CHC NEWS
For Community Health Councils
August 1977 No. 22

CHC BAKES A HEALTH CAKE

Sally Weston and Susan Thorne, St Thomas's CHC

During the Easter holiday the St Thomas's CHC ran a "Health Event" for children aged between 5 and 12 years. It was planned around the subject of nutrition and health with particular emphasis on the importance of fibre in the diet. Over four days, 30 children (though never more than 19 at a time) considered nutrition and digestion, listened to a talk from Dr Stanway, the author of a book on dietary fibre called "Taking the Rough with the Smooth", saw the local baker make his weekly batch of brown bread and made wholemeal bread themselves. This was our second "Holiday Event"; we had previously held one on the care of teeth, and we plan to have another one this summer and at present have a weekly "Health Club".

The project started five months ago when two boys living locally began calling in after school asking us if we had anything they could do in the CHC shop. This made us think about what we could do to make contact with local children. Our aims were:

1. To increase awareness of the factors affecting health.
2. To identify the health care issues that children and their parents living near the shop are most concerned about.
3. To encourage a positive attitude to health care.

It is early days to evaluate this project but we have been able to see some results:

1. When we asked the children recently "What is health?" several of the children included "being happy" as well as "cleaning teeth" and "eating properly". This already reflects a change from our earlier contact with the children when they were able to give a long list of diseases under one heading "illness" and practically nothing under the heading of "health".
2. One mother came to the CHC for advice on her family's health needs (unsuitable housing greatly affecting these) and the children themselves have talked about their experiences in hospital and their illnesses which included anorexia, depression and dyslexia. We have become aware of the special problems of one or two of the children (including two mentally handicapped children) and in the club situation are able to give some support.

A CHC member suggested that we publicise a holiday for children who would otherwise spend the entire summer in the city, and we found that at least 8 children qualified for this and five are going on the holiday.

3. Several of the children have told us that they or their mothers have made wholemeal bread at home; two boys spent their pocket-money on apples and crisps instead of sweets and most of the children are now reluctant to bring sweets into the CHC shop. One mother came in to tell us that her daughter had voluntarily eaten greens for the first time in her life "because the doctor at the Health Council had said they were good for her".

Current activities at the health club are related to two subjects: "my body" and "the environment" and include discussions and visits to a "city farm" and to the "Hall of Human Biology" at the Natural History Museum. We are continuing our evaluation of this work.

INSIDE...

Brent case over

The first ever legal case between a local council and an AHA ended in the High Court on June 27th.

Last September the AHA closed the acute wards and accident and emergency services at Willesden General Hospital and the CHC sought reinstatement of these services. In January, the London Borough of Brent started legal proceedings because it felt that the AHA "had not consulted properly with the Brent CHC as it is required to do by law". (see *CHC NEWS nos. 16 and 17*). A new consultation procedure was initiated which ended with an AHA meeting four days before the court case was due to be heard. The AHA agreed to consider using the hospital for young chronic sick, convalescent beds, day hospital facilities for the elderly and to examine the possibility of having a health centre in the hospital grounds.

In view of this, Brent Council applied for leave to withdraw the legal proceedings. Mr Justice Caulfield granted the request but ordered the Council to pay the costs of the case.

YOUR LETTERS

PUBLICITY

Mrs M. E. Bateman, Secretary Ipswich CHC

Most CHCs have had a tough struggle to make the public aware of their existence, let alone their vital role in representing the NHS consumer. Much, if not all, the blame for this lies with the Department of Health and Social Security who set up CHCs with great enthusiasm when consumer participation became fashionable and promptly left them to fend for themselves. The DHSS argument that the National Association, when formed, would take responsibility for publicity simply will not do since it was obvious that the Association could not be established overnight. In fact, we have had a three-year vacuum which CHC Secretaries have been hard pressed to fill.

Most of us have provided our own local publicity, but I wonder if some of us have gone too far? Every CHC needs basic leaflets, posters and so on, giving information about itself. I do have reservations, though, about CHCs producing literature about services (when to call your doctor, who gets free dental treatment, etc., etc.), not least because some of the material I have received from colleagues has contained inaccuracies!

Surely we should be spending our time (and money) better by making sure that the official leaflets and posters issued by the DHSS include what patients want to know and are written in a way that patients can easily understand. I hope that the Association of CHCs will tackle the DHSS on this and will resist any suggestion that it should produce patient information literature. If you keep a dog it is surely stupid to bark yourself!

HELP WITH TRAVELLING EXPENSES

J. C. Silverthorne, Secretary N Staffs CHC

In common with all the other CHC secretaries I recently received a letter from the National Council for Social Service, together with a copy of a new leaflet they have produced on assistance with travelling expenses for parents visiting their children in hospital.

I am concerned about an inaccuracy in paragraph A.1 of their new leaflet. There would appear to be no reason for the statement that persons in full-time employment are disqualified from receiving assistance. The position as I understand it is that where persons are not in receipt of supplementary benefit but derive their income from other sources, including employment, part- or full-time, then the DHSS will assess both their income and the reasonable cost of travelling. Where these travelling costs would bring the applicant's income to below the level which they would receive as supplementary benefit then the officer of the DHSS may make discretionary payments to restore the applicant's income to at least the supplementary benefit level. The paragraph A.3 does in fact touch on this, but I do not believe it adequately counters the statement in paragraph A.1.

It is no coincidence that many families whose income is just above the supplementary benefit level also have children in hospital in need of the visits they are unable to make. I have checked with the DHSS before writing to you and I know of actual cases that have been assisted in this area.

I would say, however, how much I welcome the issue of a leaflet like this, which I feel would be of great value to those professions concerned. I have found very many cases where social workers and hospital staff are insufficiently informed about the assistance which is available.

HOSPITAL KITCHENS

Lorna Mitchison, Assistant Secretary City & Hackney CHC

Our CHC has recently discussed the unsatisfactory standards in some of our district's hospital kitchens. The Chief Environmental Health Officer for Hackney had explained in a letter his frustration in trying to improve things and that conditions in at least one kitchen were so bad that the health authority would face immediate prosecution if it were not exempt under the law.

A similar situation obtains with fire precautions. Many health premises are inadequately safeguarded and again the law protects the authority.

Our Council decided that the solution would be to remove the Crown Immunity enjoyed by hospitals and other health premises so that food hygiene regulations and fire regulations could be enforced. We have written to the Secretary of State and our district MPs asking them to do what they can to initiate this and we urge other CHCs to do the same.

CROWN IMMUNITY + EMPLOYMENT PROTECTION ACT

Brian Marshall, Secretary SW Leicestershire CHC

My Council has very strongly represented to the Secretary of State the urgent need to remove the restriction of crown immunity from National Health Service hospitals particularly catering departments and kitchens in order that patients may be afforded at least the same degree of protection as given to customers of catering establishments in the private sector. The support of the North West and East Leicestershire Community Health Councils has also been sought in this connection. We notice that this matter has been raised in *CHC NEWS* in the June and July issues. On another important matter: the Employment Protection Act, letters have been sent to all Leicestershire Members of Parliament by my Council in an attempt to bring pressure on the Secretary of State for Employment to include Community Health Councils in the list of public bodies given in the Employment Protection Act.

HOSPITAL CLOSURES

The DHSS has provided the following information in response to an enquiry about the number of proposals to close hospitals which have been opposed by CHCs.

During the period from the NHS reorganisation to date (June 1977), CHCs have opposed the closure of hospitals or major departments in 17 cases. Of these, 8 have not been upheld, 8 are still under consideration, and in one case — RAF Hospital in Cosford, Wolverhampton — the CHC's case has been partially upheld in the sense that the closure has been deferred. In addition, CHCs have opposed 2 changes of use, one of which is to go ahead while the other is still under consideration. These figures should perhaps be considered alongside the total of 97 closures and 22 changes of use which have not been opposed by CHCs during this same period.

HOW DO CHCs SERVE RURAL AREAS?

T. I. Richardson, Secretary Oxfordshire CHC

Oxfordshire is a single district area covering a large square mileage and over half a million people. Obviously on our budget we cannot possibly be represented from within our own organisation in each of the market towns and centres of population. So we are trying the experiment of coming to agency arrangements with such people as Citizens Advice Bureaux and where these are not available, Information Centres and similar organisations.

So far we have two firm arrangements with Wantage Community Information Centre and Witney CAB and are well advanced in preliminary arrangements with the Didcot CAB and the Faringdon Voluntary Services Information Bureau. In each case the agreement states that the agent (CAB, etc.) should supply information which allows the CHC to fulfil a monitoring role; the CHC should be provided with monthly statistics about health queries; the agent should disseminate information coming from the CHC as required on both general and particular matters; and that the CHC will pay £100 towards the cost of telephones, postage, etc. to be used as a donation to the agent.

At a later date I hope to get our members who live in or near the particular towns involved with each organisation, together with officer involvement. I hope other CHCs, particularly those covering a wide area, will be interested in this experiment. We are not aiming to come between client and voluntary agency but to share the job of making a service available to all district residents.

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.

CHCs ON POLLUTION WATCH

The upsurge of environmental concern which began in the late 1960s seems to have made permanent changes in public attitudes, even though it is now sometimes claimed that Britain's economy can no longer afford luxuries like environmental protection.

CHCs, which have so far concerned themselves with environmental issues generally, take the line that they should be interested in anything which affects health in their district, not just in their local NHS. Industrial pollution has been to the fore in their thinking, and one CHC which has had more than its share of this kind of problem is North Derbyshire. In its health district there are three controversial chemical plants; the Coalite plant at Bolsover, and the Staveley Chemicals and Vinatex plants near Chesterfield.

Coalite, which produced dioxin, the chemical which caused the Italian Seveso disaster, was closed last September following inspections by the Health and Safey Executive. In February an outbreak of chloracne — the severe skin disease caused by dioxin at Seveso — was reported amongst workers in the Staveley plant. Vinatex makes PVC plastic using a highly toxic chemical called vinyl chloride monomer, known to be capable of causing a rare form of liver cancer called angiosarcoma.

Vinatex has applied for planning permission to double the size of its operation, and this has been refused by the local authority, resulting in a public enquiry. Leading the local campaign to prevent the development is CHC member Councillor Mrs Margaret Morris, who is also a local authority environmental health committee member. The CHC's view is that it will "support any campaign to ensure that there is no major hazard to the health of people living around the plant". At the moment there is "insufficient evidence" to convince local people that the Vinatex expansion would be safe.

Informal local liaison committees, with representatives of local authorities and industry, have been set up at Chesterfield and Bolsover, and the CHC has asked for representation on these so that it could keep a watch on possible health consequences of pollution. In both cases this request was turned down, since some environmental health committee members of the liaison committees were also CHC members.

Another focus of CHC concern is the Ferodo works near Chapel-en-le-Frith, which manufactures brake linings using asbestos. Here, too, the local authority is keeping a close watch on possible health risks, and is keeping the CHC informed on a regular basis.

"Our remit is not to act on these things, but we support other bodies who do have the right to act, such as environmental health committees", explains Keith Swann, secretary to North Derbyshire CHC. "Our approach is to raise issues, discuss them, voice our opinions and offer our support".

The impact of industry on the Scunthorpe area has been even more dramatic. In June 1974 the Nypro UK chemical plant at Flixborough, manufacturing raw materials for nylon, exploded killing 28 men and damaging villages several miles away. In November 1975 an explosion at the Appleby-Frodingham steelworks killed another 11 men.

CHC secretary John Fryer emphasises that the real Scunthorpe bears little relation to its grim music-hall image. It is, in fact, a "pleasant rural area with few environmental problems". His CHC has, however, capitalised on the two recent major disasters to secure better health services for the district, by attending last year's inquiry into the rebuilding of the Nypro plant and making a forceful case for improvements in the local accident and emergency department.

"We seized on the inquiry in order to present our case that the A and E Department is totally inadequate. This has been our main concern since we came into existence, and we've even been to see the Minister about it. We used both disasters, within the boundaries of good taste, and we've managed to get the improvements to the top of the region's A and E capital projects priority list."

In Walsall the CHC has been concerned about safety on and around sites where toxic wastes are deposited. Says secretary Richard Bray: "There is a health hazard to this, and where all your secondary care services are very short, anything that could put extra patients in hospital becomes your concern."

The CHC has corresponded with the West Midlands County Council's waste disposal officer, who has advised that as from June this year all waste disposal sites must be licensed by the local waste disposal authority under the Control of Pollution Act 1974. Where necessary this allows the local authority to "tighten and enforce conditions" on unsatisfactory sites, and the CHC will be watching closely to see how the new system operates.

North Birmingham CHC is co-ordinating a campaign amongst the city's CHCs to get the government to speed up its plans to reduce the lead content of petrol. With support from the other four Birmingham CHCs, North Birmingham has written to the Department of the Environment and the DHSS, asking for the speed-up. The CHC sees this as part of a long-term programme of reducing lead pollution in the environment generally — in air, food and water. It feels that such an inititiative from Birmingham — a city with vested interests in the motor industry — should carry particular weight.

"We don't claim to be experts, we're making a straightforward approach as laymen," says secretary David Baldwin. "We are saying that lead pollution is dangerous and can be avoided, and if our campaign succeeds in reducing atmospheric lead pollution then we are helping towards health. If you take a broad view of health then avoiding illness is part of a health authority's duty."

On the eastern side of Birmingham there is also concern about the possible mental health problems which could be caused by aircraft noise if plans to expand Elmdon airport go ahead. The East Birmingham CHC has already protested in letters to the DHSS, the DoE and the West Midlands County Council, about the expansion plans. The CHC has also set up a Birmingham Airport Sub-committee, which is considering evidence on noise and mental health supplied by the Institute of Psychiatry. Parts of the Solihull health district would also be affected by the Elmdon plans, so the CHC is supporting East Birmingham and is represented on the airport sub-committee.

Members of West Cumbria CHC have visited the Windscale reprocessing plant of British Nuclear fuels Ltd, have attended a talk given by BNFL's chief medical officer and have inspected the complex medical facilities inside the plant. The CHC is pressing its DMT to provide the same levels of medical care

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Making the most of our money

Walter Appleby, Secretary of Central Derbyshire CHC

Earlier this year I was in communication with the District/Area/Regional Officers, about the possibility of using our underspent monies on health service projects. It had become obvious to me that there would be some available monies, and my Council had agreed on a number of projects to which it could be applied. However, towards the end of the financial year, I learned that there had been a hold up because the Regional Officers had raised doubts about the legality of such procedure.

I subsequently pointed out to the Regional Treasurer, which clearly indicates CHCs had done this during the preceeding financial year. I have now received, via the Area Administration, a copy of a letter sent out from the Elephant and Castle to the Regional Treaurer, which clearly indicates that, subject to the Regional Health Authority's agreement, underspent CHC monies may be used to benefit the health district.

The letter says ". . . it is clear that the purchase of hospital equipment and the making of grants to other bodies are not allowable CHC expenses; nor is fund raising an activity which the Department would encourage CHCs to pursue. But of course where a surplus arises on a CHC's budget there is nothing to prevent the RHA agreeing with the CHC that this should be used to benefit the district, where such a gesture would help to foster good local relationships and perhaps encourage economy.

For example, the RHA might agree to the unspent balance of a CHC allocation being used to make a grant to a body suggested by the CHC using the RHA or AHA's delegated powers under Section 64 of the 1968 Act."

The letter adds, however, ". . . I am not sure however that national ground rules are likely to be particularly helpful in providing for discretionary action of this kind. Whether a region will wish to keep a tight control over the budgets of CHCs or whether they will allow CHCs a say in the disposal of any "savings" seems to be a matter best decided locally. Certainly there is no "established custom" in this respect so far as the Department is concerned and a Region can always explain to CHCs that any sums not spent by them are not lost but are available for other NHS needs, albeit not necessarily in particular localities."

My Council is loathe to see its savings swallowed up in regional activities — especially administration — and it would far rather see the money being put to direct use for the benefit of patients. In the event, we drew up a long list of schemes on which the unspent sums could be spent, and after taking the advice of a number of professional staff, we picked four:

1. A deep heat physiotherapy machine for a community hospital (£1,000).
2. Ripple mattresses for a small geriatric hospital (£250).
3. Kings Fund beds for the main geriatric hospital (£500).
4. A £250 grant to the Mid-Derbyshire Association for Mobile Physiotherapy.

At a meeting between the CHC Chairmen in Trent and Sir Sidney King, Chairman of Trent RHA, it was agreed that in future any proposals for allocating CHCs' budget savings such as these would be considered on their merits. Clearly not many CHCs will be able to make savings, but we feel we have established an important principle which can benefit projects which might otherwise have to wait a long time for support.

CHCs AND CVSs

A marriage of convenience

Sharon Collins, General Secretary of Southwark CVS

Most CHCs will by now have developed a relationship with the Council for Voluntary Service in their area. While CHCs were new, many CVSs conducted the election for that part of their membership which is drawn from voluntary organisations. And on a day to day basis there are a variety of ways in which the local CVS can be used as a support and resource by the CHC.

Primarily it provides an important link with local voluntary organisations; through the CVS a CHC can often be part of broadly based discussions about relevant local issues. Aspects of training which the CVS may be co-ordinating for its members can also be useful to the CHC. A regular point of contact with agencies in the area concerned with particular client groups, or which are used by the public as a point of reference when problems occur, can help to give the CHC a broader picture of how (and in what context) the health service is seen and used locally.

The CVS will also be a source of particular information for the CHC: its local knowledge and more direct involvement in issues which affect, but are not central to the CHC's work, will at times be a valuable resource. And active membership of the CVS will allow the CHC to seek the support of, or undertake joint initiatives with other local agencies on issues of common concern. The kind of working relationship that individual CHCs and CVSs develop will vary from area to area. But, perhaps, for most a major area of potential lies in the development of the accountability of the CHC to those it represents.

CHCs are, I know, struggling with the question of how they can interest and involve the community on whose behalf they are working. All CHC members will be concerned to make themselves accountable to "the public". Those members who represent voluntary bodies on the CHC have a slightly easier task — or an additional responsibility — depending on how you look at it. Members of CHCs who come from voluntary organisations do not represent their own agency as such: they have a responsibility towards the whole of the local voluntary sector. So at least a part of their constituency is defined and identifiable.

Clearly, the CVS, as the local focus for voluntary bodies has a part to play in helping this group of CHC members in particular to establish their lines of accountability. How this can be done in practice will depend on many local factors — CVSs, like CHCs, have a wide variety of work priorities, areas of special interest and interpretations of their function. In some area the CVS may encourage the voluntary sector CHC members to hold regular feedback forums through which they can report to the broader voluntary organisation population. Or it may itself call meetings on particular issues to mandate the CHC representatives. In other areas the CVS staff may be able to act as a clearing house for information: for example by giving CHC matters space regularly in its bulletin or newsletter. Or by encouraging particular organisations to attend CHC meetings when an issue likely to be of interest to them is on the agenda.

Local situations need local responses: there is no national blueprint for a perfect relationship between every CHC and every CVS. What is clear, however, is that nine times out of ten good contact, communication and support between the two organisations can be mutually helpful and beneficial.

PERSONAL VIEW

Who really needs us?

John Urch, Secretary of South Tees CHC

I am quite unable to sit quietly and say nothing for long, and believe strongly that the role of a community health council must be an active one. To my mind, the Davies Committee gave us an excellent definition when they said that a community health council should be the conscience of an area health authority and not its right arm.

If we are genuinely concerned in bringing about real improvement we must stimulate authorities into positive action and not rubber-stamp plans for a health care system too often designed to suit the producer rather than the user. Even though this will not always make us popular we have a duty to look critically at the health service through the eyes of those who use it. We must guard the interests of those who are least able to voice their own special needs. I see this as a great opportunity for real democratic participation and action.

In areas like the one I serve where social deprivation is high, health status and the use of preventive health care facilities are low. Good health does not depend solely upon health care provision and access to medical care; it is influenced by many factors — social, environmental, residential, occupational and educational.

Health and social care needs must be met in a co-ordinated way to contribute positively towards improving the quality of life. Our members who represent the whole range of local opinion can and must play a positive role in bringing about change. Those who serve on Joint Consultative Committees can play a vital part, for these committees must provide the mechanism whereby community needs can be jointly planned and scarce resources used to best advantage. Joint planning must be based on the needs of the community rather than provide opportunities for particular professional interests to be developed.

Members nominated by voluntary organisations can help by giving special consideration to ways in which voluntary help can best be organised and utilised. People do care and to relieve pressure on over-burdened services and to provide support in the community threatens no professional function and contributes positively to creating a caring society.

I believe that because health care matters it is too important to be left entirely in the hands of the professionals. People can be actively encouraged to care about health, individually and collectively. After all, health is everybody's business, not just because it happens to be one of the major industries of the country, but because every one of us will need to use the services at some time or other during our lives.

As I see it we must be the ones to bring about a more sensitive service responsive to our needs and the needs of those less fortunate than ourselves. If we are good at our job, we can succeed in seeing our health service run for the people and welcoming their participation.

News from CHCs

● Several CHCs have recently launched public petitions on local issues. Rotherham CHC's petition asks for a firm commitment to opening the town's new DGH in 1978/79. At the moment the building is standing empty at an estimated annual cost of £¾m. The aim is to collect at least 20,000 signatures, and the campaign has attracted good press publicity. Barking CHC recently presented Roland Moyle with a petition calling for the retention of local treatment for geriatrics. Its 8,000 signatures were collected in eight weeks, mainly by leaving copies of the petition in public buildings. Islington CHC has over 1,000 signatures so far on its petition calling for the return of a regional neurosurgery unit, which has temporarily been moved out of its district.

● Following approaches made by East Berkshire, Croydon and Southmead CHCs, it has been agreed that the following reference will appear in all Yellow Pages directories: "Community Health Councils, see Health Service and Hospital Authorities." Thomson Yellow Pages Ltd advises that each CHC should write to its telephone area office asking for an entry in the HSHA section. Provided a CHC has its own business telephone line there will be no charge for this.

● Health minister Roland Moyle has met a joint deputation from Hackney's CHC, borough council, trades council and MPs, to discuss his plans to use the money saved by closing a local hospital to open specialist wards elsewhere. The CHC argued that local services were being "robbed to maintain wards in the teaching hospitals which have no bearing at all on the needs of local people". The borough council stated its concern that "crisis management" in the NHS was endangering community health care services. Mr Moyle said he would look sympathetically on any proposals for better co-ordination between authorities in inner city areas.

● Derbyshire's three CHCs held a joint press conference to publicise the "virtually non-existent" prospects of improvement in the area's NHS this year. Revenue funds for development in Derbyshire are calculated on the basis of a "served population" of 733,000, as against the actual population of 895,000. The RHA says this happens because many Derbyshire people rely on other areas for some health services. The CHCs say this arrangement tends to "perpetuate the disadvantageous position" of the county, and have called for another £2m at least to improve nursing and community services.

● A new speech aid is now available through the NHS, thanks to an initiative by Central Nottinghamshire CHC. The council was approached by a member of the Nottingham Chatterbox Club, for people who have had a laryngectomy, who explained that the standard artificial larynx provided by the DHSS did not permit normal conversations because of embarrassment caused by its tone. He drew the CHC's attention to an alternative German-made speech aid, called the Servox, which was far superior but was not available through the NHS. The CHC took the matter up centrally with the NHS, which has now agreed to make the improved aid available.

● Leeds Western CHC has defended its objections to the proposed gift to its AHA by "a group of anonymous individuals" of a £300,000 body scanner. The CHC's monthly newsletter argues that areas of agreed need will be "robbed" of the £50,000 pa which the AHA estimates will be needed to run the scanner. "If the agreed list of priorities is to be by-passed there must be some good and rational reasons commonly agreed by people responsible for health care in the city. Why were no such reasons given at the meeting of the authority?"

● Alastair Mackie, director general of the Health Education Council, was the main speaker at the Prevention and Health Day organised recently by the West Essex and District CHC. In a talk titled "Rocking the boat" he claimed that investment in the NHS had not greatly changed illness statistics, and suggested that future emphasis should be on health education rather than technical advances. Over 100 members of the caring professions, voluntary groups and the public attended, and the meeting attracted valuable publicity in the local press.

EDITORIAL

Can CHCs set an example to others by making their meetings and offices accessible to disabled people? Recently Lady Masham asked a question about this in the House of Lords. She is herself disabled and Chairman of the Spinal Injuries Association as well as being a CHC member. She was told that "a substantial number of community health council offices can be entered only by steps with no ramps or are on the upper floors with no lifts"; although people would "generally be able to attend council meetings even if offices are inaccessible".

The Lords agreed that much health and local authority accommodation lacked even quite elementary provision, such as ramps, for disabled people, but that progress on implementing relevant sections of the Chronically Sick and Disabled Persons Act had been slow because of the need to economise. The Minister for the Disabled has now launched a campaign and set up a committee to encourage greater efforts in adapting premises.

At its recent AGM the Association of CHCs decided to look for premises that would be accessible for disabled people, but individual CHCs have not all been able to do this. For them an additional problem was that was that they had to find a base quickly in order to get going within a reasonable time of being established. Some CHCs have had difficulty in obtaining suitable permanent premises and may be forced to spend a fourth year in temporary offices that are not really satisfactory. Other CHCs have managed to find permanent places, but may now be contemplating a further move because their view of what they require has changed.

This problem is clearly one about which it is easy to pontificate and also to be complacent. Will CHCs find a way through?

CHC NEWS

AUGUST 1977 **No 22**

126 Albert Street, London NW1
01-267 6111

CHC NEWS and Information Service staff:
RUTH LEVITT (Editor)
DAVE BRADNEY, RUTH COHEN

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, designed by Ray Eden and printed by The Chesham Press Ltd., 16 Germain Street, Chesham HP5 1LJ.

THE HUMAN FACE OF MEDICAL EDUCATION

About 40 per cent of all UK doctors work in general practice, handling from start to finish nine out of every ten episodes of illness which doctors see. Marshall Marinker, professor of community health at Leicester University, argues that the needs of future GPs and their patients must be given greater emphasis in medical education.

Whenever we think about medicine we tend to think about drama. Medical drama is closer to the classical theatre or the Japanese "Noh" play than it is to the more naturalistic theatre of our own times. In operative surgery, for example, the doctor is swathed in a mysterious gown, and like the actors of classical drama he wears a mask. The patient lies spread-eagled as though bewitched, or at least made ready for a sacrifice. Tubes weave in and out of every imaginable hole in the body.

Yet this is not at all typical of what goes on between doctors and patients. After five years of work in the medical school, and four more years of postgraduate study in hospitals and in general teaching practices, most typically the medical graduate will be sitting in his consulting room listening, for instance, to a young woman complaining of heavy periods, loss of appetite, acne and uncertainty about whether or not she should sleep with her boy-friend.

Contributing to the way in which the doctor will solve this young woman's problem will be all the hours of learning which he or she has done in the departments of anatomy and biochemistry, sociology and psychology, clinical, medicine and surgery and gynaecology, lectures, laboratory sessions, ward rounds and out-patient consultations.

IVORY TOWER

Until very recently, medical students' education was largely bounded by the walls of the university for the first two years and the walls of the teaching hospital for the next three. Only rarely did they get a direct experience of the illnesses that occurred outside those walls, and of the medical care provided.

In my own case, as a medical student at one of the great London teaching hospitals, the weeks spent in the casualty department were some of the most exciting and disturbing. The man stabbed in the chest by his friend during a fight over a woman, the anxious mother hauling in her hot and screaming five-year-old daughter, the down-and-out tramp vomiting blood — these people still had on them the smell of the street, or the kitchen, or the factory where they worked. They had not yet been transformed into those neatly pyjama'd figures, responding with their carefully rehearsed histories, coyly revealing their surgical lumps or cardiological murmurs, who had temporarily abdicated being people to become *patients*, and "surgical" or "gynaecological" or "psychiatric" patients at that.

The second such experience, which I myself missed, was the most highly prized of all. Some of the students from my medical school went over to Dublin, to the Rotunda Hospital, where they were allowed to deliver babies on the district. This was the most rewarding experience of all for undergraduates. They went into the patient's home. They saw the life of the poor Dubliner at first hand. They were actually allowed to do something useful like deliver a baby, and the folklore of London medical undergraduates was rich with the bawdy stories of those heady days.

It is a paradox that medical students must be taught to be unspecialised doctors by specialists — anatomists, biochemists, surgeons, psychiatrists and so on. After all, the very nature of modern medicine suggests that GPs are people who have *less* knowledge, *less* skill than every one of their colleagues in each and every field of specialist practice.

Twenty years ago, before the extraordinary renaissance of general practice in the UK, this was the current view of GPs in the profession itself. They were seen as doctors who dealt with trivial illnesses in a perfunctory way. If patients' problems required any sort of diagnostic or therapeutic skill, they were shipped off to hospital. At best the GP was seen as a safe hack — a not too inefficient sorting clerk who would distinguish between good clinical material on the one hand and rubbish on the other.

RENAISSANCE

The modern GP, in his postgraduate training, learns that doctors should at one and the same time take into account the physical, psychological and social aspects of the patient's problem; that knowledge about diseases must be used in relation to a different sort of knowledge, concerning the unique individual who is consulting; that family relationships are important in understanding the patient's condition and in planning treatment; that time is an important factor in medical care.

An understanding of time is essential in clinical medicine: people and their illnesses change with time. So do patients' relationships with their doctors, and with other important people in their lives. The average time for a consultation in general practice in this country is six minutes. It would be nonsense to imagine that the resolution of a patient's problem, using all the accumulated knowledge and skills of a doctor, can always be achieved in six minutes. In general practice the consultation should be seen not as an event but rather as a process, which lasts not for six minutes but for six years, or sixteen years, or more. It is against the back-cloth of a developing life-history that the life events of illness must be seen by the doctor — and particularly by the GP.

The student should not only be capable of recognising the diseases that he sees in hospital, he should also recognise those that are prevalent in the world outside. Most important of all students must realise that medicine is about people as individuals and about the society in which we all live.

At Leicester, medical students in their first two years follow a course which we call "Man in Society". In addition to my own department of community health, the departments of sociology and psychology and the school of social work contribute to this course. The students learn that health is not simply a question of the absence of disease, but is rather a statement about social and cultural expectations. They learn about the process of becoming ill, the way in which people are identified and identify themselves as being sick, and about the social consequences of being recognised as a sick person. They learn about communication and, most important of all, about the doctor/patient relationship.

For much of this teaching, the situation of general practice provides us with a sort of human laboratory. Long before the students meet their first dead body, long before they use the complicated glassware associated with the measurement of biochemical materials, they will be attending health centres and visiting patients in their own homes. In these first two years they are expected to study the sciences of human behaviour in the community as seriously as they study the sciences of human structure and function in the laboratory.

This kind of learning experience is essential if we are going to produce doctors who are prepared to accept that illness is not only a series of abnormal cells magnified on a microscope slide, but also a form of human communication.

EMOTIONAL GROWTH

This kind of medicine not only involves the same kind of intellectual activity that is involved in determining which valve of the heart has gone wrong, or how to restore the salt balance of the body, but it also involves something which has *as much* to do with the *emotional* growth of students as with their *intellectual* growth. It involves an understanding of human behaviour and, perhaps most importantly of all, an understanding of the human behaviour of doctors themselves. Medical students of the future will learn not only about the problems of patients, but also about the problems of being a doctor.

I must make something very clear. Nothing that I have said in this article should be taken to suggest that it is only in departments of community medicine and general practice that medical students will learn about the human face of medicine. If that were true it would be terribly depressing. What *is* true about general practice is that it has certain characteristics which make it particularly appropriate for students to learn this aspect of their future job.

In general practice information about the patient is often scant and the diagnostic picture is usually incomplete, so students can learn how to tolerate ambiguity and uncertainty. This is a very important part of learning how to be a doctor. Paradoxically, the doctor who feels he must always know everything there is to be known about the patient and the disease is not a safe doctor, but a very dangerous one.

Another valuable characteristic of general practice is that there is an absence of high technology. High technology is important in certain areas of medical practice, but it is much easier to teach students about the techniques and pathways of solving problems when they do not have to hold too many *facts* in their heads. A famous contemporary medical teacher called Lawrence Weed once said: "If you hold a man too long in the memory mode, he cannot function properly in the problem-solving mode". Patients need doctors who will help them solve their problems.

A third characteristic (one might almost say a virtue) is the absence of a history of high clinical prestige. The young GPs we are training today are learning to question the basis of all the judgments of their predecessors, and to be anxious to measure the effectiveness and the efficiency of their own clinical performance.

PERSONAL CARE

Lastly, GPs are not only doctors who provide very personal care to individuals and families who they come to know quite well. They are also doctors who accept a statutory responsibility not only for individuals but also for a whole population. That is to say, they are not only personal doctors but also the managers of health care for defined groups of people — those who are on their NHS lists. This means that in the organisation of their practices, in the *way* in which they allocate time to discuss some of their patients' more difficult problems, *how* they organise well-baby clinics or institute programmes for visiting the elderly, or look for undiagnosed high blood-pressure among their patients, GPs reflect a daily and practical use of epidemiology in the delivery of health care.

Most importantly of all, medical education must include the notion that medicine is about patients before it is about diseases, that medicine should be concerned not with satisfying professional goals but with meeting the needs of society.

BOOK REVIEWS

A PROFILE OF PATIENTS' PROBLEMS
Liverpool Central & Southern CHC, 80 Rodney Street, Liverpool 1. Free.

Three hundred people approached Liverpool Central & Southern CHC for help in 1976. This report contains an analysis of their enquiries and seven detailed case-studies covering problems with hospitals, ambulances, an appeal tribunal and dental treatment. The report makes it clear that it is difficult to make a complaint and that people are sometimes unwillingly propelled towards taking legal action because the information on how to channel their complaint through the administration is not made available to them at the right time. A quarter of all complaints involved other public services and the CHC suggests a need for an extension of the powers of the local government ombudsman.

RESIDENTIAL CARE REVIEWED
Personal Social Services Council, Brook House, 2-16 Torrington Place, London WC1E 7HN. £1.10.

In 1974 the PSSC set up its working group on residential care in response to an invitation by the Secretaries of State for Social Services and for Wales. This is the second report of the working group which covers all types of residential care for adults and for mentally handicapped children. The report concentrates on presenting a framework within which those working in homes and administering them can consider the needs of the residents.

The recommendations are stated in very practical terms and while there is nothing particularly original about them, they do provide a useful check-list. The final section of the Report consists of questions for staff on daily living. The working party believes that staff who are encouraged to think and question for themselves will encourage residents to do likewise. It therefore poses some of the questions that it believes staff should ask themselves with particular emphasis on attitudes and behaviour.

BATTERED WOMEN AND THE NEW LAW
by Anna Coote and Tess Gill. NCCL and Inter-Action. Available from bookshops and NCCL, 186 Kings Cross Road, London WC1 9DE. 60p.

Since the passage of the Domestic Violence and Matrimonial Proceedings Act 1976 the law has been able to afford battered women more protection than before. In simple language, this booklet goes through, step-by-step, the procedures for obtaining an injunction and what happens thereafter, whether a woman has a solicitor or not. The Act applies to couples living together, whether married or not, and there is a section explaining what to do in cases of assault when the couple are not living together. The Act applies only to England and Wales and the authors call for its extension to Scotland and N. Ireland. They also discuss the problems of the men involved and give examples of the documents that would be involved in proceedings under the Act.

SIMPLE RELAXATION
by Laura Mitchell. John Murray, £1.95 p/back, £3.95 H/back.

The book describes Ms Mitchell's method of physiological relaxation — using the muscles, nerves and skin. She outlines the functions of nerves and the ways we react to fear and stress. Simple exercises are described which can be practised at almost any time and there is a section for ante-natal, labouring and post-natal mothers.

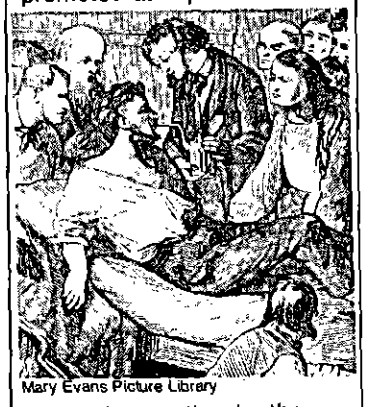
ANAESTHESIA

The search for effective ways to control pain has existed since the earliest times, but it is only in the 20th Century that sophisticated techniques have been developed which allow complicated and lengthy surgical operations to be performed safely. In ancient Greek and Roman times hemlock, mandrake and Indian hemp were used for their narcotic effects, while in China acupuncture was developed. Alcohol was also used to deaden sensation but these Western methods were crude and dangerous and permitted only the quickest operations (e.g. tooth extractions, amputations) to be done.

In 1800 Humphrey Davy published a paper based on his researches as a surgeon's assistant, suggesting that the gas nitrous oxide could be used as an anaesthetic since he found it destroyed the sensation of pain briefly when it was inhaled. Michael Faraday similarly observed this effect when ether vapour was inhaled. These discoveries met with almost no reaction in England except that a young medical student, Henry Hill Hickman, conducted experiments with animals to see if pain could be removed by the inhalation of carbon dioxide gas, but he was refused permission to extend his research to human subjects.

Meanwhile in America the effects of inhaling nitrous oxide and ether had become well-known and were used as the basis of public entertainments put on by travelling chemists at "ether frolics" and "laughing gas parties". It was at such an occasion in Georgia in 1842 that the physician Crawford Long got the idea of using ether as an anaesthetic. He successfully removed a small growth from a patient's neck without causing any pain by using ether.

Similarly in 1844 in Hartford Connecticut the town's dentist Horace Wells was given the idea of using nitrous oxide to deaden the pain of tooth extractions by witnessing one of these entertainments. He used the gas successfully on himself, but at a demonstration later in Boston it failed to work. Wells's colleague W. T. G. Morton took up the problem and greatly improved the practical methods of using these gases for general and dental surgery. The news of these advances spread back to England and in 1847 ether was used for the first time in a major operation. The anaesthetist was John Snow, and in 1853 he administered chloroform to Queen Victoria to relieve the pain at the birth of her eighth child, Prince Leopold. Chloroform had been promoted as a preferable


Mary Evans Picture Library

alternative to ether by the eminent surgeon Sir James Young Simpson. Side effects were a major problem with all these gases, and although they did relieve pain, it was a crude and unpleasant experience for the patients. In addition, the gas mixtures used later (e.g. nitrous oxide with oxygen) were highly explosive and a number of fatal accidents occurred in operating theatres.

Alternative general anaesthetics were only really available after 1932 when quick-acting barbiturates were introduced. By injecting these drugs intravenously, reversible loss of consciousness was quickly induced. Local anaesthetics have also been developed in the last 100 years, mainly using derivatives of cocaine. These enable pain-free operations to be carried out on a particular site without inducing total loss of consciousness.

Modern surgery, which can involve major operations of several hours' duration, is now made possible by a combination of anaesthetics. Intravenous injections are used to induce muscle relaxation and drowsiness rapidly, and complete insensitivity to pain and loss of consciousness is completed by the inhalation of carefully controlled gas mixtures. This technique avoids the use of a face mask — which is so unpleasant — while the patient is conscious, and modern equipment permits the closest observations of the patient's condition during the period of anaesthesia so that any dangerous side effects can be avoided.

JOINT PLANNING AND FUNDING

The concept of co-operation between Health Authorities and Local Authorities was enshrined in the NHS Reorganisation Act 1973. Section 10 of the Act provides for the establishment of Joint Consultative Committees (JCCs) to include representatives of AHAs and of relevant Local Authorities (LAs) within the area covered. One of their functions is to advise the Authorities "on the planning and operation of services of common concern to those authorities".

In April 1976 a new arrangement was announced for joint financing of selected projects. The draft circular (HC(76)18 described in *CHC NEWS No 7*) explained that "effective joint planning is vital to the Government's overall strategy of developing community based services to the fullest extent practicable so that people are kept out of hospitals and other institutions and supported within the community." The services that were specifically mentioned were those for the elderly, the disabled, the mentally handicapped, the mentally ill, children and families and for socially handicapped groups such as alcoholics and drug addicts. The amount available for England in 1976/77 was £8 million.

Following the first year's experience and discussions with the relevant authorities, the DHSS issued a second circular (HC(77)17) in May 1977. This stresses that the aim of joint planning should be for LAs and AHAs to develop strategic plans for several years ahead. The criterion for AHA use of joint financing money is that "the spending is in the interests of the NHS as well as the LA, and can be expected to make a better contribution in terms of total care than if directly applied to the health services". The final decision on the allocation of this money rests with the health authority.

Joint financing arrangements can be considered under three headings:

1. assistance with capital projects
2. assistance with revenue spending a) arising from capital projects whether assisted or not or b) not associated with capital projects
3. arrangements for the use of NHS lands and property.

Proposals for jointly financed projects can be initiated by either authority and should relate only to services which come under the remit of the LA Social Services Committee.

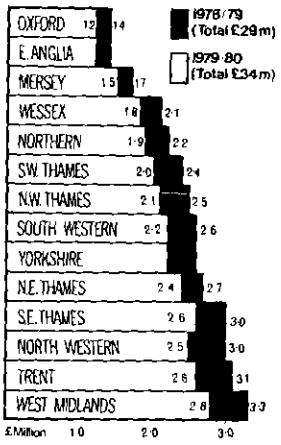
Allocations for joint financing are made to AHAs through RHAs. In general, the criteria for allocation are based on population weighted to take account of people over 75, the mentally ill and the mentally handicapped. AHAs have discretion to apportion funds between capital and revenue as they see fit.

Agreements for support of revenue costs are initially for not more than five years but there can be a review after three years so that support for a further two years can be considered — that is, for seven years in all. The amount of revenue support given is to be tapered so that AHA support may be, for instance, 60 per cent in the first year reducing gradually to, say, 20 per cent in the fifth year and nothing in the sixth. The actual arrangements are at the discretion of the authorities concerned. At the end of the five (or seven) years, the LA has to take on all continuing financial responsibility for the project. Because of current financial stringencies, many LAs feel unable to accept revenue responsibility for future years for capital projects started now so "a significant proportion of these funds" is allowed to be used to support revenue activities for the next few years.

Leases on NHS land and property can be granted to LAs and part or all of the rental paid out of joint financing money. The one proviso is that any change of use of the land or property must have the approval of the Secretary of State and if it ceases to be used for personal social services purposes, the land or property reverts to the Secretary of State.

The numbers and composition of planning teams in health districts are decided by the AHA on the advice of the JCC. Their role is to advise on "essential rationalisation or redeployment and not simply plan for development and growth". Membership is meant to include NHS and LA officers concerned with particular groups and services as well as individuals from outside the NHS or LA such as voluntary bodies or CHCs. Some CHCs do not wish their members to serve on planning teams and some DMTs or

Joint financing allocation by region



AHAs are against CHC involvement. The official view is that "the Secretary of State would wish to encourage CHC membership wherever councils and health authorities favour this approach".

The amount allocated for joint financing in the current year is £21 million and this is expected to rise to £40 million (at current prices) by 1980/81. The allocations are to be spent in full and unused amounts can be carried over to the following year. The money is a separate allocation by the Public Expenditure Survey Committee (PESC) and has not been taken from the budgets of the NHS or Local Authorities.

Some of the schemes put forward under joint financing have included homes and day centres for the elderly; hostels for psychiatric patients; training centres for the mentally handicapped; fire precaution work; extension of home help services; adult education scheme for psychiatric and geriatric patients; hostel for alcoholics; provision of transport, intercom systems, home insulation, aids and adaptations for the elderly and handicapped; sheltered housing; dental service for the elderly; employment of training instructors, educational psychologists, development officers, social workers; assessment unit for handicapped children; mobile screening unit for hearing impaired; financial assistance to voluntary organisations; laundry equipment; heated container system for domiciliary meals service; training kitchen at day centre; social worker attachment to GPs; night sitter service; chiropody aide; radio paging systems.

The money has clearly been — and is being — used in some very imaginative ways as well as for more conventional projects. Problems can arise with housing and education schemes where the LAs responsible for these are not the same as those responsible for social services. If NHS land is used it can only be for personal social services so housing schemes cannot be integrated with the general community.

Joint financing can be seen as a way of removing administrative barriers in order to find the best local solution for those groups of people whose needs now fall between the two services. The scheme has to cope with the historical obstacles of inherited administrative divisions and the contemporary obstacles of current financial difficulties. Nevertheless, it is the only development money available at the moment and it is encouraging that the DHSS is prepared to be flexible in its allocation and use.

Potential hazards in household products

Rev Nigel Ovenden, Chairman of Winchester and Central Hampshire CHC

In January a standard aerosol spray can "Scotchguard Shoe Spray" manufactured in the USA by the Minnesota Mining and Manufacturing Company was referred by the CHC to the District Community Physician for comment because the small print "caution" was considered inadequate relative to its content which included Trichlorethane, a chlorinated hydrocarbon similar to chloroform.

The DCP sent the container to the Chief Health Officer of the Winchester City Council who agreed that on the advice of the County Public Analyst and Scientific Adviser, while the constituents of the spray were normal commercial ingredients, nevertheless, if Trichlorethane were to be inhaled in sufficiently dense concentration the effects could be harmful. On the point regarding whether or not the cautionary labelling on the canister gave adequate advice to the user, the matter was referred to the County Consumer Protection Officer (CCPO) of the Hampshire County Council.

The CCPO agreed that in view of the potential hazards presented by household products such as this, adequate warning should be given on the container in a conspicuous form. He then undertook to forward the container to the Consumer Safety Unit of the Fair Trading Division of the Department of Prices and Consumer Protection with a suggestion that this product should be one of those considered for inclusion in any proposed EEC regulations. The Department's comment about the propellant used was "one of the most widely used of all aerosol propellants and the solvent used is regarded as one of the safest", therefore both components would be quite acceptable under reasonable conditions of use. The Department added, "the extract (on the label) about intentional misuse concerns the potentially fatal practice of sniffing and not a reasonable condition of use as already mentioned." The CHC was asked to reply to the Department's comment which it did saying that the caution given was so obscure that in its present form anyone with imperfect eyesight would be at a disadvantage and would have to use a magnifying glass.

On this point of inadequate size of lettering used to promote the warning on the container, the CCPO pursued the matter further with the Department and wrote back to the CHC to say that the Consumer Safety Unit accepted the criticism and it was their intention to suggest to the suppliers that this be put right. The suppliers have now accepted that the present method of wording is confusing and they have obtained from the manufacturers in the USA permission to dispense with much of the wording on the container which will enable larger lettering to be used for the warning. New containers are now being prepared and delivery is expected in August.

The foregoing saga has taken up a good deal of time in a number of different locations, however, if it has prevented even one admission to hospital or possibly fatal accident, in the opinion of the CHC the exercise has been worthwhile.

Community care in Suffolk

John Swain, Member of Ipswich CHC

In 1971 the Royal British Legion asked Needham Market town council if it would look into the possibility of a welfare committee to cover the whole town. After several meetings of interested people a community care committee was formed, supported by 21 organisations.

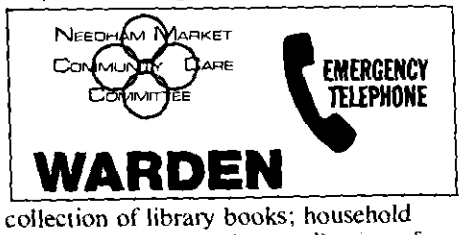
The object of the exercise was, and still is, to promote the welfare of the community living in the town by relieving distress or sickness and improving the quality of life of the persons for whom the facilities are intended. The town has over 350 pensioners and 10-20 at risk (a person considered not to be independent and needing daily assistance).

The main committee is responsible for overall policy, the selection of Head Warden, wardens and assistant wardens who are picked from volunteers for their ability and qualifications for the job. The wardens are given areas of up to 30 dwellings but from experience in some areas a warden could cover up to 100 houses.

The wardens have the names and addresses of all people in their area and all relevant information concerning whether they are deaf, registered blind, diabetic, heart condition, war pensioner etc. The Head Warden has a phone and each warden a window notice.

THE PUBLIC MUST GO TO THE WARDEN

The services and aid that can be given in an organisation of this type are: visits to hospitals, nursing and convalescent homes;



collection of library books; household duties; help with gardens; collection of medicines; shopping for housebound; wireless and TV sets; transport to hospitals and for urgent need; warning lights and buzzer for those at risk; advice on rate and rent rebates etc; social services, social security etc; obtain qualified tradesmen (electrician, plumber etc.) to deal with home hazards; help and advice on home aids for the handicapped; supply of furniture, beds and bedding, floorcovering, etc — requests are made in the town newsletter published monthly; supply of aids for sick and elderly on demand; after care with discharged psychiatric patients by visit and daily phone contact.

This is a fairly comprehensive list built up over six years and can be altered to suit the need within available resources. A scheme of this sort readily commends itself to the general public and finance is not difficult to raise. This scheme for about 3,000 people costs under £250 per annum, mostly on transport and phone calls.

The wardens keep no written records of cases (confidentiality) and a minimum amount of paperwork is used — just minutes and an annual report. Cooperation with all other organisations, doctors, hospitals etc. has been first class. Appropriate lectures, film shows are given to wardens. The Head Warden arranges warden meetings when required. The scheme seeks to help in a most fundamental and acceptable way, a whole range of people who may have little or nothing in common except the need of friendly caring eyes and a sympathetic willing hand. However friendly and helpful a community may be, a scheme of this sort commends itself to a whole range of other communities too, and particularly in towns where incidents of old people being found in rooms days after death are unfortunately not uncommon.

The organisation is non political and seeks to serve all.

SALE OF NHS LAND

Several CHCs have already been involved in discussions about the disposal of NHS land and buildings from which health services are no longer provided. As more closures take place this issue can be expected to grow in importance, with CHCs voicing their views about the disposal of valuable resources located within their districts.

The Secretary of State has power to acquire land under Section 58 of the 1946 NHS Act and Section 53 of the 1973 NHS Reorganisation Act, but his power to dispose of land, buildings and other interests had no such statutory basis. Power of disposal derives from Treasury Circular 1/66 *Disposal of Surplus Land by Government Departments*, overall responsibility for which now rests with the Department of the Environment.

Before the 1974 reorganisation, land sales were handled centrally by the DHSS, which encouraged Hospital Boards to identify surplus land and acted on their recommendations for disposal. Proceeds from land sales were refunded, via the Department, to the Exchequer.

On 20 March 1974 the Secretary of State issued Directions to RHAs, under Sub-sections 7(1) and 7(5) of the 1973 Act, which devolved disposal powers to the regions. Further Directions dated 17 December 1975, the *Health Authorities (Land Transactions) Directions 1975*, allow RHAs to devolve to AHAs the power to lease NHS land "for a period not exceeding three years".

Receipts from land sales were passed to the Department, which fed them back to the RHA's concerned, phased over several years, as "land sale supplements". This procedure has not been overtaken by the introduction of cash limits (see cash limits and capital spending Circular HC(77)6, March 1977). Under the new arrangements receipts from land sales are retained by the RHAs, and are "available to finance any category of capital spending" (see para 12 of HC(77)6). The need for land sales supplements has therefore ceased, except in the case of some transitional arrangements.

On 13 June this year Roland Moyle told Parliament that proceeds from the sale of surplus hospital land should be spent "in accordance with strategic and operational plans drawn up by AHAs and agreed with RHAs". However, the DHSS also says it recommends RHAs to "take into account the interests of the Area concerned" when spending such sums.

When an RHA has decided that a piece of its land is surplus to NHS requirements, it will begin the following procedure:

1) Before declaring the land surplus it will contact the relevant local authorities and Joint Consultative Committees, to see if there is a local need for the land or premises to be used in the personal social services field.

2) If no such need exists it will declare the land surplus, and will circularise Government departments, all relevant local authorities and the Housing Corporation. If the land is passed to another Government department no money will change hands.

3) If none of the above bodies shows interest, the RHA may offer the land to any voluntary organisation providing a service related to health or personal social services.

4) Finally it will attempt to dispose of the land on the open market, taking advice from the District Valuer.

Details of this procedure are laid down in the Department's *"Handbook on Land Transactions"*, an updated version of which should be published this month. There are no specific provisions for CHCs to be consulted on land sales, but they will generally be aware of such proposals by stage one of the above procedure.

The recent Circular on joint care planning (HC(77)17, May 1977) gives detailed suggestions for the use of NHS land (Appendix 1, paras 20-22). This "represents a considerable potential asset for the development of services of joint concern", which should be "kept in view in all joint planning". In some cases joint financing can be applied to NHS land "to the economic advantage of both parties", through leasing arrangements in which the local authority or the AHA might contribute part or all of the rental.

From the AHA point of view, the Circular comments that "sums from the joint finance allocations, to support payments due from the local authority, will be available along with any sum actually received from the local authority, to finance spending on health services".

Some voluntary organisations are pressing nationally for surplus NHS land to be sold, and the money so raised put to work. In 1975 a joint publication* by MIND, the Campaign for the Mentally Handicapped and The Spastics Society proposed that large mental illness and mental handicap hospitals should be sold and the proceeds used to resettle residents in small-scale community developments. The three organisations noted that land occupied by hospitals of this type, with over 200 beds, totalled about 25,000 acres in England alone.

**HOSPITAL LAND – a resource for the future? July 1975, 25p from MIND, CMH or The Spastics Society.*

Parliamentary Questions

ECT TREATMENTS

In answer to a question from Bryan Gould MP, Roland Moyle said that statistics on ECT treatments are not kept centrally at the DHSS. According to the Royal College of Psychiatrists the usual number of treatments per patient is about 6 although in some cases it may be necessary to give 12 or more over a period of weeks.

BURNS UNITS

Replying to a question from Michael Ward MP, Roland Moyle said that a sufficient provision of beds in specialist burns units is approximately 0.8 per 100,000 population. A burns unit should normally serve a whole region and be associated with a major plastic surgery department.

HEARING TESTS

The DHSS is undertaking wide-ranging consultations on the Court Report's recommendation that all children be screened for hearing at about the age of eight months. Replying to a question from Laurie Pavitt MP, Roland Moyle said that AHAs arrange for children to be tested for specific defects at key ages and this can be done in the child's home by a health visitor.

INVALID TRICYCLES

Alfred Morris gave a firm undertaking that the Government's aim is to make sure that no-one who is now mobile is made immobile by the phasing-out of the tricycle. He was replying to a question from Robin Corbett MP.

TUBERCULOSIS

The Joint Committee on Vaccination and Immunisation has recommended that immigrant children should be vaccinated with BCG, either as soon as possible after entry to this country or at birth if born here. Immigrants are normally seen at ports of entry by a medical inspector and screening arrangements in countries of origin include X-ray examinations where necessary. This information was given by Roland Moyle in reply to questions from John Hannam MP.

SPEECH THERAPISTS

There were 860 speech therapists in post (whole time equivalent) at 30 September 1975 compared to the long-term target of 2134 based on the recommendations of the Quirk Report in 1972. Eric Deakins gave these figures, together with a regional breakdown, in reply to a question from Dafydd Wigley MP.

NOTES.....

BENEFITS FOR THE DISABLED
The Disability Alliance has published a detailed critique of benefits paid to disabled people. It analyses the recent impact of inflation and shows how cutbacks in subsidies and social services expenditure have reduced living standards. A number of case studies are included as well as correspondence with the Secretary of State for Social Services which provides some illumination on Government thinking. *Living Standards in Crisis* is available from The Disability Alliance, 96 Portland Place, London W1, price 50p plus 15p postage.

TOBACCO SUBSTITUTES
Action on Smoking and Health (ASH) has called on the Government to implement a firm code of conduct for the advertising and marketing of cigarettes containing tobacco substitutes. ASH is concerned that most of the "new" cigarettes contain 75% tobacco and have a tar-yield that makes them virtually indistinguishable from middle-tar cigarettes.

ASSOCIATION OF CHCs
The Standing Committee has decided on its procedure for choosing nominees to any national bodies or committees. Normally, member CHCs will be asked to put forward names of suitable candidates before the Standing Committee decides who to nominate.

RECEPTIONISTS' TRAINING
The Association of Health Centre and Practice Administrators is holding a residential weekend course in Yorkshire 28-30 October. It is hoped that the course will assist doctors, managers and administrators in their role as trainers and particular emphasis will be given to the training of receptionists. The costs to non-members is £32 and further details can be obtained from Miss C Flanagan, Haxby and Wigginton Health Centre, The Village, Wigginton, Yorks.

WAITING LISTS
The Health Services Board has recommended that responsibility for admitting patients to hospital from waiting lists should remain with consultants and that a patient's place on a waiting list should normally be related to the date he or she is first referred by his or her GP. The Government has asked for comments on these and other recommendations by 30 September from a number of bodies including CHCs.

HC(77)19 DHHS PLANNING GUIDELINES FOR 1977/78
This circular sets out the main planning tasks for health authorities for the current year and also give amounts for capital programmes, revenue figures and joint financing for each RHA for the next two years. For the period beyond 1979/80, RHAs are asked to assume similar revenue growth rates, allocations between regions and capital resources to those for the previous three years. But for both revenue and capital spending, planning should be sufficiently flexible to take account of the possibility of significant variations either way. Guidelines on manpower are given and approval for new consultant posts in some specialities will be limited for the next two years, mainly because the supply of trained candidates is likely to be substantially less than the demand. Guidance on prospects for Senior Registrars and Registrars is to be given in future years.

ROYAL COMMISSION EVIDENCE
Residential care of the mentally handicapped should be taken out of the hands of the NHS and responsibility given to Local Authority Social Services Departments. In its evidence to the Royal Commission on the NHS the National Society for Mentally Handicapped Children also says that it considers use of NHS resources on residential services improper because mental handicap is a life-long disability and not an illness.

DENTAL SURVEY
Students at the Polytechnic of North London have carried out a survey, sponsored by Islington CHC, into dental care among elderly residents of Islington and Hornsey. The majority of people in the sample wore dentures and made very infrequent visits to the dentist. The recommendations call for a dental service geared to the special requirements of the elderly and for increased information and advice on maintenance of teeth and dentures. The report costs 30p (10p for pensioners) from Dept of Extension Studies, Stapleton House, N London Polytechnic, Holloway Road, London N7.

SECURE UNITS
A working group has been appointed by the DHSS to give practical help and advice to RHAs on setting up secure units and on making interim secure arrangements in the meantime. It is not a policy forming or decision making body. The group's 19 members have been nominated by NHS authorities, the Royal College of Psychiatrists, the Royal College of Nursing and the TUC.

ABORTION BILL
81 CHCs were among the 244 organisations in England and Wales which responded to the DHSS' consultation letters on the Abortion (Amendment) Bill. 127 of these were generally opposed to the Bill against 24 who generally welcomed it. A further 28 gave a qualified welcome to the Bill and 65 made no general comments. Many organisations expressed the view that the restrictive nature of the Bill would lead to the reintroduction of abuses which had existed before the 1967 Abortion Act. None of the medical organisations consulted was in favour of the Bill and the only group of organisations consulted which was constant in its general support for the Bill was the police. David Ennals has said that one of the reasons he is against the Bill is that it will do nothing to improve NHS provision.

Pollution watch *continued from page 3*

and screening for families and children who live around the BNFL works. As in North Derbyshire there is a local authority/industry liaison committee, and again the CHC has been refused membership. The reasons given were that the AHA was already represented on the committee, and that several CHC members were also on the committee in other capacities.

Yet there are some hazards for CHCs in getting involved with environmentalists. In Wolverhampton last year, for instance, the CHC came under pressure from the public to oppose the building of a new galvanising plant near a housing estate at Strawberry Lane, Wednesfield. Residents were concerned that zinc fumes from the factory stack might affect their homes, and it was also possible that the nearby New Cross Hospital might have been affected.

Representatives of the General Galvanisers company and the Strawberry Lane Action Groups spoke at a public organised by the CHC, but the CHC later decided not to support the action groups. At one stage it appeared that the residents would make a maladministration complaint to the Local Ombudsman, on the grounds that the then CHC chairman was also chairman of the local authority planning committee which had already approved the new development. The factory is now being built, and the CHC has not yet been notified of any complaint.

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 15: NW Herts CHC
Chairman: Denis Perrett
Page 18: Basildon & Thurrock CHC
Secretary: Maureen Narbeth
Page 25: SW Surrey CHC
Secretary: Eve Mervyn-Smith
Page 29: Basingstoke & N Hants CHC
Chairman: Mrs E M Dibben
Telephone: Basingstoke 50348
Page 38: Sandwell CHC
Chairman: Albert Handley
Page 44: South Manchester CHC
Secretary: Neil Pearlman

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.