their work. It is a wide ranging discussion which could be useful for those members of CHCs interested in ethical problems and especially those who are members of ethical committees.

Although the subject matter is difficult and theoretical the author, who is a Professor of Christian Ethics, has managed to use fairly simple language which can be understood by the layman. He explains how the morality of medical care is a part of the moral beliefs of society as a whole and gives useful examples which illustrate how difficult it can be to resolve some of the dilemmas that occur in the practice of medicine.

Even Codes of Practice can be confusing —the first clause of the Nursing Code is "to conserve life, alleviate suffering and promote health" but these three ideals are not always compatible. He discusses the whole area of conscience and shows how our consciences do not lead us all to the same conclusion, so that each person does what is right for him even if it contradicts what is right for other individuals. He also discusses a number of philosophical theories and shows, for example, how a theory of 'the common good' will not help to determine individual actions and priorities.

WHEELCHAIRS AND THEIR USERS
HMSO, £3.65

There are 2.3 wheelchair patients among every thousand people in England and Wales. This is just one of the many facts to be found in this report which describes a very thorough survey of a thousand adult wheelchair users, most of whom were found to be reasonably satisfied with their wheelchairs. Sixteen per cent of those surveyed were living in institutions and thirteen per cent lived on their own. There were twice as many women as men. Respondents made suggestions for improvements in wheelchair design and allocation and on the running of the service as a whole. Over half of those who drove cars experienced difficulties in stowing their wheelchairs in their vehicles —two thirds of these drove trikes. Eighteen per cent of those living in the community were in need of ramps and handrails to enable them to gain access to parts of their accommodation.

HEALTH SERVICES IN RURAL AREAS
National Federation of Women's Institutes, 39 Eccleston Street, London SW1W 9NT. £1 incl. postage

This booklet is a report of a survey carried out in 700 Women's Institutes throughout the country. Most of the problems will be familiar to CHCs in rural areas but some of the statistics could provide some useful ammunition. 89 per cent of villages were without an optician, 84 per cent without a dentist, 75 per cent without a chemist and 54 per cent without a doctor's surgery.

Suggestions are made for improvements in the administration of the NHS and the need for cooperation with CHCs is stressed. Included at the end is an impressive list of resolutions related to health adopted by the NFWI since 1922 as well as the texts of the questionnaires used in the survey.

Lord Dawson 1864-1945

In current discussions about the future of the health service, the provision of health centres and hospital services, the role of teaching hospitals and the place of health education are crucial items. But over fifty years ago these were the very same points to be raised by the Consultative Council on Medical and Allied Services. This group was established after informal discussions between the Prime Minister, David Lloyd George, the first Minister of Health, Dr Christopher Addison and Lord Dawson.

Dawson was made Chairman of the 20-member Council which had the task of advising the Minister on developing new policies for health services. Their Interim Report* was published in 1920. It recommended a scheme for the organisation of local health care which proposed for each district a system of domiciliary services provided by doctors, dentists, nurses, midwives, health visitors and chemists. These services would be brought together in Primary Health Centres which would be staffed by GPs and other professionals providing day-to-day care for the local people.

A group of these Primary Health Centres would be based on a Secondary Health Centre which would be situated in a main town, and staffed by consultants and specialists. The services would necessarily be more complex, requiring special facilities and equipment. Secondary health centres would be brought into relation with a teaching hospital having a medical school. There would also be several supplementary services including those for mental and infectious illnesses, orthopaedic treatment, etc. The overall scheme was designed to provide "the best services for the health of the people" and co-ordination of preventive and curative services was central to the plan. Although the Dawson Report took great care to recognise the interests of the medical profession and the tenor of public opinion, it apparently offered too radical a step for the government to take. The report was shelved indefinitely, to the continuing disappointment of Dawson himself, and for the rest of his life he attempted to get its philosophy recognised.

Many other aspects of Dawson's work were radical and original, yet he attained high status as a respected establishment figure. After training as a medical student at The London Hospital he became a consultant physician there. He quickly built up a private practice and developed a reputation for outstanding ability both as a clinician and a teacher. He was appointed Physician to King Edward VII and subsequently to George V, Edward VIII and George VI. He was knighted in 1911, made a peer in 1920 and a viscount in 1936. During the First World War he was consulting physician to the British Army in France, and it was following this experience that he became concerned with the development of peacetime health services for the country.

Lord Dawson

In the 20s and 30s he played an active part in the House of Lords, and his more radical side was evident in his support for the liberalisation of laws relating to birth control and prostitution, and improvements in housing and other social conditions. He constantly urged the government to recognise the need for rational planning of the health services. Equally he tried to influence thinking in the medical profession through his Presidency of the Royal College of Physicians and the British Medical Association.

As the approach of the National Health Service became a probability, Dawson was chosen (at the age of 79) by the BMA to lead them as their president in these discussions. He prepared comments on the government's White Paper of 1944, but he died in the following year before the legislation had completed its passage. Although he found fault with many details of the White Paper, today's health service owes much to the wisdom of Dawson's original report.

*Consultative Council on Medical and Allied Subjects. Interim Report on the Future Provision of Medical and Allied Services. Cmd. 693, HMSO, 1920.

ASSOCIATION NEWS

At least 160 CHCs are expected to be represented at the first Annual General Meeting of the Association of CHCs in London on 15th June. By mid-May there had been a 70% take up of membership, and the Standing Committee is expected to have 27 members plus 7 CHC secretary observers:

REGION	Members	Non members	Standing Ctee Reps
Northern	16	1	2
Yorkshire	15	2	2
North Western	14	4	2
W Midlands	13	9	2
South Western	12	2	2
Trent	11	7	2
NW Thames	10	8	2
NE Thames	10	7	2
SW Thames	10	4	2
SE Thames	7	9	1
East Anglia	7	0	1
Mersey	7	5	1
Oxford	5	2	1
Wessex	3	7	1
WALES	20	2	4
TOTAL	160	69	27

Membership will be free for the first year as the DHSS has agreed to meet all the Association's costs, but representatives will be asked to endorse a subscription of £150 per member CHC for 1978/79.

Regulations are being laid before Parliament, to come into effect by 15 June 1977, which will statutorily establish the Association of Community Health Councils for England and Wales (ACHCEW), and make provision for its constitution, membership and financial arrangements.

The Provisional Standing Committee confirmed at its meeting on 18 May that the offices of the ACHCEW would be in Inner London. Suitable premises are being sought by the Acting Secretary. Agreement was also reached about the future arrangements for CHC NEWS and the information service. An Editorial Board consisting of the Chairman and Vice-Chairman of the Association, another member of the Standing Committee, the Secretary and the Editor will be responsible for CHC NEWS to the Standing Committee. The ACHCEW will be the official publisher of CHC NEWS (and employer of all the staff). The Secretary will be responsible to the Standing Committee for the information services although arrangements will be flexible in practice until the pattern of work becomes clearer. Non-member CHCs will continue to receive CHC NEWS free of charge and be able to use the information service as at present.

The post of Secretary is now being advertised nationally (and in this paper) so that shortlisted applicants can be interviewed in July.

Member CHCs have received a letter from the Acting Secretary which explains the procedure for notifying names of regional Standing Committee representatives. They have also been asked if possible to indicate which of these nominees wish to stand for election as Chairman or Vice-Chairman of the ACHCEW. Nominations are also being accepted from the floor at the AGM itself, and all candidates are required to address the meeting. Ballot for these posts will be by simple majority if there are two candidates. If there are more, successive votes will take place, the candidate receiving the least votes being eliminated on each round until the top candidate has a majority of votes cast.

The AGM will be asked to adopt the Constitution after considering outstanding amendments. Then the Chairman and Vice-Chairman will be elected, and an Honorary Treasurer may also be chosen. Estimated budgets and the subscription fee have to be adopted, and Standing Orders for future AGMs accepted.

Non-members CHCs are not being allowed to send observers to the AGM, although the meeting will be open to the press. Only those resolutions covered by the Rules of Business for the meeting will be allowed on this occasion.

The next issue of *CHC NEWS* will carry a full report of the AGM proceedings.

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND AND WALES

APPOINTMENT OF SECRETARY

Applications are invited for this post from persons with suitable qualifications and experience.

This is a new Association and the first appointment to the post. The headquarters office will be in Inner London. The Secretary will be responsible for the conduct of the business of the Association including the provision of information services, and will be a member of the Editorial Board of CHC NEWS. Further particulars may be obtained on application to the address below.

The salary will be £5574-£6867 plus earnings supplements totalling £520 and London weighting of £354. Applications should be sent to the address below, accompanied by the names of two referees, by 15 June.

Association of CHCs, Provisional Standing Committee, King's Fund Centre, 126 Albert Street, London NW1 7NF. (Telephone 01-267 6111 ext. 266).

Fire risks in residential homes

Continued from page 3

the life of a fire. Where there is full compartmentation in a building, smoke detectors should still be provided in laundry rooms, sitting rooms, circulation areas and stores, but need not be provided in bedrooms except those at the dead-ends of corridors. Where compartmentation is incomplete or absent, the Home Office recommends smoke detectors in all rooms where there is a "poor prospect" of smoke and fire being contained by existing walls and ceilings. Heat detectors should be provided in boiler houses and main kitchens.

FIRE-RESISTING DOORS. These self-closing doors must be in the closed position to do their job in the event of fire. If they have been wrongly sited — for instance between residents' living areas and the WCs — they will inevitably be wedged open and thus rendered useless. Where existing doors are seen to be wrongly placed, staff should discuss this tactfully with the residents. Residents who normally go unaided to the WCs at night could be provided with commodes in their rooms.

RUNNING OF THE HOME. Except in very extreme cases, confiscation of cigarettes, matches and other personal belongings is against modern principles of care. Rigid rules will not ensure 100 per cent safety, and staff should keep in mind the smoking habits of individual residents. Ash-trays of sufficient size and stability should be strategically provided, and fire-resistant or retardant materials should be used wherever possible for bedding, fabrics and blankets.

NIGHT STAFF. In homes for the elderly at least two staff should be available at night to deal with emergencies, and at least one of these should be on wakeful watch. In other homes with less than 15-20 residents one member of staff on wakeful watch may be sufficient, depending on the condition of residents. The DHSS advises that "Where staffing is not already at these levels improvements should be made as resources allow". Permanent night-duty staff should have received appropriate training from the local Fire Service.

REFERENCES

1. Fire precautions in existing residential homes, DHSS Circular LAC(77)6, Welsh Office 62/77, 6 April, 1977.

2. Homes Advice Broadsheet No. 1: Fire precautions in old people's homes, 1976, 25p from NCCOP, Nuffield Lodge, Regent's Park, London NW1.

3. Report of the committee of inquiry into the fire at Fairfield Home, Edwalton, Nottinghamshire, on 15 December, 1974. HMSO Cmnd. 6149, 1975.

4. Letter from Home Office Fire Department to chief fire officers, May, 1976, reprinted as Annex A to LAC(77)6; Fire Prevention Note No. 2/1964: Fire precautions in old person's homes, Home Office Fire Department, November, 1964.

5. Annex B to LAC(77)6.

Mobility for the Disabled

by Nigel Harvey, Secretary of the Disabled Drivers Motor Club and member of Ealing CHC

The rehabilitation of patients disabled by disease or accident has always been an important part of the National Health Service and has extended to the free provision of aids, appliances and artificial limbs. Those who met certain clearly defined criteria were, prior to 1976, eligible for an invalid tricycle. Alternatively, if patients preferred to run their own private cars they could have claimed a tax free allowance of £100 per annum plus exemption from vehicle excise duty worth £40 per annum. Criteria of eligibility were (1) double amputees with one leg amputated above or through the knee; (2) those unable or virtually unable to walk; (3) those slightly less severely disabled, but who needed a vehicle in order to get to and from full time employment.

As from 1 January 1976 the government introduced a taxable Mobility Allowance of £5 per week which is being phased in over 3 years for disabled persons between the ages of 5 and the statutory retirement age (60 for women and 65 for men) who meet the single medical criterion of being unable, or virtually unable to walk. This new allowance was being made available for the first time to those who were unable to drive themselves. Previously, help in the form of the invalid tricycle or private car allowance was only available to those who could drive themselves, thus leaving out those who were more severely disabled. However, for those who could drive there still remained the option of the invalid tricycle.

Despite the many well documented shortcomings of the invalid tricycle, about 2,000 were issued to new patients each year before 1976. However when the new criterion for the mobility allowance was introduced the number of successful applicants was more than halved. This followed logically from the exclusion of the elderly, the exclusion (in practice) of all double amputees who could stagger a few yards on artificial legs, and the total exclusion of all those less severely disabled people who needed a vehicle to get to work.

Encouraged by the deliberately engineered reduction in the take-up of the invalid tricycle, the Secretary of State, David Ennals, finally announced on 23 July 1976 that he would no longer supply invalid tricycles to any new applicants and would phase them out altogether for existing users over the next 6 or 7 years. In future there would only be the mobility allowance worth £169 per annum to a tax paying person who now has to pay £50 per annum vehicle excise duty.

On 26 April 1977 The Secretary of State announced that the mobility allowance would be increased from £5 to £7 from November this year, and confirmed that the supply of trikes would be maintained for those who wanted to keep them until "possibly 1983".

The vital importance of personal mobility in the successful rehabilitation of disabled people was previously recognised by being provided free on prescription. It is now dependent on the individual's ability to pay. The provision of a £7 per week mobility allowance in the context of today's motoring costs is ludicrous. The government's action has been condemned by its own Party Conference and has been deplored by every disabled group in the country.

The most worrying aspects of the future position, if no changes in this policy are made, are that school leavers who are disabled will be severely disadvantaged in an already difficult employment market, and that any possibility of converting the mobility allowance to a lump sum to finance the purchase of a vehicle by disabled people cannot come for at least 2-3 years. The point which Mr Ennals must be persuaded to agree is that the allowance is not a true alternative to a vehicle, so the present policy is bound to condemn many disabled people to a dependent, housebound institutionalised existence — which could be avoided.

Medical social work

JENNY BROWN, a medical social worker at a London teaching hospital

Social work is a profession concerned with the problems of living and with helping people to overcome and find their own solutions to difficulties which cause them distress. Social workers based in hospitals are particularly involved with alleviating the stress of serious illness and physical handicap. Often an admission to hospital brings into focus a problem which has been troubling someone for a while and enables a solution to be found at a time when that person is very ready to receive help.

For instance: Mr Jones, a large wheezy, lonely Welshman who had led an itinerant life for many years was admitted to hospital having been found unconscious in the street. After enjoying being cared for in hospital, he decided that the time had come to go into an old peoples home. I saw him and we talked over this idea. I then helped him with the application forms and discussed his application with the relevant people in the local authority.

Our work involves practical help, such as requesting domiciliary services (home helps etc) for patients on discharge and we have even arranged for a pet budgie to be looked after while the owner was in hospital as his anxiety over it was preventing him from getting better. We follow up some patients at home, especially if they are likely to be attending the hospital for future admissions, and others we refer to social workers in the area team as happened with Mr Jones.

We also support and counsel patients who may be overwhelmed by the experience of being in hospital and feeling ill, while at the same time having to make important decisions which will have repercussions on their families. Mrs Wood, a reserved and stoic lady, was told that she had a terminal illness, and she had to decide whether to go into a terminal home or return home to be nursed by her husband. Mrs Wood wanted to talk about her death and found it a great relief to talk to someone outside the family as she then did not feel disloyal when she eventually decided that the task was too much for her husband.

I work in a team sharing the work of many consultants which provides an interesting variety of work. There are some social workers who are attached to a particular unit, such as paediatrics. The social worker will usually be called to see someone by a member of the medical or nursing staff, who are the first to see how a patient is reacting to the implications of his or her illness. It is often valuable for the medical staff to have available on the medical notes, in the form of a social report, my understanding of a patient's individual circumstances. This report, which includes the patient's view of the situation, is often used as the basis for discussion when we have our weekly social work meeting with medical and nursing staff to discuss future plans for each patient. To a large extent we act as a bridge between the hospital and the outside world and are, perhaps, very aware of the danger in the hospital setting, of seeing a patient in isolation apart from their families and responsibilities. For instance, Mrs Wood who needs to be sure her husband can manage at home before she goes for terminal care.

Like all qualified social workers, the medical social worker has usually undertaken two courses of study. The first a degree or diploma and the second a professional course leading to the Certificate of Qualification in Social Work (CQSW). Although medical social workers work in hospitals, they are, in fact, employees of the local authority.

MEDICAL RECORDS

The medical records department is frequently the first and last contact a patient has with a hospital. The functions of medical records departments include booking appointments, maintaining waiting lists, arranging transport, clerical and secretarial support, reception duties, compilation of statistics and discharge and deaths administration.

Where the system breaks down problems will occur. South Tees CHC investigated 89 complaints about waiting times for outpatients appointments and in about half the cases the records had been lost, usually where a consultant had referred the patient to another consultant or when clinics were held in more than one place. All the records were eventually found but if the CHC had not made this investigation about 20 patients would never have been seen.

A problem as identified by the DHSS is that medical records are not always set out in an easily comprehensible form. A report issued in 1965 (1) laid great emphasis on the need for standard paper sizes and filing systems in hospitals. Methods of storage have also given cause for concern, partly because it is necessary to ensure that records do not deteriorate and partly to ensure that access to records is open only to those who should have such access.

Over 30,000 people are employed by the NHS to carry out medical records duties and a recent report (2) found that the fundamental problem was one of neglect by management at all levels from the unit right up to the DHSS. There was a tendency by other health service staff to dismiss medical records as a low-level function and this was reflected in the calibre of staff employed and their generally low morale. There is little formal training or technical guidance available. In general practice records are usually maintained by a receptionist who is unlikely to have received training for such duties.

All NHS medical records are legally the property of the Secretary of State for Social Services and official publications lay great stress on confidentiality. Historically records were seen as the property of the individual doctor but in recent times it is accepted that all members of a medical team need access to some information about a patient. Patients are expected to understand that their relationship is to the agency (hospital) rather than to the individual (doctor, nurse or therapist). Official literature continually stresses that the patient should not be allowed to see his or her records: "the records should never be left in a position where the patient, the patient's relatives or unauthorised persons can obtain access to them." (1)

In November 1976 Roland Moyle stated in the House of Commons that "it is a matter of clinical judgement for the doctor concerned to disclose to his patient such information as he considers necessary and advisable in the circumstances."

Trent RHA's Code of Practice (3) states: "Medical records should not be made available to patients or their relatives or representatives" and also that "the patient's general practitioner has no automatic right to a sight of his patient's hospital records". Exchange of information about a patient between a hospital and the community health services is usually done by means of standardised forms.

Although GPs are expected to maintain strict confidentiality of their patients' records they are required by law to disclose information in the case of certain notifiable diseases and in some other instances. Members of the Medical Defence Union are advised (4) "as soon as the member receives a complaint he should . . . send it to the Union together with a factual report, the patient's record card, any specialists' reports and his comments on each allegation . . ."

Record Linkage

Record linkage is the phrase used to describe the bringing together of various pieces of information about a person in order to build up a picture of his or her life — it can also be done on a family basis. It is seen as having implications for genetics, community health and epidemiology. Where records are not brought together risks may be under- or over-estimated. Work on record linkage is being done at Oxford and in a book published in 1967 (5) E D Acheson explains how developments in technology (eg computers) have increased the possibilities of record linkage. He mentions the risks of abuse by the State or by 'malicious persons' but maintains that for many research purposes it is essential to have identifiable records.

REFERENCES

(1) The Standardisation of Hospital Medical Records. Report of a sub committee chaired by Prof R E Tunbridge. HMSO. 1965

(2) A Study of the Work Role of Medical Records Officers. Inbucon. 1976.

(3) Code of Practice. Trent RHA. Published in *Medical Record* Vol 17 No 1.

(4) Complaints to Family Practitioner Committees. Medical Defence Union. 1975

(5) Medical Record Linkage. E D Acheson. Oxford University Press. 1967.

Exhibition stands

A kit comprising 10 panels is available on free loan to CHCs. Overall dimensions when assembled: 7ft 8ins high x 10ft wide. Bookings and further information from CHC NEWS office.

Parliamentary Questions

CHCs AND PLANNING TEAMS

In response to a question from Doug Hoyle MP, David Ennals said that while he encourages CHC membership of District Planning Teams some CHCs prefer to be consulted about planning proposals rather than serve on planning teams.

HOMOEOPATHIC MEDICINE

Any doctor who wishes to do so may provide homoeopathic treatment under the NHS and there are no plans to alter this arrangement said Roland Moyle in reply to a question from Lena Jeger MP.

HEARING AIDS

There were 47,000 people waiting for hearing-aid appointments in December 1976 said Alfred Morris in response to a question from Percy Grieve MP. He added that the DHSS has made special funds available to health authorities to assist them in implementing the current hearing aid programme.

MIXED WARDS IN HOSPITALS

Patrick Jenkin MP asked whether it was DHSS policy to encourage or discourage mixed wards in hospitals. Roland Moyle replied that this was essentially a matter for local decision but should follow DHSS guidelines.

FINANCIAL COMPENSATION

£726,154 was paid in 1975-6 by health authorities by way of compensation in respect of all claims of all types including those for negligent treatment. In 1971-2 the figure was £305,789. This information was given by David Ennals in reply to a question from Patrick Jenkin MP.

MENTALLY HANDICAPPED CHILDREN

At the end of 1975 there were estimated to be nearly 5,000 children under 16 resident in mental handicap hospitals and units. Replying to questions from Nigel Forman MP and Colin Shepherd MP David Ennals added that the Government has urged field authorities to give high priority to development of community residential and support services. He felt that joint financing should be helpful in this respect.

DHSS APPOINTMENTS

In reply to a question from Laurie Pavitt MP Eric Deakins gave details of paid appointments under the patronage of the Secretary of State for Social Services. There are 2,061 part-time appointments with fees ranging from £50 per day for the chairman of the Attendance Allowance Board to £18.90 per day for the Chairman of the National Insurance Advisory Committee. Members of the various committees, panels and boards receive fees varying between £35 and £6.30 per day. The 90 chairmen of AHAs and 14 chairmen of RHAs receive £2,000 pa but members are not paid.

NOTES.....

EVIDENCE TO THE ROYAL COMMISSION

AHAs should take into account the presence of ethnic minority communities and the implications that this might have for services. This is one of the recommendations of the Community Relations Commission in its evidence to the Royal Commission. Special services could be developed such as family planning clinics staffed by doctors and nurses with the same cultural backgrounds as their patients. The CRC also draws attention to the low numbers of overseas-born people at the higher levels of employment such as consultants, registrars and senior nurses.

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The NHS Consultants Association was formed in Spring 1976 by a group of consultants who were dissatisfied with the stance of the BMA and the Hospital Consultants' and Specialists' Association about important medico-political matters. In evidence to the Royal Commission the NHSCA comes out against any charges to patients and affirms its belief that the NHS is best served by whole-time hospital consultants. Doctors and other health service staff need to be informed more about the financial implications of their decisions and the principle of review by peers and by administrators must be established — but as a learning process, not a witch hunt. If significant savings can be made without detriment to patient care, the relevant departments should be allowed to use at least part of this money elsewhere in developing their services. The NHSCA suggest an increased intake of mature students, especially of paramedicals, to medical training, and that teaching hospitals should primarily be good district general hospitals and vice versa. "The concept of 'centres of excellence' is misleading as the health service as a whole should become a network of teaching and learning."

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Five MPs and eight dental health workers have produced evidence on dental services for the Royal Commission. The submission emphasises that Government policy must be changed to a recognition that prevention of dental disease is both possible and urgent. At present, only one per cent of expenditure on dental services is spent on prevention. Most dental treatment fails to reduce pain and does not alter for the better the natural history of the two major dental diseases. Dentists prepared to give a firm commitment to treat all patients under the NHS should be offered new contracts and innovations are needed in the training and employment of dental ancillary workers.

SEASON TICKETS FOR PRESCRIPTIONS

The DHSS is encouraging publicity of the pre-payment scheme for prescription charges. Certificates cost £2 for six months and £3.50 for one year. These amounts represent a saving for patients who have more than 10 prescriptions in 6 months or more than 17 in a year. They are available from FPCs on completion of Form FP95.

LITERATURE ON THE ELDERLY

The National Corporation for the Care of Old People is offering a new bi-monthly annotated literature list for people interested in the elderly. *New Literature on Old Age* costs £2 from NCCOP, Nuffield Lodge, Regent's Park, London NW1.

CONTRACEPTIVE ADVERTISING

The Code of Practice that allows TV commercials containing explicit sexual messages but bans ads for contraceptives is outmoded and hypocritical. This is the message of *Advertising and Contraceptives* (Birth Control Trust, 27 Mortimer Street, London W1, 50p). The booklet gives examples from Europe, USA, Australia and Jamaica and concludes that current ads for family planning products and services are ineffective and do not reach many of the people most 'at risk'.

HC(77)9 NHS CHIROPODY SERVICES

This circular suggests ways of improving the organisation of the NHS Chiropody Services. Provision of transport to enable patients to get to chiropodists would allow an efficient use of the latter's time and not necessarily increase the total costs of the service. A new category of foot care assistants is envisaged. Their tasks will include simple foot care and hygiene under the supervision of trained chiropodists. Terms and conditions of service for their employment are outlined in circular HC(PC)(77)3. It is also suggested that staff in homes for the elderly could be trained to give simple foot care to residents.

HC(77)10 REVIEW OF MANAGEMENT COSTS

This circular sets out guidelines for reviewing the managements costs of the health services. The aim is to reduce these by 5 per cent between March 1976 and 1979/80. Regions are to be allowed 'maximum flexibility' in the review but certain suggestions are made — such as merging functions into a single post, creating posts to serve more than one Area or District and looking for advice to officers at a different level of the service. General structural reorganisation is ruled out at this stage but the Secretary of State is prepared to consider proposals for the merger of existing districts or establishment of single district areas. RHAs are asked to inform the Department of proposals in outline before AHAs proceed to local consultations. There is some concern about the recruitment and geographical spread of specialists in community medicine and control of establishments and vacancies is to be exercised centrally by the Department.

Directory of CHCs

This Directory gives addresses and telephone numbers for all CHCs in England and Wales, plus names of chairman and secretaries. Price 60p from CHC NEWS office. Corrections are published monthly in CHC NEWS.

Page 3: SW Durham CHC
Address: 10 Market Place, Bishop Auckland, Co. Durham DL14 7NJ.
Telephone: Bishop Auckland 5013.

Page 9: East Leicestershire CHC
Address: Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW.
Telephone: Leicester 737932.

Page 16: South Hammersmith CHC
Secretary: Andrew Farnese.

Page 18: Chelmsford CHC
Chairman: Mrs Diana Leveratt.

Page 19: North Camden CHC
Chairman: Mrs Jane Awty.

Page 27: Wandsworth and East Merton CHC
Chairperson: Mrs Cheryl Scott.

Page 28: Southampton and SW Hampshire CHC
Address: 57 Above Bar, Southampton.
Telephone: Southampton 30283.

Page 33: Exeter and District CHC
Secretary: Tony Day.

Page 39: Wolverhampton CHC
Chairman: Mr G. K. Wones.

Page 39: Chester CHC
Address: 2 Stanley Street, Chester, Cheshire CH1 2LR.
Telephone: Chester 317622.

Page 48: Pembrokeshire CHC
Telephone: Haverfordwest 5816.

Page 50: Cardiff CHC
Address: 15 St David's House, Wood Street, Cardiff.
Telephone: Cardiff 34407.

Operational research

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approach can be applied in quite a different way.

We are interested in discussing with CHCs the ways that we could work together along these lines. Areas for discussion might include: helping to develop cases against hospital closures where the local community feels this to be in their interest, or alternatively, developing cases to ensure that resources traditionally invested in local hospitals will be re-invested in the health of the community if a closure is accepted; exploring the implications of facility siting, in relation to transport etc.; investigating the cost of private practice; exposing cuts that are disguised by changing patterns of work; revealing the social and economic assumptions underlying policy decisions.

If you would like to help develop these ideas further or have a specific problem which you feel we may be able to help you with, please contact me via the Editor.