CHC NEWS

For Community Health Councils

October 1977 No 24

Campaign by CHCs rescues St Wulstan's

The West Midlands RHA has dropped its plan to close St Wulstan's Rehabilitation Hospital, at Malvern. This follows a campaign spearheaded by West Midlands CHCs, co-ordinated by their regional association, and supported by other groups such as the National Schizophrenia Fellowship.

In its consultation document of January, 1977, the RHA claimed that rehabilitation facilities comparable with those at St Wulstan's were available elsewhere in the region. But the objectors — including 15 CHCs — showed that this was not the case, even though alternative facilities were being built up. Only three of the 22 West Midlands CHCs supported the RHA proposals.

Most objectors argued that the closure should be deferred until these alternatives had reached acceptable standards, and the RHA has now undertaken not to re-open consultation on St Wulstan's until 1981.

The hospital lies in the Worcester Health District, and CHC secretary, Barrie Essex, believes that until his council contacted other CHCs in the region, its role as a centre of excellence and the inadequacy of alternative facilites had not been fully understood. "Now there is a greater appreciation of St Wulstan's pioneering work. Closure is still on the cards in a few years' time, but at least the staff now know where they are.

"The regional association was a very appropriate forum — it helped us to impress on other CHCs that St Wulstan's was their problem as well as ours."

Dr. Rod Griffiths, chairman of the West Midlands Regional Association of CHCs, said the decision showed the value of CHCs pooling their information to mount a co-ordinated response to regional proposals. "It shows the importance of challenging a lot of the documents which emanate from the regions, which do not always present information impartially."

St Wulstan's was set up in 1961, to provide industrial and social rehabilitation for psychiatric patients, mainly long-stay schizophrenics. The hospital pioneered the "community psychiatric nursing" approach, in which nurses stay in close contact with patients after they are discharged into the community.

Since 1961 it has accepted 1,200 patients, with an average ten years in other mental hospitals prior to admission. Most have come from within the region, but others have been accepted from elsewhere in England and Wales. Around 40% have been successfully rehabilitated.

The way forward

Last month CHCs received copies of a new statement from the DHSS on health and social services priorities for the next ten years (with circular HN(77)140).

Greater support in the community, emphasis on primary care, services for the elderly and disabled, the mentally ill and handicapped, and prevention are its main points.

INSIDE....

A kidney transplant donor card has been included with this issue of *CHC NEWS*. If you decide not to use it you could pass it on to someone else who might. For further cards send SAE to British Kidney Patient Association, Bordon, Hants.

News in brief

RAWP next year

Money for the health service will be allocated to the regions for the next financial year (1978/79) in the same way as it has been for the current year.

David Ennals announced on 19 September that the same RAWP formula would be used again, even though he had received several suggestions for modifications — particularly that the population base and price/cost levels in the formula should be changed.

A working group is being set up to advise Mr Ennals on any changes he should make to the formula in the future.

Front page news

A copy of our June front page — featuring the growth of the patients committee movement — has been sent by SE Cumbria CHC to every GP in its district. Two have already expressed an interest in the possibility of patients committees being formed within their practices.

Mental Health

From the 23rd to the 29th of this month MIND in England and Wales, and its equivalents in Scotland and Ireland, are running Mental Health Week, a campaign of action and publicity. Volunteer helpers are needed for local activities: contact MIND locally or ring 01-637 0741.

Term of office

Regulations are being prepared by the DHSS which extend by two months the term of office of those CHC members who were due to finish at the end of June 1978.

YOUR LETTERS

UNDERSPENDING — OURS OR THEIRS?

Geoffrey Callaghan, Secretary, Lincolnshire North CHC.

The article in *CHC NEWS 22*, "Making the most of our money", was disturbing. The right of a Council to recommend a use for unspent budget allocations is accepted and a few pounds under or over is not the issue. But a "saving" of £2,000 on a CHC budget certainly is.

First, I find no reason to assume that unspent money is "ours". True, a forecasted need might not arise, in which case the surplus is not needed and should be surrendered to the providers — for it is "theirs". Should the Region offer the surplus for local disposal there is no problem, but it is hard to envisage a Region which would not first wish to consider the position of all its CHCs. After all, what about the Council hit by a quite unforeseeable expense or which could use a little extra for some urgent project? If the surplus is ours then so is the deficit!

Secondly, the article is disturbing in that the "saving" involved implies that Councils, and specifically Secretaries, are "thinking of a number and doubling it". In reality most of us put considerable effort into budget calculation and expenditure management.

I believe Secretaries have no authority to suggest that Councils have an automatic right to play Fairy Godmother with substantial unspent monies. What do others think?

VOYEURISM AND GP TRAINING

Josie Hicks, London N7.

As a medical student at "one of the great London teaching hospitals" I have sympathy with much of what Professor Marinker has to say about medical education (*CHC NEWS 22*). Perhaps part of the problem is that most medical students start their training straight after school, and have very little experience of being "Men (or women) in society" themselves. Courses such as the one at Leicester enable students to become voyeurs of human behaviour in the hope that they will use these ideas and experiences as they formulate their approach to their work as doctors. I am sure it is better than nothing.

I was lucky enough to have some experience of general practice with a group of doctors who are providing a level of primary care undreamed of in most practices, because they all have specialist skills and a lot of hospital experience. They are able to undertake 70 per cent of the surgery and 98 per cent of the casualty treatment required by their practice, and so their patients get continuity of care from their own doctor and his partners.

Of course these doctors know their patients and what makes them tick, but they also know how to deal with the large amount of real clinical pathology which they meet — without having to refer their patients to remote specialist centres. Surely this is what most people would ask of their primary health care service?

PUBLIC SHOULD DECIDE ON FLUORIDE

E. C. Walker, Secretary, Calderdale CHC

Sir George Godber (*CHC NEWS 21*) adopts the usual professional attitude of dismissing opposition to fluoridation as either unacceptable to a scientific person, or as unreasonable. He suggests that fluoridation simply brings the amount of fluoride in water supplies to a safe level. Fluoride in most water supplies is already at a perfectly safe level without adding more. To suggest that fluoridation is comparable in any way with fluoridation is comparable in any way with pasteurisation of milk really does stretch the imagination to its extreme limit. Fluoridation can only be seen as mass medication, whichever way one looks at it, whilst pasteurisation of milk makes the produce safe for human consumption without adding or taking away anything.

CHCs are there, as he states, to interpret the wishes and needs of the public. This is the reason why some CHCs oppose fluoridation, not because they are swayed by unscientific argument. Where the community in a district, as is the case here in Calderdale, expresses through the local authority, other bodies and the press the view that it does not wish its water supply to be used as a vehicle to ensure that each member of the population takes his or her daily undefined dose of fluoride, then the CHC has a duty to oppose fluoridation by all means available.

The decision on fluoridation should be taken by the community not the experts "who know best".

HEALTH AND SAFETY IN THE NHS

W. Appleby, Secretary, Central Derbyshire CHC

The provisions of the Health and Safety at Work Act, 1974, as regards safety committees and safety representatives come into force as from 1 October, 1978. This will lay a very heavy financial burden on the various Health Authorities, and at the moment many of them have no idea where the money will be coming from.

My Council has protested to the DHSS that if the Government wish to implement this Act they should find the money to enable the Health Authorities to carry out the various regulations. The Department has intimated that it is very much aware of the financial implications, and will be issuing guidance before the regulations come into force.

It is suggested that all CHCs should press this matter at national level, in order to ensure that Health Authorities are provided with the necessary finance to carry out the duties imposed upon them by this enactment.

VOLUNTARY ORGANISATIONS AND JOINT FUNDING

Frank Topping, Secretary, West Surrey and NE Hampshire CHC

Your article on joint planning and funding, in *CHC NEWS 22*, was interesting and informative, but I was disappointed that no mention was made of joint funding for schemes originated by local voluntary organisations. These are often able to identify a need and prepare proposals of sufficient merit to attract the support of the Health or Local Authority.

In this District, the West Surrey Society for Mentally Handicapped Children is developing a scheme for a hostel for up to 20 mentally handicapped residents. These would come either from hospital (possibly via a hostel run by Social Services) or from the community, where ageing parents are often concerned about the future of their mentally handicapped children when they are no longer able to look after them. There are indications that such a scheme, involving perhaps up to £80,000 of initial capital, with a decreasing level of revenue support, will be acceptable to the AHA provided that the project is shown to be viable beyond reasonable doubt.

EQUAL OPPORTUNITIES

June Ayling, Secretary, Maidstone CHC.

We have recently had a number of cases where terminally ill wives have not received adequate care because their husbands refuse to pay nominal sums for home helps, etc., and the wife in her own right cannot be recognised because she is not a "householder". The Equal Opportunities Commission tell us that this is outside their jurisdiction, but that they have made representations to extend their role in view of various anomalies relating to Social Security.

We wonder whether other CHCs have come across this dreadful plight, and whether they will join to press for changes and support the EOC in their endeavours to extend their role.

OUR DIRECTORY — RIGHT OR WRONG?

Judie Langton-Lockton, Secretary, Kings CHC, 75 Denmark Hill, London SE5 8RS

Could people please update their CHC Directories, using the Directory Corrections published every month on the back page of *CHC NEWS*? We are still getting mail from other CHCs redirected from St Giles' Hospital — one year after we moved!

When your kidneys FAIL....

Every year about 2,000 people in England and Wales develop chronic renal failure — their kidneys permanently lose the ability to filter waste products out of the blood. If these people are to live they need immediate treatment by "haemodialysis" (i.e. on a kidney machine), and in the longer-term many could benefit from a transplant.

Guido Pincherle, a Senior Medical Officer with the DHSS, has estimated (1) the total need for such treatment as follows: 1,500 transplants per year, 2,650 hospital dialysis places and 5,200 patients dialysing at home. In 1975 some 540 transplants were done, 620 patients were on hospital dialysis and about 1,300 were dialysing at home. These figures show clearly that thousands of people who could have benefited from dialysis and transplantation are dying because of a shortage of these facilities.

In 1976 the UK had 43 dialysis patients per million population, the second lowest figure in the EEC. France's figure was 107, West Germany's 97. In 1975 the figure for the USA was 95. Looked at from the point of view of the number of hospital dialysis units per million population, Britain was 21st in the 1975 European "league table", with a figure lower than Spain and Greece. The proportion of British kidney specialists to patients with kidney diseases is the lowest in Europe. (1, 2, 3)

The DHSS also admits that "considerable regional variations" exist in the provision of dialysis facilities (1, 2). Regional figures for combined hospital and home dialysis per million population, in June, 1975, include the following: NE Thames 85, Oxford 63, SW Thames 11, Wessex 21, West Midlands 22, Wales 40; English average 39.

Because of these shortages, the first — crucial — question for people with chronic renal failure is whether they will be accepted for dialysis. This decision rests with the dialysis unit's consultant nephrologist, possibly in consultation with the unit's psychiatrist, medical social worker, home dialysis administrator and registrar. Factors which might be taken into consideration include age, severity of illness, likelihood of rehabilitation, availability of support from a relative, psychological maturity, ability to keep strict rules about diet, personal and home cleanliness, and intelligence. Statistically, young adults with no medical complications to their illness have the best prognosis, and people of average intelligence tend to cope best with home dialysis.

In general there is a hospital dialysis unit for every two AHAs in England and Wales. A DHSS Circular (4) explains that units "aim to rehabilitate the patient to the stage of being as self-reliant as possible . . . training the patient to carry out his own dialysis at home, usually assisted by a relative who will also receive some training in the unit . . . training can usually be completed within about three months . . . the medical staff of the dialysis unit have full clinical responsibility for the treatment of home dialysis patients".

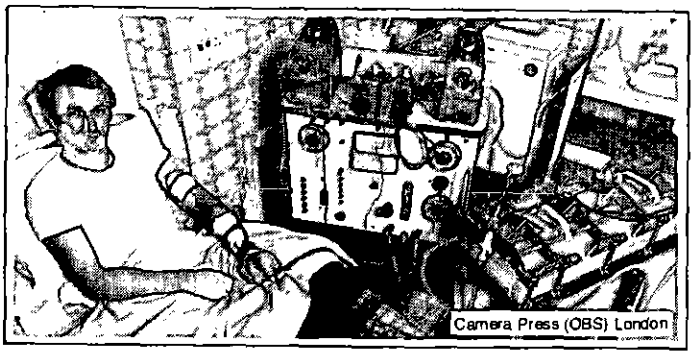
The Circular also details the AHA services and other DHSS benefits to which home dialysis patients are entitled. The AHA must provide and maintain the dialysis machine, provide the necessary drugs; dressings and concentrates, pay for electricity to run the machine and heat the dialysis room, and meet the installation costs and rental for a phone if one is not already available. It must adapt the patient's home to create a suitable dialysis room — by modifying a spare room, building an extension or providing a mobile "cabin". When the Circular first appeared it laid down that no charge for home adaptation was to be passed on to the patient, but the DHSS now says that AHAs can charge at their discretion. Normally they only do this in certain cases where a patient's property has been enhanced by an extension. Where modification is not practicable, rehousing must be arranged through the local housing authority.

AHAs have a duty to be aware of every home dialysis patient in their area so that health visitors are kept informed, and to enable RHAs to arrange for standby electricity supplies during major power cuts. AHAs should also keep local authorities informed, in case social work support or special arrangements for the disposal of dialysis waste are needed.

Home dialysis is preferable to hospital treatment, provided the patient can cope, but it is not a bed of roses (5, 6). A Havering CHC working party on local facilities for kidney patients found that: "Life in the patient's home revolves round the machine . . . Some people try to hold down a full-time job, and that means dialysis at night. A relative has of course to be trained to work the kidney machine and that leads to a fair amount of lost sleep for them . . . Patients are often exhausted when they come off the machine and may require attention. Other members of the family, particularly children, may develop a feeling of neglect and even resentment. The machine may seen like a rival for affection. After dialysis, patients may be extremely irritable and lose patience easily."

Havering identified 16 home dialysis patients in its district. Of the 12 who replied to a CHC questionnaire, ten were satisfied with their machine but eight felt that adequate arrangements did not exist to cover days when their relative/helper was sick or away. The CHC then suggested that a small group of nurses be trained to cover these occasional emergencies, and their local kidney unit has now offered to give special training to community nurses seconded by the DMT. The CHC's research also uncovered details of a local association for dialysis patients, and of two holiday schemes for dialysis patients, bookable through nearby kidney units.

One way to relieve the pressure on treatment facilities would be to improve response to the DHSS' Kidney Donor Transplant Scheme. Transplants are a cheaper form of therapy and offer patients a more natural way of life — though the intense disappointment of kidney rejection is still a risk that has to be taken. Gloucester CHC has broken new ground in this field by contacting large firms in its district, asking if they would like supplies of donor cards. Response to this has been encouraging, and the CHC has also distributed an explanatory leaflet called "The need for more kidney donors".


Camera Press (OBS) London

FURTHER READING

1. Services for patients with chronic renal failure in England and Wales, by Guido Pincherle, Health Trends, May, 1977, p41.

2. Distribution of nephrological services for adults in Great Britain, report of the Executive Committee of the Renal Association, British Medical Journal, 16 October, 1976, p903.

3. Parliamentary Question, Stephen Ross MP, Hansard, 20 July, 1977.

4. Services for chronic renal failure, DHSS Circular HSC(IS)11, March, 1974.

5. Life on a kidney machine, by Jo Campling, New Society, 26 June, 1975, p770.

6. Home dialysis, by Pat Gordon, British Journal of Hospital Medicine, May, 1973, p629.

Literature on dialysis, transplantation and donation is also available from the British Kidney Patient Association, Bordon, Hampshire. Tel: Bordon 2021/2.

Grassroots CHC Panel

Dr Rod Griffiths
Chairman of Central Birmingham CHC

Just over a year ago, Central Birmingham CHC decided to try and establish a panel of people in the community who could act as a sounding board by answering regular questionnaires, on subjects such as priorities in the NHS, cuts and GPs. We felt that "representative randomised validated sampling" would be too costly as a regular tool, and by collecting details about the makeup of the panel we could allow for bias in the sample.

Secondly the panel could give us an outward channel through which to push information into the community, and for this we certainly needed people who had selected themselves on grounds of keenness, connections and interests. Our target is to recruit 500 or so people to the panel, and so far we have over 100. Recruitment tends to be slow, and is largely the result of an active process on our behalf.

We sent out initial publicity about the panel via every channel we could think of. Voluntary organisations, the churches and personal contact have proved most successful, although the local radio station and a free advertising newspaper have produced a number of useful contacts from outside our district. This seems to suggest that our own local network is a better communication channel than the traditional media — which cover much greater areas than even our AHA, let alone our health district. Recently we have been using paid adverts inside buses, which have increased enquiries to the office and should swell the panel in due course.

Office time spent on servicing the panel is reduced by using an addressograph machine, but analysing replies is time-consuming. The same would be true of any other sampling method, and other methods would not have the economies produced by a relatively static list. The response rate to questionnaires is high, and we try to maintain interest by sending the annual report when available and a newsletter with each quarterly questionnaire. Panel members' opinions were surprisingly uniform on cuts and priorities, and largely reflected those already expressed in the council (the same social bias, perhaps?) Some of the specific points mentioned have led to action by the council which might not have been stimulated in any other way.

Is it worth it? Certainly in our context — with a hostile AHA — any backing we can muster is vital. We can at least show that we represent something that does exist in the community, and we can much more clearly identify sections of the population and parts of the district that we are not sampling as yet. We may need to tackle these in different ways. What is clear is that there is a reservoir of enthusiasm and willingness in the community to apply their minds to the questions we ask. The replies leave little doubt that we are only seeing the tip of the iceberg as yet, and that community participation has vast potential.

More staff for CHCs

A number of CHCs have been using extra staff through the schemes Commission (MSC) such as Job Creation Programme (JCP) and the various training and employment schemes for young people. (For more details see *CHC NEWS* No 8.) Next year, opportunities for unemployed people will be somewhat simplified and here we give brief details of the proposals.

UNDER-19s

The new programme for unemployed young people aged 16-18 will go under the title of Work Experience. The two main elements of the programme will be courses to prepare young people for work and work experience projects on employers' premises, in training workshops, community service etc. It is hoped that at least 234,000 young people a year will participate. A standard allowance of £18 per week will be paid and places will normally only be available to those who have been unemployed for at least six weeks since leaving school. Opportunities provided under the programme will normally be for a maximum of 12 months. Each programme or project is expected to include four elements: induction, planned work experience, training or further education and counselling.

ADULTS

For unemployed adults aged 19 and over the new programme is to be called Special Temporary Employment Programme (STEP). It is aimed to provide up to 25,000 jobs for adults in sponsored projects. The criteria for these will be broadly similar to those of the present JCP. When temporary jobs under STEP are to be filled, preference will be given to people aged 19-24 who have been continuously unemployed for more than six months and those aged 25 and over who have been continuously unemployed for a year or longer. There will be an additional 8,000 vacancies for adults to help supervise the Work Experience programme. All adults will be paid wages at the appropriate negotiated rate. It is anticipated that projects will mainly be concentrated in areas hardest hit by unemployment.

TIMING

The existing JCP will take applications until 31 December for projects which may commence up to 31 March 1978. From April onwards, implementation of the new programmes will start, leading to full-scale operations by 1 September 1978.

ORGANISATION

It is proposed to establish 21 Area MSC units (three of these in Scotland, two in Wales) which would replace present offices. Areas would cover specified local authorities and each area would be under a Board composed of representatives of employers, trade unions, local authorities and voluntary organisations.
Funds would be generally be allocated to each area on the basis of unemployment figures for that area. Handbooks for sponsors will be produced which will contain suggestions and information rather than rigid guidelines.

CHCs

CHCs interested in using staff under any of the existing or proposed programmes should contact their nearest MSC office (get the address from your local Employment office). Bear in mind that a CHC does not have the power to employ staff. Although it can conduct all negotiations for a project an 'employer' will have to be found, for instance, a health authority or a local voluntary organisation.

PERSONAL VIEW

Members should be directly elected

Frank Topping, Secretary of West Surrey and NE Hampshire CHC.

Newly appointed CHC members occasionally wilt visibly when they realise just how much time and effort is needed to fulfil the commitment they have made, and the fairly rapid turnover of members suggests that CHC activities are not being given the same level of priority as the member's prime interest. There is the further problem that, in districts other than those comprising tight-knit urban communities, the geographical spread of membership is often uneven, with pockets of over- and under-representation tending to foster parochial interests. This makes the accurate identification of community needs difficult and limits the options that are considered for discussion.

It seems to me that to resolve these dilemmas it is necessary to look at the way in which members are chosen. Local authority appointments make up at least half the membership, and — although individual councillors are excellent — we all know the councillor who missed the relevant council meeting and found himself on the CHC. The complexities surrounding the election — and particularly replacement — of voluntary organisations members do not bear thinking about, so we are left with the RHA appointments that seem to be made with the minimum of fuss. I find it interesting that no-one can achieve membership of a CHC other than via an intermediary. A keen, knowledgeable individual, who doesn't belond to a political party or to a voluntary organisation, cannot by his or her own efforts achieve membership.

Would not the whole procedure be simplified and would not a more balanced representation result from a system of direct elections for all CHC members on a straightforward first-past-the-post basis? I visualise relatively few difficulties in such elections, and would support these being held in parallel with and for the same terms as local authorities. There is considerable evidence to suggest that citizen involvement is greatest in populations between 8,000 and 20,000, and this indicates that the local authority ward system would provide an ideal base size.

Whenever I have outlined these proposals, there have been two objections immediately raised: cost, and the involvement of party politics. There are other objections, but these are the popular ones and must be considered. The parallel election proposals would naturally necessitate expenditure on printing and publicity, and the additional costs associated with vote counting, but these costs would be partly offset by the standardised procedures and the benefits of the increased stature and credibility that would accrue. Party political involvement does not appear to me to be a problem, since already over half CHC membership is appointed via political groups, and, in virtually all forms of public service, political considerations are included in deliberations and decisions.

I see the advantages of having an even geographic spread of membership, together with a larger proportion of members with an active commitment, due to their being accountable to an electorate, as outweighing the cost disadvantage and enabling CHC to make a more positive contribution to the future health of the nation.

News from CHCs

● Exhibitions are a focus of activity for several CHCs this autumn. Weston and NE Essex CHCs are both arranging exhibitions of aids for the physically handicapped and elderly, and Worksop and Retford CHC has just held a similar exhibition titled "Man's ingenuity to man". Medway CHC member John Bell spent two weeks taking photographs inside St. Augustine's hospital, to illustrate the life of a psychiatric patient. His pictures were exhibited at the Kent County Show, and are now touring local libraries.

● A party of ten from Doncaster CHC visited the town's Yorkshire Main Colliery last month. The group went underground, and investigated the arrangements for treating men injured at the pit. CHC members have also recently visited a local crematorium and the Rampton special hospital.

● A report on services for the mentally handicapped in Hillingdon has been published by the CHC's Mental Handicap Working Group. Called "An inch, but a mile to go", it gives details of national planning and local facilities. Harrogate CHC has prepared a leaflet for mentally handicapped people and their relatives, listing local services, DHSS benefit leaflets and voluntary organisations.

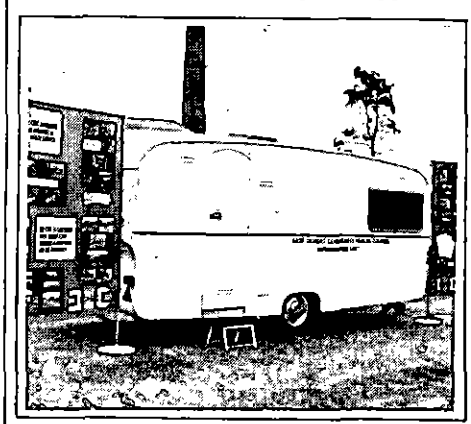
● Kettering CHC is spending about £500 on a TV advertising campaign. Nine 15-second adverts will appear on Anglia TV during September-November, some on weekdays and some at weekends. The CHC decided on the TV experiment as an alternative to adverts in the local press, and because there is no local radio in its district.

● West Roding CHC has launched a six-weekly "CHC Bulletin", to put across information in a more general way than CHC minutes. Issue 1 is a single sheet, designed with display on notice-boards in mind. Other CHCs which have published newsletters include: Hillingdon, Leeds Western, South Tees, Crewe and Bristol.

● A committee to raise funds for a hospice for the chronically sick and dying has been formed in Havering, following thorough groundwork by the CHC. A CHC working group spent two years researching the needs of the dying in its district, visiting hospices in London and Sheffield, and preparing a report. The new committee was formed following a CHC meeting attended by about 300 people.

● South Hammersmith CHC has prepared a range of cheap leaflets — on dental treatment, opticians and the role of CHCs. Using a Roneotronic stencil-cutter and inexpensive paper, the CHC can produce 1000 leaflets for £3.60.

● Oldham CHC is backing a plan to convert the disused Chadderton Chest Hospital into a regional sports complex for the disabled. The proposal comes from the Oldham Owls Disabled Sports Club, and is being considered by the North Western RHA. The club has also written to the Minister for Sport, seeking his support.



This 14-foot caravan has been acquired by East Dorset CHC for use as a mobile advice and publicity centre in rural parishes, and at hospital fetes, fairs and shows. It was previously used by the Bournemouth Drugs Advisory Service as a mobile advice centre. Cost of the whole project, including purchase, re-spraying, insurance, letter and equipment, was £300 – less than the caravan's current market value.

EDITORIAL

CHCs will be interested, and perhaps a little disappointed to read a recent circular from the DHSS: *Observers from Community Health Councils at Family Practitioner Committee Meetings* (HC(FP)(77)2, September 1977).

It arises in part from the efforts of a number of CHCs whose family practitioner committees have been unwilling to admit CHC observers to their meetings. The circular says that those FPCs are now "asked to consider inviting each CHC in their area to send one of its members to meetings of the FPC to act as an observer".

There are certain reservations however. Discussion of confidential matters concerning individual patients and practioners *may* merit exclusion of CHC observers, but, as with AHAs, they will not automatically be excluded from those parts of the meetings which are not open to the press and public. The cirucular says that exclusion of CHC observers *may* therefore arise when the FPC is discussing reports of service committees which have held hearings of complaints. Not must, *may*.

Also on the positive side, it spells out why CHCs' interest in FPC business is appropriate: "The services provided by FPCs are an important part of the local health services and most contacts between the public and the health services are through the primary care services. Councils therefore have a legitimate interest in the work of FPCs".

So even if this circular does not go far enough for some in establishing CHCs' presence at FPC meetings in parallel with AHA meetings, it certainly makes several clearly supporting statements which CHCs should be able to use in persuading their own FPCs to welcome them in.

CHC NEWS

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Meet your regional reps

Introducing the members of the Standing Committee of the Association of CHCs, and the Secretary observers.

NORTHERN REGION

GORDON BESSEY, 66, married, Chairman of the Association of CHCs, and of the Northern Association of CHCs. RHA nominee to East Cumbria CHC and Chairman since 1974. Formerly member of East Cumberland HMC. Particularly interested in the elderly and health education.

HOWARD THOMAS, 36, married with two young sons. Vice-Chairman of the Northern Association of CHCs. RHA nominee to Durham CHC. Vice-Chairman 1974-75; Chairman 1975 to date. Observer at AHA and JCC meetings. Particularly interested in primary health care and preventive medicine.

YORKSHIRE REGION

KEN HENDERSON, 60, married, appointed by RHA to Scarborough CHC, and Chairman since 1975. Retired this year after 45 years local government service.

LESLIE ROSEN, widower, local authority nominee to Leeds (Eastern) CHC and Chairman since 1974. Chairman of Yorkshire Regional Association of CHCs. Particular interests: health and safety at work, industrial diseases and injuries.

TRENT REGION

A.A. GOODSON, 56, married, local authority nominee to South Lincolnshire CHC and Chairman from the start. This year's Chairman of Trent Regional Association of CHCs, and formerly member of Boston Group HMC. Particular interest: hospital services.

FRANK HAYNES, 51, married, local authority nominee to Central Nottinghamshire CHC and its Chairman since inception. For 10 years previously was a HMC member. Interested in all CHC activities.

EAST ANGLIAN REGION

A.S. WATTS, 63, married with one son. Voluntary organisation nominee to Norwich CHC and Chairman since August 1974. Particularly interested in mental health. Formerly treasurer of a local authority.

NW THAMES REGION

MARY MARRE, 57, married. Vice-Chairman of Edgware/Hendon CHC since 1974, nominated by the Disablement Association of Barnet. Particularly interested in handicap, mental health, and (through the London Council of Social Service), the need for inter-service planning in metropolitan areas.

JOY MOSTYN, 60, nominated by the Family Planning Association to South Hammersmith CHC in 1974 and its Chairman since then. Former local authority member, and particularly interested in community services.

NE THAMES REGION

RUTH BUCKY, 53, married with 2 children 20 & 21. Local authority nominee to Haringey CHC in 1974 and its Chairman since 1976. Particularly interested in community services. Formerly a medical social worker.

DR JAMES FAIRLEY, 73, married, RHA nominee to West Essex and District CHC and its Chairman since April 1976. Interested in welding together the efforts of all those concerned with the consumer needs of total health care.

SE THAMES REGION

JOHN AUSTIN-WALKER, 33, married with three very young children. Local authority nominee to Greenwich CHC and its Chairman from 1975-77. Particularly interested in children and mental health.

SW THAMES REGION

JOHN EVANS, 45, married with 4 children 11-21. RHA nominee to West Surrey/North East Hampshire CHC since 1974 and Chairman in 1974-75. Whole-time hospital chaplain for 10 years and former HMC member.

ROY STEPHENSON, 49, married. Local authority nominee to East Surrey CHC and Chairman from the start. Current Chairman of SW Thames Regional Association. Particular interests: a DGH for the region, regional secure units and mental health.

OXFORD REGION

EILEEN COLLINS, married with 3 children 19-22. Nominated by the National Council of Women to High Wycombe CHC and Vice-Chairman since 1976. Chairman of Greenwich Social Services Committee since 1974.

SOUTH WESTERN REGION

GRAHAM ANDREWS, 45, married with 2 daughters under 20. Nominated by local authority to North Devon CHC; Vice-Chairman 1974-76 and Chairman 1976 to date. Vice-Chairman of the Devon Association of Parish Councils. Particularly interested in construction and opening of new DGH and its effect on the whole district's hospital services.

DESMOND HARPER, 47, married with 2 children 18 & 23. Chairman of Gloucester district CHC since 1974, and appointed by local authority. Particularly interested in community services.

WEST MIDLANDS REGION

Dr RODERIC GRIFFITHS, 32, married with two young children. Vice-Chairman of the Association of CHCs, Chairman of West Midlands Association of CHCs. Local authority nominee to Central Birmingham CHC, Vice-Chairman from 1975-77 and now Chairman.

MERSEY REGION

IRIS BOURNE, 63, widow, Chairman of Crewe CHC since 1974, nominated by the local authority. Particularly interested in the elderly and mental health. Chairman of the District Council Environmental Health Committee.

NORTH WESTERN REGION

HENRY GUTERMAN, 51, married with 3 children 7-16. Appointed to Tameside CHC by RHA in 1974 and its Vice-Chairman since 1975. Particularly interested in geriatrics and hospital friends.

NORMAN SWIFT, 55, married, and Hon Treasurer of the Association of CHCs. Nominated to Bury CHC by Salford Diocesan Catholic Welfare Services, and Chairman for 1975/76. Particular interests: maternity services, child and school health, family practitioner liaison.

WALES

IDRIS DAVIES, 60, married with 3 sons 18-23. Nominated by the Anglesey Physically Handicapped Society to Isle of Anglesey CHC and Chairman since 1974. Particularly interested in geriatric services and joint planning. Vice-Chairman of the Association of Welsh CHCs.

WILLIAM G. DAVIES, 59, married. Nominated by Royal British Legion and Rotary to Montgomery CHC in 1974 and Chairman to date. Former HMC member. Particular interests: services for rural areas, community hospitals and health education.

WILLIAM D. EVANS, 65, widower, Chairman of Welsh Association of CHCs. Nominated by local authority to Carmarthen/Dinefwr CHC and Chairman from 1974-1976. Particular interests: mentally ill and handicapped.

D.M. THOMAS, 69, married, nominated by Secretary of State for Wales to Cardiff CHC and Chairman since 1974.

Secretary Observers

Northern + Yorkshire: J. HENNESSY (Durham CHC)
Trent + East Anglia: JOHN HOLDEN (Kings Lynn CHC)
NW + NE Thames: BARRIE TAYLOR (SW Herts CHC)
SE + SW Thames: ALAN BROOKES (Brighton CHC)
Wessex + South Western: MICHAEL QUINTON (Bristol CHC)
Oxford + West Midlands: DAG SAUNDERS (Salop CHC)
Mersey + North Western: PHIL TOPHAM (Blackburn CHC)
Wales: E. GRIFFITHS (Llanelli-Dinefwr CHC)

THE EUROPEAN COMMUNITY

The United Kingdom joined the European Community on 1 January 1973, and a number of changes in health care and related services are resulting from this step. Innovations in three areas are particularly relevant to CHCs: (1) health services and social security benefits; (2) professional qualifications of doctors and nurses; and (3) special funds to advance social policies.

There are numerous other important changes to aspects of UK social policies and legislation resulting from Community membership, and the references below should help in following these up.

The European Community is really three communities: *The EEC* (European Economic Community), *Euratom* (European Atomic Energy Community) and *ECSC* (European Coal and Steel Community).

It has nine members: Belgium, France, Germany, Italy, Luxembourg and the Netherlands (the 6 original signatories of the Treaties in 1952 and 1958) plus Denmark, Ireland and the UK (which joined in January 1973).

The three communities share four institutions:
European Commission which has 13 members (2 each from France, Germany, Italy and the UK and one from each of the rest) who make plans and policies through specialist departments, mediate between governments and execute detailed decisions. Roy Jenkins is currently its President.
Council of Ministers which has 9 members, one from each member government, often the Foreign Minister but may be some other Minister, depending on the subject under discussion. The Presidency is held in rotation for 6-month terms.
Court of Justice is the supreme court of 9 independent judges which deals with all legal disputes within the Community under the terms of its Treaties.
European Parliament currently consists of 198 members chosen by and from national parliaments. Its task is to monitor the work of the Commission and the Council and to approve the budgets. There are plans to increase the powers of the Parliament after a system of directly electing 410 members has been instituted.

A number of committees and advisory bodies also assist in the Community's work, notably the *European Council* (which is a regular meeting between all the European heads of government) and the *Economic and Social Committee.* These and the four institutions are served by over 12,000 permanent staff based in Brussels and Luxembourg. The Community is financed through levies and customs duties on imported goods and direct contributions from member countries. It issues policies, after agreement has been reached between members, in one of four ways: *Regulations* are community laws directly binding on member countries; *Directives* are community laws which state aims, leaving national authorities to decide how to carry them out; *Decisions* are laws binding on those to whom they are addressed (states, firms, individuals); *Recommendations* and *Opinions* have no binding force.

HEALTH CARE AND SOCIAL SECURITY

A guiding principle of the Community is that all citizens have the right to work in any member country of their choosing. They are therefore able to transfer their social

security benefits, to move from country to country and job to job, to bring their families with them or send their family allowances back home to join trade unions. These arrangements are set out in the *EEC Social Security Regulations for Migrant Workers.*

Under the Regulations all medical treatments are also provided free to workers and their families, except for charges normally levied on insured patients resident in those countries. Certain treatments are also available to visitors from other Community countries (described in *Social Security leaflet SA28*), but provision for unemployed and self-employed people is still being negotiated.

PROFESSIONAL QUALIFICATIONS

The EEC Medical Directives now enable doctors who are nationals of any of the nine member countries to practise in the UK (*Statutory Instrument 1977 No. 827*). From 1979, new directives will also establish mutual recognition of state registered nurses' training and qualifications.

SPECIAL FUNDS

Through its Social Fund, the Community is able to give grants to assist disadvantaged groups: the handicapped, young workers and women workers particularly. These sums can support vocational and retraining programmes and special housing, for example. The Community also sponsors research and exchange of information about health and safety standards at work, environmental pollution, and consumer protection in relation to foodstuffs and other retail products.

FURTHER READING

The European Community: Facts and Figures; People Come First: Social Policy in the European Community; both published by the Commission of the European Communities, London office: 20 Kensington Palace Gardens, London W8 4QQ, 01-727 8090.
Influencing Europe: a guide for pressure groups by Roy Manley and Helen Hastings. Fabian Research Series 332, May 1977, 65p from Fabian Society, 11 Dartmouth Street, London SW1.

Virtually all publications of the Community can be consulted by the public at the Central Reference Library, St Martins Street, London WC2H 2HP, 01-930 3274.

BOOK REVIEWS

SUBJECT INDEX, *Institute of Health Service Administrators, 75 Portland Place, London W1, 60p inc post.*
How do you keep track of all those DHSS Circulars? And when some issue takes you hunting back into the files to the days before CHCs were born, how do you cope with that?

Probably the best way is to use a copy of the IHSA's "Subject Index", which lists Official Memoranda to Hospital Authorities, Reorganisation Circulars, Interim Series Circulars, Health Circulars, Whitley Council Circulars and Statutory Instruments issued under the NHS Acts. All entries in this comprehensive index apply to England and Wales, and were current at 31 March 1977. It's all there, from Absent voter arrangements (*See* Voting) to Zuckerman report (*See* Scientific and technical services).

PROFILES OF THE ELDERLY, VOLUMES 1 AND 2 *From Age Concern, 60 Pitcairn Road, Mitcham, Surrey, £1 each.*
Age Concern's Research Unit has begun to publish a series of monographs on the

Not another survey!

Vera Bolter, Secretary, Newcastle CHC

Maternity Services

Our CHC believes that it is important to have the means of assessing accurately the views of patients rather than relying on approaches by pressure groups, aggrieved individuals, or the picture presented by the mass media. We have formulated a project to interview a random sample of 200 mothers who have had babies in two local hospitals and all mothers who have had babies at home during the period of the survey (or until a minimum of 20 interviews are obtained). The mothers are interviewed in their own homes some four to six weeks after the birth. Permission is obtained from the obstetrician and the patient's GP and mothers are informed that an interview can be refused at any stage, either before or during its course.

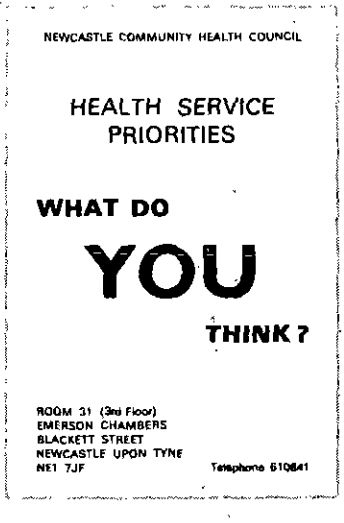
The objectives are to assess mothers' reaction to their maternity care and make recommendations for improvements. To obtain names from the AHA's birth registers, it was necessary to follow the same route through Research and Ethical Committees as any other research workers. A series of discussions, both hostile and amiable, took almost two years but we now have a questionnaire covering, on a consensus view, the most important aspects of patients' experiences. To overcome objections of bias, it became necessary to employ a trained interviewer instead of volunteers, and to have an independent research consultant to oversee the analysis of results. We have been successful in applications for funds to cover these costs. By the time results are ready for publication next year there will have been a lapse of three years since the project was initiated.

Conclusion: Costly exercise in time and money, only possible because of the support both of an enthusiastic voluntary research worker, and our obstetricians. For final results, watch this space!

Neighbourhood Survey:

A completely different technique was used in a neighbourhood where a small hospital providing a local casualty service was the subject of temporary — pending permanent — closure. Protests were vociferously expressed at a public meeting. To obtain an objective assessment of local opinion a simple questionnaire was posted to a one in ten sample from the electoral register, with factual questions about treatment following accidents, and future intentions and preferences.

In all, we distributed 450 questionnaires and 198 were posted back. A further 173 were returned following a postal reminder or a personal call. The overall return of 82 per cent gives a valid and representative sample. Over 80 per cent of the members of the households in the sample had experienced an accident at some time and 75 per cent of these were treated at the local hospital. Seventeen per cent were treated at the Royal Victoria Infirmary while only 2 per cent were treated at their GP's surgery. Respondents were asked where they would go following an accident if the local hospital was open and 77 per cent chose this option. Reasons for this choice included nearness and convenience, speedy and friendly service, and lower travelling costs. The minority preferring a main hospital casualty department tended to be respondents who had previously received treatment at those hospitals and references were made to the better equipment and more comprehensive service available. Many respondents referred to the difficulties arising from GPs' appointments systems when help was needed urgently.


NEWCASTLE COMMUNITY HEALTH COUNCIL

HEALTH SERVICE PRIORITIES

WHAT DO

YOU

THINK?

ROOM 31 (3rd Floor)
EMERSON CHAMBERS
BLACKETT STREET
NEWCASTLE UPON TYNE
NE1 7JF

Telephone 610841

This evidence of demand for a local service has made more impact than would have been created by purely subjective presentation, and discussions are now taking place about what facilities should be provided in the neighbourhood.

Conclusion: Costs of £70 and approximately 70 hours work by staff and volunteers produced rapid and effective results.

Priorities:

The public's views about priorities in the health and social services are more complex to assess but still need to be known. *CHC NEWS* produced a draft questionnaire on priorities last year and we adapted this slightly and distributed it with our Annual Report. There were no illusions that this was a statistically valid exercise but the 52 questionnaires returned (out of 800 or so) included some thoughtful reactions and are a more useful response than would have resulted from an open invitation to send general comments. Respondents showed an almost unanimous approval of increased spending on prevention of ill-health and a ratio of two to one in favour of priority for the 'deprived' groups in society. The main interest will be in following up comments and suggestions in Study Groups and Joint Planning Team discussions.

Conclusion: Costs minimal; some limited usefulness in provoking debate and collecting comments on a structured theme.

elderly, pulling together "submerged" information from various sources, such as Government agencies and university research. Volume 1 contains the first three monographs, titled *Who are they? Standards of living,* and *Aspects of life satisfaction.* Volume 2 — perhaps more central to the work of CHCs — consists of monograph 4, *Their health and the health services.* This has chapters on health services provision and manpower, incidence of diseases, handicap, causes of death, drugs, and sources of information.

The report notes that probably only one in eight of all handicapped people is on the local authority register. Arthritis and associated conditions are the greatest single cause of impairment in the handicapped elderly.

SHARED CARE *By Gillian Pugh and Philippa Russell. From Book Sales, National Children's Bureau, 8 Wakley Street, London EC1, £1.20 inc post.*

This gives eight "good practice" examples of schemes in which parents and professionals have worked together to build support services for handicapped children and their families.

The schemes differ in their origins and methods; some are part of local authority or health services, others are run on a voluntary basis but have developed close links with local statutory services.

Promising start at Weston

Edgar Evans, Secretary, Weston CHC

I feel that the public recognition afforded to the Weston CHC should be placed on record because it is, in effect, a model in public participation and emphasises the need for CHCs to relate to a community. Weston Health District is small by comparison and in this fact lies the secret of its CHC's success.

The CHC gets an average of 40 column inches each week in the local paper. The Bristol-based paper regularly features its activities and the local radio station gives plenty of air space. Both TV channels show considerable interest.

It is, of course, true that the CHC has had a major issue thrust upon it by the AHA which wants to merge our district with Bristol, thus creating an amorphous district quite incapable of any community relationship. To their credit, both the AHA and RHA have recommended the retention of the separate Weston CHC.

For the benefit of the cynic who will say that it is the merger issue alone which has caused public awareness of the CHC, I would mention that an Aids to Living Exhibition in the Town Hall in April, 1976, attracted some 3,000 visitors. A public showing of the film on rabies '*Once Bitten*' sponsored by the CHC packed in some 300 people. A hospital closure meeting attracted 150 people. Public meetings in connection with the merger proposals were attended by 160 and 450 people respectively.

Petitions of protest, not sponsored by the CHC, poured into the centrally situated office and invitations to address Councils, Trades Unions, Churches, Residents Groups, flooded in. Copies of our comments on the AHA proposals had to be reprinted over and over again. Editorials in the local press in favour of the CHC counter-proposals were legion.

The local authority in Weston-super-Mare backed the CHC. The relationship between Health District and local authority is first-class. A phenomenon, as far as Weston is concerned, is the fact that the people have cried out in defence of their DMT. They want their local bureaucracy.

In addition to meetings with the ATO, RTO and the respective chairmen, the CHC had a meeting in Weston with David Ennals. It also organised a deputation to see him in London, led by local MP Jerry Wiggin. The CHC sponsored another deputation to meet Roland Moyle and, prior to this, on the separate issue of a new hospital for Weston, the CHC met Barbara Castle and David Owen.

CHCs must be wary of giving overt support to proposals before democratic opposition has had a chance to establish itself but since everything is done to a ridiculously rapid time-scale the task of the CHC in leading public opinion in health care matters is difficult indeed. The situation must change if consultation is to have any meaning and bring any benefit to the management of the service.

We have evidence to prove that on occasion the patient and the CHC have come to different conclusions. For there must be times when, with good reason, we must just beg to differ.

Speech therapy

Margaret Edwards, Area Speech Therapist, Nottinghamshire AHA

The title "speech therapy" is to some extent a misleading one because it represents only a very limited aspect of the work carried out in the field of communication disorders. In the mind of the lay public it is still associated with elocution or speech training, whereas in fact, its links with aspects of aesthetic speech production are virtually non-existent.

The speech therapist is concerned with disorders of speech and language in relation to receptive (understanding) and executive (expressive) aspects. While disorders of spoken language are the predominant concern, these often cannot be dissociated from writing and reading disabilities. Hearing also is an integral part of language.

Not only is the speech therapist responsible for remedial work but also for the assessment, diagnosis and early detection of language disability and where appropriate, prevention of its onset. Because language is an intrinsic facet of human behaviour, disorders of communication rarely exist in isolation. The speech therapist is associated with a range of workers in allied disciplines drawn from the fields of medicine, education, sociology and psychology.

The decision of the Committee of Enquiry into *Speech Therapy Services* (Quirk Report HMSO, 1972) to place speech therapy services within the aegis of area health authorities was therefore not received with unanimous approval and there were strong arguments advanced by some that it should be part of the education service, while other views favoured inclusion in Social Services.

The traditional pattern of practice has been for patients to be seen either in school or hospital clinics often on a once weekly basis. The speech therapist has, as a result, tended to work in isolation with insufficient contact with other workers who are concerned with remediation. Adults are usually referred through a medical consultant and children through a variety of agencies; virtually an open referral system. While the majority of patients fit quite easily into this pattern, it must be remembered that a speech disability is not synonymous with illness and in some cases, e.g., stammering, it seems unnecessarily cumbersome for the stammerer, first of all to see his GP, then for a further appointment to be made for a consultation before he finally reaches the speech therapy clinic.

I would therefore favour the extension of referral channels to include GPs and other agencies, including the patient himself, with the proviso that a medical opinion can be obtained if there is the slightest doubt about the condition underlying the speech disorder. It is unlikely that an open referral system would produce any dramatic upsurge in referral numbers, but the advantage would be that it would afford the opportunity of treatment for those who might be deterred by the complications of the present system.

Suggested policies for different groups of patients might be as follows:

Pre-school children: Investigation of speech and language development as part of the primary care programme. Identification of language defect or disability by speech therapist as a member of a team. Remediation by language intervention groups, parental counselling, individual therapy.

School population: Investigation on a multidisciplinary basis with special emphasis on hearing. Remediation by intensive courses in schools, vacation courses, language classes/units. Review and follow-up in health centres. Residential provision for children for whom none of the above conditions are appropriate.

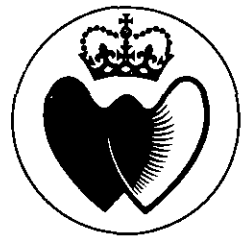
Children with multiple handicaps: Intensive therapy is essential and should be supported by helpers reinforcing remedial work.

Adults: Open referral, investigation by multidisciplinary team when appropriate. Remediation by individual therapy, group sessions, relative group sessions, domiciliary therapy, periodic intensive sessions and self-instruction programmes.

CORRECTION

In August's article on "Sale of NHS Land", paragraph five, we inadvertently gave the impression that the procedure of "land sales supplements" from the DHSS to RHAs was still in force. The sentence should have read: "This procedure has *now* been overtaken by the introduction of cash limits . . ."

The National Blood Transfusion Service



by Brian Grundy, Administrator, Wessex Regional Transfusion Centre

The Blood Transfusion Service is a direct descendant of a voluntary organisation. The first voluntary blood donor organisation was the London Blood Transfusion Service in 1921. This was followed by Local Authority and voluntary organisations in other cities. The Ministry of Health, in preparation for the Second World War, brought all those organisations into the Emergency Blood Transfusion Service. This, on the "appointed day" in 1948, was renamed the National Blood Transfusion Service and, regionally based, became part of the National Health Service. Largely as a result of this, the 1974 reorganisation had little effect on the NBTS.

With one exception, each English RHA maintains its own transfusion centre: there are five in Scotland, one in Wales and one in N. Ireland. In addition to the transfusion centres there are the central laboratories. The Blood Group Reference Laboratory is where stocks of rare sera are maintained and unusual blood group factors are identified — the National Panel of Donors of Rare Blood Types is also maintained there. The Blood Products Laboratory at Elstree prepares blood products and researches the use and production of plasma fractions, the Plasma Fractionation Laboratory at Oxford prepares special products for the treatment of haemophilia and related diseases.

The tasks of a regional transfusion centre are: to collect blood from donors; to produce the various blood products required by its Region (and, in special products, contribute to national requirements); to distribute these products and take part in research; to provide a consultant service on transfusion matters to the hospitals of the Region; to provide tissue-typing services for organ transplant units and an ante-natal service aimed at preventing or minimising haemolytic disease of the newborn.

Each hospital having a need for blood products maintains a small blood bank for its immediate needs with an additional stock for emergencies. The main blood bank for the region is at the transfusion centre. Blood or its products can be obtained at any time and will be sent by normal road or rail services or, if the request is urgent, by the centre's own emergency delivery vehicles (complete with siren and blue light).

In 1948 there were about half a million donations of blood, by 1974 it had risen to 1.8 million. This year it will be over two million and the increase in demand is forecast at 5 per cent per annum. There are a number of reasons for this increase — transplant and cardiac surgery, expansion of knowledge of a number of diseases and the use of blood products to control them.

In order that a regular "guaranteed" supply is available, donor volunteers are organised into "panels" and are called by letter to the appropriate session being held as near as possible to their home. It is the responsibility of the regional donor organiser to arrange these panels and call up sufficient donors so that, allowing for those who cannot turn up for any reason (which he has to guess), those who may be asked not to donate for medical reasons (ditto) and casual donors (ditto), there will be enough donations to maintain the centre's supplies.

No article on the NBTS could be complete without reference to the invaluable work done by members of the voluntary organisations in acting as "hostesses" (or hosts), supervising the rest beds and serving the refreshments to the donors after the donation has been made. These services are not window-dressing, they are essential, and we are all grateful for the help that we get.

There are three types of donor session (excluding special sessions for emergency needs): the public session where a panel of local donors will be invited to attend; sessions at service establishments which, despite an ever-changing population, are always well attended; and sessions held in industrial premises — it is to the credit of these firms that they agree to sessions being held in paid time, because one session can mean something in the order of 100 hours of employee time.

Recommended for further inspection:
Film: *A Little Goes a Long Way*
Booklet: *The National Blood Transfusion Service.*
Leaflets: a) *11 Good Things That Come Out of Blood* and b) *Blood Component Therapy*
Book: *The Gift Relationship: from Human Blood to Social Policy,* Richard M. Titmuss. Allen & Unwin.

Parliamentary Questions

MEETINGS WITH CHCs
Replying to a question from David Hunt MP, David Ennals said that he had met CHC members on 14 occasions as well as at the national CHC meeting last November. *In reply to a question from Tony Newton* MP the Minister said that he made every effort to meet CHCs and representatives of local professional opinion on his visits around the country and welcomed opportunities to hear their views.

PATIENTS IN TEACHING HOSPITALS
Responding to questions from MPs Richard Wainwright, Robert Kilroy-Silk and Arnold Shaw, David Ennals said that while CHCs do not have a statutory relationship with Boards of Governors of postgraduate teaching hospitals, patients in these hospitals may seek the advice and assistance of CHCs in the same way as other NHS patients.

MEDICAL RECORDS
Roland Moyle said that disclosure of his medical record to a patient is a decision for the doctor responsible for treatment at the time to take as a matter of professional judgment. The Minister does not consider this a matter appropriate for legislation. He was replying to a question from Arthur Lewis MP.

RADIOLOGISTS
Replying to a question from Michael Ward MP, Roland Moyle said that there were 48 unfilled consultant posts in radiology in 1976. He added that the DHSS has recently commissioned research into the factors that influence a doctor's choice of career.

FIRE SAFETY IN HOSPITALS
There are no fire safety regulations applicable to NHS hospitals. This information was given by Roland Moyle in reply to a question from Eric Moonman MP. David Ennals, replying to Patrick Jenkin MP, said that the DHSS, the Welsh Office and the Home Office are co-operating with health and fire authorities in a survey of fire precautions in NHS hospitals. This is designed to indicate costs and priorities of measures needed to bring hospitals into line with the Fire Precautions Act, 1971.

GP COMPLAINTS
In 1976 there were 52 appeals to the Secretary of State for Social Services by people whose complaints against GPs had been adversely decided by FPCs. Six of these were upheld. The figures for 1975 were 65 and 3 respectively. This information was given by Roland Moyle in reply to a question from Bruce Grocott MP.

FAMILY PLANNING SERVICES
Replying to a question from Patrick Jenkin MP, David Ennals said that he would not be satisfied until total demand for family planning services is ascertained and met. He added that he was confident that health authorities would give priority to the need to continue to offer a full choice of service to patients and prospective patients.

NOTES.....

LEAD IN WATER
The Department of the Environment has published the results of its 1975 survey of lead in drinking water*. About 4% of houses in Gt Britain had more than the maximum recommended level of lead in water during the daytime while about 9% exceeded the level at 'first draw'. Older houses, particularly those built before 1914, tended to have higher concentrations of lead because the water pipes are more likely to be made of lead or lead and copper. In some areas of the country, water has a tendency to dissolve lead and the highest concentrations are found when water has been standing in lead pipes for some hours. Lead is also absorbed through the air and from food and the important point is total intake. Further studies being undertaken include ones on reconstituted baby food, an epidemiological survey, physico-chemical treatment of water, the character of different sources of water and further research on piping material.
**Lead in Drinking Water: A survey in Gt Britain (Pollution Paper No 12) HMSO £1.15*

PROFESSIONS SUPPLEMENTARY TO MEDICINE
The 1976/77 Annual Report issued by the Council for Professions Supplementary to Medicine contains some fascinating details about the activities of the Council itself and its constituent boards. These cover chiropodists, dieticians, medical laboratory technicians, occupational therapists, orthoptists, physiotherapists, radiographers and remedial gymnasts. The report is available from CPSM, York House, 199 Westminster Bridge Road, London SE1 7UH.

FOOT CARE ASSISTANTS
The Society of Chiropodists had advised its members that foot care assistants "should only be used to cut the normal nails of patients who are unable to do it for themselves because of blindness or some other disability". The Society is worried that pending closure of the profession of chiropody, a foot care assistant could set up in private practice as a 'chiropodist' following a period of employment in the NHS.

EMPLOYMENT OF THE DISABLED
A guide on the employment of disabled people has now been published by the Manpower Services Commission and the National Advisory Council on Employment of Disabled People. *Positive Policies, A Guide to Employing Disabled People* is available at any office of the Employment Services Agency.

TV AND THE COMMUNITY
A voluntary body "to facilitate cooperation between social agencies and broadcasters" is being set up, following a three-day conference organised by the National Advisory Group for Voluntary Action Through Television and attended by 230 people. The group will draft a constitution for the new body, and will develop a code of practice and guidelines for people cooperating in 'social concern' programmes. Contact: Eileen Ware, 29 Lower Kings Road, Berhamsted, Herts. 04427-73311.

DISABLED HOUSEWIVES' BENEFIT
A new tax-free benefit of £10.50 per week will be payable to disabled housewives from 17 November. The government estimates that 40,000 married women will be eligible to claim — they must be incapable of carrying out normal household duties or paid employment. Claims can be made on the application form included with the leaflet explaining the new benefit.

STATUTORY INSTRUMENT 1103. MEMBERSHIP OF HEALTH AUTHORITIES
This SI came into force on 1 August and deals with the appointment and tenure of chairman and members of AHAs and RHAs. Previous arrangements are adjusted on the lines set out in HC(77)12 — see *CHC NEWS* no 21.

HC(77)26 COUNSELLING FOR PATIENTS SEEKING ABORTION
The Lane Committee on the working of the Abortion Act recommended that every woman seeking abortion should have an opportunity to obtain adequate counselling before an abortion decision is taken. This circular outlines arrangements for the provision of counselling and gives guidance to all those concerned with the welfare of women who seek abortions. These will include GPs, health visitors, social workers and people working in voluntary organisations.

HC(77)30 HOSPITAL FACILITIES FOR CHILDREN
This circular reminds health authorities that special facilities should be available for children in hospitals. Guidance on this was contained in Circular HM(71)22. RHAs are now asked to let the DHSS have reports on the adequacy of hospital facilities for children by 31 December.

HN(77)104 EMERGENCIES IN DENTAL PRACTICE
The memorandum *Emergencies in Dental Practice* has been revised and FPCs and AHAs are asked to ensure that all dentists receive a copy. Advice is given on diseases and treatments which may give rise to trouble in the dental surgery and stresses that before the administration of any general or local anaesthetic or of any drug enquiries should always be made about the patient's past history. Where any doubts exist the patient's doctor should be consulted before the dental treatment is given. A list of drugs which may cause emergencies is given as well as criteria for safety in dental anaesthesia.

HN(77)116 NATIONAL HEALTH SERVICE ACT 1977
The NHS Act 1977 became law on 28 August. It is a consolidating Act which brings together existing statutory provisions which were previously scattered over various Acts of Parliament. The substance of the law has not been changed and all existing orders and regulations remain in force.

HN(77)121 STATISTICS ON PSYCHOSURGERY
This gives advance notice of a new statistical return, to be completed by AHAs, detailing the number of psychosurgery operations performed. The first set of annual statistics will relate to the year beginning 1 January 1978 and will be available in 1979.

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 6: Airedale CHC
Chairman: Coun K G Emsley

Page 11: Northern Sheffield CHC
Chairman: Mrs Pat Morley

Page 15: Brent CHC
Address: 16 High Street, Harlesden, London NW10
Telephone: 01-961 2028

Page 20: Enfield CHC
Chairman: Mrs Dee Heaps

Page 26: Chichester CHC
Chairman: Mr E M Lock

Page 31: High Wycombe CHC
Chairman: Mrs E Collins

Page 31: Oxfordshire CHC
Address: 2 Market Street, Oxford
Telephone: Oxford 723569/0

Page 37: Central Birmingham CHC
Chairman: Dr R K Griffiths
Secretary: Stephen Burkeman

Page 45: Salford CHC
Secretary: Colin Clews

Page 46: Clwyd North CHC
Chairman: Mrs Sheila Morton Evans

Page 57: East Anglian Regional Secretaries of CHCs
Secretary: Raymond Allen,
c/o Great Yarmouth and Waveney CHC,
Municipal Offices, Hall Plain,
Great Yarmouth NR30 2QD,
Tel: Great Yarmouth 58922

Page 59: South Western Regional Association of CHC Secretaries
Secretary: Edgar Evans,
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