CHC NEWS

For Community Health Councils

December 1977 No 26

Eraldin side-effects

Merthyr calls for national survey

An inter-CHC survey to trace people suffering from side-effects of the heart drug Eraldin has been launched by Merthyr and Cynon Valley CHC.

The council became concerned about Eraldin when it received a longer version of the letter reproduced on this page, from Mrs Thea James of Merthyr. CHC member Ken Brown researched the subject and submitted a detailed report to the council. Its decision was to write to health councils in England, Scotland and Wales, urging them to do surveys in their own health districts to identify sufferers of "Eraldin Syndrome".

Secretaries of the Regional Associations have been asked to collect the survey results and a national conference of CHCs may be arranged to consider the findings.

Mrs Thea James wrote to the CHC:

I am writing to you to ask for help.

Since 1972 I have been suffering from deteriorating eyesight and hearing, and a variety of other complaints, which I believe are the result of having been treated with a heart drug called "Eraldin". My eyesight is extremely poor, my hearing is impaired, and I experience constant pain in all my limbs and my abdomen. My other complaints have included severe depression, skin-rashes and numbness in my right side. On many occasions I have become convinced that I am dying.

During the last five years much of my time has been spent consulting specialists. Despite these numerous visits I have never been told officially that my symptoms are related to one another, or that they are the result of any known illness. My symptoms are all physical conditions reported by patients treated with "Eraldin".

Obviously I am concerned about my claim for compensation against ICI. So far I have been offered nothing. But the worst feature of the "Eraldin" problem is that it could happen at all, and that so little has been done officially to prevent similar mistakes in the future, to find out how many people are involved in this case , or to help individuals take collective action for just compensation.

I believe it is terribly unfair that people who are by definition weak and sick should be obliged to tackle the question of compensation unaided.

I hope the CHC can help.

Eraldin is the trade name for the drug Practolol, developed in 1964 by Imperial Chemical Industries for treating severe heart conditions. In 1970, after passing the required safety tests, it was given a Government licence. Adverse reactions began to be noticed in 1972, and in July 1974 ICI issued a warning letter to the medical profession. At that stage the Committee on Safety of Medicines — which has a statutory responsibility to advise on drug safety — had issued no warning. In October 1975 ICI withdrew the drug from general use.

There is no implication of negligence on ICI's part. The company accepts moral but not legal responsibility for the damage caused by Eraldin, and has set up a voluntary compensation scheme which has so far received about 1700 claims. About 100,000 people are believed to have been treated with Eraldin, and up to 6000 may be eligible to claim.

The ICI scheme recognises four main side-effects:

- Drying up of the tear glands, sometimes leading to corneal scarring and blindness;
- Severe skin rashes;
- Loss of hearing;
- Severe inflammation of the intestines, sometimes fatal.

Campaigners in the Eraldin Action Group say a number of other serious side-effects should also be included in the compensation scheme.

Merthyr CHC believes the Eraldin affair shows a need for improvements in the monitoring of new drugs, and for better advice to patients who have suffered side-effects. Within a month of local publicity about Merthyr's initiative, 23 people claiming "Eraldin Syndrome" symptoms had approached the CHC and many others had contacted other South Wales CHCs. Merthyr hopes the national survey will demonstrate the need for a Government enquiry into the affair and its wider implications.

Earlier this year Birmingham MP Sydney Tierney collected the signatures of over 100 MPs on an early day motion calling for an independent enquiry, but Minister for Health Roland Moyle has so far not agreed to this.

More details from Merthyr CHC, 3 Garth Villas, Merthyr Tydfil, Mid Glamorgan, and from the Eraldin Action Group, 261 Barclay Road, Warley, West Midlands.

INSIDE.....

YOUR LETTERS

THE WAY FORWARD FOR CHCs

May Clarke + Nancy Dennis, joint secretaries, Greenwich CHC

The Way Forward could perhaps be called the way backward for CHCs if para 2 page 1 is anything to go by: "hard decisions will be needed to hold back some services to allow others to be developed. Here Community Health Councils have a key role in influencing public expectations." The South East Thames RHA has added a similar pious statement to its Interim Strategic Plan. What do they mean?

Is it now the CHC's job to convey the official health service line to an erring public? As we understand it CHCs were set up to give consumers a voice in the health service, not an ear. To put the voice to good use people admittedly need to be properly informed about the health choices that are available to them. But *The Way Forward's* two lazy sentences belie a huge and important area of debate about public expectations and public participation in the health service.

As CHCs surely we should be saying that public expectations of health and of treatment and care are often too low and that many of the current problems have come about because expectations have been too low in the past.

Underlying *The Way Forward* is the continuing debate about the cost/benefit of acute medical care. Firmer agreement about priorities might be better achieved if the document was more positive about public participation, encouraging more questioning of medical myths, education to help people use health services more efficiently and effectively and the development of services to meet the needs of people rather than professionals.

SEPARATE ACCOMMODATION

Dilys Palmer, Secretary S Tyneside CHC

My Council, in July 1976, after an approach from mothers who had been terribly upset at a time of natural miscarriage to be nursed in the same wards as abortion patients, requested the Area Health Authority to plan for separate accommodation for these two types of patient.

They deprecate the fact that the AHA has not yet resolved the matter and ask me to seek the views of other CHCs through these columns.

CHILD PROOF CONTAINERS

Patricia Derham, Member Hounslow CHC

We have been doing some research amongst consumers and pharmacists in our district and find that the majority in these groups are not entirely in agreement with the use of child proof containers. One must remember that it is the adult who is normally responsible for the safe-keeping of tablets and indeed the adult who is normally prescribed tablets.

We are concerned that should manufacturers be geared to making child proof containers, no alternative will be available for the arthritic adult, the blind or any other similar groups.

The whole question of the safety of children and the many and varied dangerous substances with us in the home is basically a question of health education.

This cannot be left to the few professional health educators but must be geared through them to the public via the school and the child in the first instance (see the Cohen Report) and, continued publicity through the media.

CHC MEMBERSHIP

RL Payne, Secretary Rotherham CHC

A point was recently made to me that CHCs have become 'middle class' organisations speaking to and acting for a limited part of the community. It is not truly representative of that part of the community in social classes IV and V. Frank Topping's "Personal View" (*CHC NEWS 24*) seems to me to support this theory when it makes reference to the difficulties an individual may face in seeking CHC membership. In other words CHC membership is restricted to those who belong to an organised group or party.

The problem facing a CHC in trying to ensure that its message reaches all sections of society is fraught with difficulties and maybe we, as secretaries, have the easiest way out by using the organised groups as a convenient method of broadcasting our publicity. By so doing we have chosen to overlook the greater majority who choose not to seek membership of the organised. Perhaps other secretaries may choose to comment on this.

John Hunter, Member King's Lynn CHC

While some newly appointed CHC members may wilt when they are faced with the time and effort needed, this ensures that those members who remain are those prepared to give of their time and effort for the local community. It has been my experience that in the main the real work that is done in sub committee is done by voluntary organisation members.

Local authority members attend full council meetings, presumably collect their attendance allowance, and you do not see them again until the next full meeting. Direct elections will open the flood gates to party politically-orientated candidates, those who are the most vociferous and interested only in vote catching, and not in serving their local community.

A far better move would be to dispense with or reduce local authority members, and replace them with more members who represent various local interests. These people, generally speaking, are interested in local people and events for their own sake, and not for party ends, which seems to be the main preoccupation of local authority members, whatever their party affiliation.

ACHCEW REGULATIONS

Jean Coupe, Secretary Tunbridge Wells CHC

I requested an interpretation of paragraph 3(c) of the new statutory instrument allowing for the establishment of the Association of CHCs. I was concerned that this paragraph could be construed as placing a responsibility on the Association to represent the interests of all CHCs whether or not they are in membership of the Association, and can undermine the independence of individual CHCs. This paragraph could also mean that in future CHCs would not be able to express their views on an individual basis and that the DHSS may seek consensus views.

While the DHSS cannot interpret regulations formally they have described what is intended and the policy on which the regulations are based. In a letter of the 19th September 1977 Mr KS Jacobsen of the DHSS stated:

"It is certainly not the intention of regulation 3(c) to undermine the independence of any individual community health council. The new regulations do not in any way limit the existing powers of CHCs or their right to express views on an individual basis. What regulation 3(c) does is give the Association the function, in addition to the other functions prescribed in paragraphs (a) and (b) of the same regulation, of representing at a national level, the interests of the public as represented locally by individual councils.

In arriving at this formula we have tried to create a framework to enable the Association to perform the object, as set out in its constitution, of "expressing views on NHS matters to Ministers, government departments, or other bodies, and to publicise such views," and also to enable it to undertake other activities in its own right which would come within the broad scope of the regulations".

CHCs, whether in membership of the Association or not, should watch the way in which this clause is implemented over time.

HELP NEEDED

J Fryer, Secretary Scunthorpe CHC

The Scunthorpe health district is some 450 miles square in size geographically and caters for the health needs of 186,000 people. In the whole of this district there is not one hospital bed provided for adult male sub normals. A service is given from a hospital in a neighbouring health region but this has a very long waiting list.

This situation has received a great deal of publicity locally due to the plight of a 17 year old adolescent boy who has a mental age of 2, is an epileptic, is physically handicapped and doubly incontinent and yet there is no hospital place for him within the district. The strain on the parents and

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A tankful of trouble

Get into your average family saloon car, drive two miles and stop. Over those two miles your car has emitted 100 milligrams of lead — probably enough to kill a man.

The lead comes from lead-based "anti-knock" compounds which petrol companies add to their product to increase octane ratings, to meet the needs of modern high-compression engines. In the UK, about 9000 tonnes of lead are currently being emitted annually from exhaust pipes. It emerges in a spray of very fine particles, which can float in the air for days and are readily absorbed into the body through the lungs. In most places lead from petrol accounts for over 90% of all airborne lead.

Lead is a highly toxic substance, capable of accumulating in the body and damaging the brain, nervous system and kidneys. Early symptoms of chronic lead poisoning in adults are vague — headache, fatigue, loss of appetite and muscular pains — so it may not always be correctly diagnosed.

Even before these early signs become apparent, lead may be damaging the body, especially the central nervous system. This is one reason why anti-lead campaigners say lead standards should be tightened up, despite reassurance from Government and industry.* Earlier this year a study (1) published jointly by the United Nations Environment Programme and the World Health Organization concluded that: "Adequate studies of the relationship between lead exposure and health status in the general adult population have not been carried out".

Because most lead is stored in the bones, blood lead levels cannot be taken as an indication of the total amount of lead in a person's body. Blood levels are, however, an indicator of recent exposure to lead, and have been found to be higher in people living near sources of lead pollution. The Government's view is that "evidence of harmful effects in adults is rarely seen at blood lead levels below 80 µg/100ml", but that a level of 36 µg/100 ml is "the upper limit of normality in people not occupationally exposed to lead, and . . . a threshold beyond which investigative action to determine the cause of undue exposure is necessary". (One µg is one microgram, meaning a millionth part of a gram. An ml is a millilitre, one thousandth part of a litre). Most people in Britain now have blood lead levels in the range 10-30 µg/100ml. A committee of the US National Academy of Sciences has proposed a safety limit of 30 µg/100ml for children.

Children are more sensitive to lead than adults, and several scientific studies have suggested that excessive lead intake in children may be linked to mental retardation, though this link has yet to be conclusively proved. According to the UNEP/WHO report: "The major concern today is that young children with elevated lead exposure, as reflected in blood lead levels of 40-80 µg/100ml, may be experiencing subtle neurological damage".

Of course there is lead in people's food and drink, as well as in the air they breathe — though it is not yet known how much lead in food and drink arrived there as "fallout" from the air. A recent Department of the Environment report on lead in drinking water (2) estimated that an average adult consumes about 170 µg/day of lead in food and drink. This compares with the "provisional tolerable intake" for adults of 430 µg/day suggested by the WHO in 1972.

Of this 170 ug, only about 30 µg/day should normally come from water in the average household, where there is 20 µg/litre of lead in tap-water. However, the DoE report also revealed that tap-water in 4.3% of the British households surveyed exceeded the WHO's recommended limit for water of 100 µg/litre. As predicted by an earlier DoE report on lead (3), adults in many such households may well be exceeding the WHO's tolerable intake figure, a situation described in the report as "clearly undesirable".

Air in big cities can contain an average 2 µg/cubic metre of lead and an average adult man may breathe in about 15 cubic metres a day, giving an intake of 30 µg/day. This may seem small in comparison with the 170 µg/day from diet, but the comparison is more complicated because what really counts is the amount of lead actually absorbed into the body. Only about 10% of lead eaten and drunk is absorbed so that implies 17 µg/day absorbed from diet. In contrast, 40% of the 30 µg/day of inhaled lead may be absorbed through the lungs, which means that city dwellers could be absorbing 12 µg/day of lead from air as against 17 µg from diet. Thus the DoE is in danger of misleading people when it asserts that air is generally only a "minor" source of lead uptake.

In the case of children the situation is less well understood. Per kilogram of body-weight children eat more than adults, and breathe two to three times as much air. They may absorb as much as 50% of the lead in their food and drink, as against 10% for adults. The WHO states that its tolerable intake figure of 430 µg/day "does not apply to infants and children". How much lead children absorb through their lungs is unknown. Also it has been estimated that during play in city streets children take in 20-200 µg/day of lead from street dust, via sticky sweets and finger-sucking.

As the DoE says, "what matters medically is the total amount of lead absorbed from all sources", and the only major source of lead which could be quickly reduced or eliminated is lead in petrol. Most oil companies argue that refining petrol to higher standards instead of adding lead would be too costly. But at least one US oil firm claims there would be a net *saving* to the motorist, because engine wear and exhaust corrosion associated with lead additives would not occur.

In the UK there is a limit of 0.50 grams/litre on lead in petrol, and next month this will be reduced to 0.45 g/litre, with the intention of meeting a

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Richmond Town Centre, May 1976: One of a series of demonstrations organised by branches of the Conservation Society, in support of National Campaign Against Lead in Petrol Week.

MEDICAL PRACTICE VACANCIES

Philip Hunt, secretary of Edgware/Hendon CHC has asked the Medical Practices Committee about dispersal of patients onto other doctors' lists when a vacancy arises in a single-handed practice. His CHC believes that it should be consulted at an early stage when such cases arise, and these extracts from his correspondence with the Secretary of the MPC may lead other CHCs to feel the same.

Is it correct to say that if a proposal is made by a Family Practitioner Committee to the Medical Practices Committee that a single handed medical practice should be dispersed, it would be premature for the Family Practitioner Committee to disclose its proposals other than to the Medical Practices Committee? If this is so, the implication is that the CHC has no standing in the matter, although such action would be of obvious concern to those patients in the practice.

I cannot give you an authoritative view as to what extent, it any, Family Practitioner Committees are obliged to consult Community Health Councils. However, I understand informally that the Department of Health and Social Security considers that Area Health Authorities have no power to instruct Family Practitioner Committees to disclose information. No doubt there are two main reasons why FPCs are not required to consult CHCs on proposals for dealing with medical practice vacancies as they arise. Firstly a decision needs to be taken quickly, in the interests of the patients and the doctors who may be concerned. Secondly reports by FPCs to my Committee on the need for filling vacancies contain a good deal of information which is highly confidential.

If the Medical Practices Committee agrees to disperse a single handed practice, for what reasons would it make such a decision?

Any decision by my Committee to disperse a single handed practice will depend on a number of factors. The work loads, ages, health and location etc of the nearest family doctors are all factors which are taken into very careful account. Any above average percentage of patients over age 65, the availability of practice premises, demolition and house building programmes, or traffic congested roads are among the other important factors which also may be relevant.

Why are the numbers of patients with each practice regarded as strictly confidential?

Family doctors are not employees of the National Health Service and therefore details of their practices (from which can be deduced individual incomes) are regarded by the Health Departments and the various NHS Authorities as confidential. My Committee concurs with that view.

In classifying areas for medical classification purposes is the criteria of using numbers good enough; particularly when dealing with deprived areas? Ought not classification to be based on ratio of visits or ratio of patients seen?

The Committee readily agree that there are many factors other than numbers of patients which affect a doctor's work load. they have therefore from time to time considered, in relation to the classification of practice areas, the practicability of using statistics of such factors as mortality and morbidity rates, social deprivation, hospital services — to mention only a few. Such statistics are however rarely broken down to a degree where the effect on practice areas can be identified. Where local details are available they have proved so out of date as to be unreliable for use.

Renewal of the Good Neighbour Campaign

by Roger Barnard, Secretary of the Campaign

The Good Neighbour Campaign sprang into life a year ago as a personal initiative by David Ennals, the Secretary of State for Social Services. He wanted to emphasise the importance of the good neighbour spirit and encourage people of all ages, and of all races and creeds, to give simple practical help to their neighbours in need — especially the old and the sick, the housebound and the physically disabled. The aim was not to supplant but to strengthen the good work being done by the health and social services and voluntary organisations.

Since then tens of thousands of people have been involved in good neighbour activities through the 50 national organisations that pledged their support to the campaign or through local 'do it yourself' initiatives. A growing number of neighbourhoods now have informal street warden schemes, supported by the campaign publicity material, with a canvassed list of people who can give or benefit from good neighbour help. The campaign now has the benefit of a small but independent unit of its own, together with an Advisory Group, based on the Personal Social Services Council. Its jobs are to promote good neighbour activities, respond to local requirements, and tap the limitless potential of schools, press and broadcasting, trade unions, and churches.

Although our main targets for practical help and support will still be the old, the housebound, and the disabled, we now want

to cast the net wider. And we want to bring into the campaign everyone who for reasons of work goes out to people's homes: not just the postman and the milkman, who have given us so much support already, but the rent collector, the dustman, the meter reader, the television serviceman, the social worker, and the GP, health visitor and district nurse.

But the immediate need is for able organisers to come forward who can harness the goodwill and talent of those willing to lend a hand — in every community there should be someone who is known to be co-ordinating good neighbour activities. And in saying that we're confident that CHC staff and members will be foremost among those involved in the next stage of our work, let me emphasise that the campaign is not a metropolitan device to build yet another bureaucratic layer at local level, that it does not seek to supplant the skills and experience of professional workers, and that it's not a cosmetic to conceal the effects of restrictions on public expenditure or the long standing deficiencies of the statutory services.

The growth of the Good Neighbour Campaign and the widening of its scope and impact will take time.

But there really is a need to humanise our society at every level, or we shall find ourselves living in a social machine that runs for its own sake and sometimes runs wild. My own view is that there is a growing need to change the ingrained character of social and professional policy in favour of a new kind of action at local level that seeks always to discover what citizens can share, and how what they share can be enlarged. The Good Neighbour Campaign can be an important educational force in that process. We ask you to join us in renewing the campaign: Your neighbour needs you — and you need him.

PERSONAL VIEW

Grass rooting

by Bill Ashworth, Chairman of Burnley, Pendle and Rossendale CHC.

Some of our Community Health Council sometimes feel a little downhearted, particularly after some rebuff from the managers, or after they have been asked when the CHC is going to build a health centre here or get more therapists there and they have had to explain we have no power to do this. After three years on the road we still stumble over the answer to that simple but deadly question, "What can you actually do?"

So how can we answer this simple question? For a start we have to accept that the nature of decision making has changed in this country for better or for worse. Deference and obedience have ceased to be dominating characteristics of the governed and in fact very few people in this country can "do" anything without prior discussion and consultation. As this is broadly true of the country as a whole, so it is broadly true of the Health Service in particular. And we of the CHCs are an essential part of the process of discussion and consultation in the Health Service.

An example may make this clearer. Months ago, a member presented details of bed sore cases to the management. These were acknowledged but not admitted and all went quiet. Suddenly out of this silence came a reference to our interest in bed sores in a document from the managers, which showed that whether our original details had been right or wrong, our shaft had struck home.

No one is going to stand up and applaud us when we put our finger on important spots like this. We may have to be content with achievement by stealth, as it were, but over the years, the cumulative effect will be beneficial and important.

I think it is vital to get support from and in the community. We have got to put down roots in our own localities as a CHC, and come to mean something for a growing number of people.

Why not enourage the public to speak at any stage of our business meetings? Our CHC does, and in three years the practice has not led to riot, rape or even commotion. Perhaps it would be more inviting if it did! But seriously, we have had some useful comment or information at virtually every one of our business meetings from the public because of this.

One final example will show how this can work. One young lady at a late stage of such a meeting held us for 10-15 minutes with her sincerity and eloquence as she told us of the plight of women whose babies had been stillborn. Within two nights she was on Nationwide TV and the centre of a group with whom hundreds of women all over the country have communicated. With an achievement like this, who says any more that we can't "do" anything? So by encouraging the public to come and talk to us we can both achieve something and create contact with them which can be the making of us.

News from CHCs

● The circular governing closure and change of use of health buildings should be amended, so that CHCs are not obliged to make a "constructive and detailed counter-proposal" when opposing AHA plans. This is the view of Hounslow CHC, which has written to ACHCEW asking it to take the matter up with the DHSS. HSC(IS)207 says a CHC should pay "full regard to the factors, including restraints on resources, which have led the AHA to make the original proposal. The AHA should extend to the CHC all reasonable information and help they may require in formulating a counter-proposal". South Tyneside, Huddersfield and West Birmingham CHCs have also indicated dissatisfaction with these procedures, and ACHCEW secretary Mike Gerrard has already written to the DHSS pointing out the drawbacks of depending on AHA officers for counter-information.

● Provision for local care of long-term mentally ill patients is insufficient in over half London's health districts, and in many places short-stay, day and out-patient services are also inadequate. These are amongst the findings of a survey conducted recently by an ad hoc group of London CHC members. The survey — available from Croydon CHC — also looks at statistics for planning, emergency admissions, catchment areas, community psychiatric nurses, and joint planning and finance.

● East Cumbria CHC is pressing its AHA to set up a health education department. During October the CHC ran a highly successful nutrition week, based on the slogan "Feed right, Feel right", during which it emerged that the Cumbria AHA has no plans to set up such a department despite earlier approaches from the CHC. Rotherham CHC is planning a one-day seminar on the dangers of heart disease caused by fatty foods and too little exercise. The CHC hopes local teachers, education authority officials and industrial managers will attend.

● Southampton and SW Hampshire CHC has investigated patients' views on hospital food, as part of a Wessex RHA survey being coordinated by District Catering Officers. Many patients felt that helpings were too large and there was not enough choice, but some also said there was no need for two cooked meals a day. Preston CHC is querying the introduction of "continental breakfasts" as a pilot scheme in local hospitals. The CHC has been told that patients can have boiled eggs if they ask, but wants to make sure that they realise they have a choice.

● David Ennals has approved the merger of Bristol and Weston health districts, despite energetic opposition by Weston CHC. In a statement Mr Ennals said in-patient facilities in Weston would remain the same, but out-patient and diagnostic facilities would improve, and the CHC would be retained as a "separate community voice", as agreed by the RHA and AHA.

● West Berkshire CHC has helped set up a self-help group for asthma sufferers and their families, following a well-attended public meeting organised by the CHC and the Reading Voluntary Service Council. Leeds Eastern CHC is assisting a self-help group for people with Parkinson's disease.

● The Home Office has refused permission for members of Lincolnshire North CHC to inspect medical facilities at Lincoln Prison. The CHC had only requested an informal visit, but was told by the HO that it had "no standing in the health care of prisoners".

● In its annual report Bristol CHC proposes the replacement of FPCs with "entirely lay investigating committees able to call for professional advice, rather than Service Committees consisting ostensibly of equal numbers of lay and professional members". The report quotes an instance of a Medical Services Committee hearing at which three of the four members present were GPs. The report asks David Ennals to "stand firm against the pressure from the Medical Protection Society and others who wish to deter CHC secretaries from accompanying complainants to assist them in presenting their case".

● A survey of local pharmacies carried out by the NW Herts CHC showed that 22% of patients at evening surgeries found difficulties and delays in getting their prescriptions dispensed. The people with problems tended to be in the older age-groups and did not have private transport.

EDITORIAL

We haven't made a very good job of informing our MPs about the work we do, if a recent debate is anything to go by. The House of Commons Fifth Standing Committee on Statutory Instruments spent 1½ hours on 22 November discussing the establishment of the Association of CHCs in a way that should provoke us to rush out immediately and brief them much more thoroughly!

There were some alarming gaps in the MPs' knowledge and some strange inconsistencies in their reasoning.

For example, they criticised the government for spending money on the setting up of the Association yet they were scornful of the staff salaries and thought them too low to attract the right people to the jobs. They wanted CHCs to be more effective but they complained about the steps CHCs had taken to strengthen themselves — such as the formation of regional groups. John Wells MP described CHC secretaries as "well-salaried ham-handed amateurs who do not know their job".

Although the Minister, Eric Deakins, defended CHCs and supported the establishment of the Association, it is unlikely that the whole debate managed to clarify any issues or improve understanding.

CHCs certainly need well-informed public interest in their activities and it is to be hoped that there will be another debate about them soon. However, CHCs and the Association cannot afford to sit back and let any inaccurate impressions gain ground; so they will need to take a great deal of trouble over discussing all aspects of their work with the MPs — not just dramatic headline-making ones.

CHC NEWS

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- The pattern of representation on planning teams is most varied. Many CHCs are already taking part fully and others would like more opportunities to be represented, whereas some do not want to be involved in this way at all.
- At least a quarter of CHCs are now allowed to send observers to family practitioner committee meetings.
- Almost one third attend joint consultative committee meetings.
- A little under 30% of CHCs have so far been involved in helping complainants to present their cases at Service Committee hearings.
- 17% are using or planning to use the government's Job Creation and Work Experience schemes.

  3 out of 4 CHCs said they were doing survey work. In all, 287 surveys were mentioned.
- On whether it would be useful to have more staff, four out of five CHCs said yes.
- Almost two thirds of CHCs have between 26 and 30 members.
- 42% have coopted members.
- 90% of CHCs have full-time secretaries, and 84% have full-time assistant secretaries.
- 83% of the secretaries are graded on Scale 9; 69% of the assistant secretaries are graded Higher Clerical Officer and 15% are graded Personal Secretary.

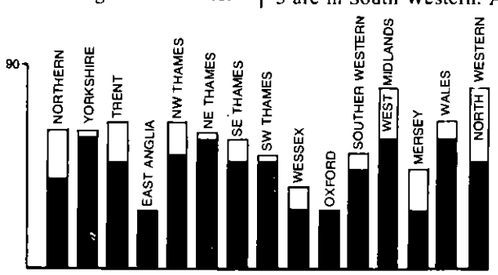
CHCs AT WORK

In August this year we sent a 15-point questionnaire to each CHC Secretary in England and Wales. Our aim was to gather up-to-date information about representation on planning teams, involvement with family practitioner complaints, survey work and projects being undertaken by different councils. We also hoped to get some feedback on *CHC NEWS* and the information service so that we could improve and extend our activities in line with CHCs' needs.

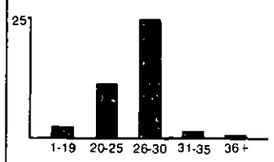
By October, 180 CHCs had replied. This report therefore relates to four out of five (79%) of the CHCs in England and Wales. One reply was received too late to be included, but if others who have not yet replied complete their questionnaires, it is not too late for us to revise the figures subsequently.

The main results are highlighted above, and in the report that follows here we describe the findings in more detail. When we quote numbers and percentages these always refer to the 180 replies, and not to the total of 229 CHCs.

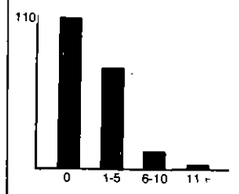
QUESTION 1 asked for the name of the CHC. The figure shows how many replies came from each region and Wales:



QUESTION 2 asked how many members CHCs have. The figure shows the breakdown. SW Thames region has 3 of the smallest CHCs and Northern has the 2 biggest.



QUESTION 3 asked how many coopted members there are. Two CHCs in NE Thames have more than 11 each.



QUESTION 4 asked how many staff work for CHCs, their salary scales and official working times. 163 councils have full-time secretaries, 149 of them on Scale 9. 14 of the full-timers are on lower grades and 5 of these are in Wales. 17 CHCs have part-time secretaries. 7 of the part-timers are in Wales and 3 are in South Western. A single CHC — Isles of Scilly — has no assistant secretary. Most of the rest have one full-timer although 6 have two and 1 has three. 14 CHCs have one full-timer plus a part-timer, and this applies particularly in the NE Thames and Oxford regions. Almost 70% of the assistant secretaries (both full- and part-time) are graded Higher Clerical Officer and 16% are graded Personal Secretary. A small number are on lower grades, but 5 assistants are on the higher GAA grade — 3 of them in the NE Thames region.

QUESTION 5 asked what additional staff CHCs would wish to employ if extra money was available. 72 CHCs think someone to do research specifically for them would be particularly helpful. 54 would like extra help for office work so that the secretary can be freed to do more things out in the community. 17 would find it useful to have additional help for publicity and liaison work. However, 44 CHCs think there should be no extra staff for CHCs, the main reason given being that any extra money would be better spent directly on the care of patients.

QUESTION 6 covered CHC projects done with the help of Job Creation and Work Experience schemes. Eight CHCs have finished this type of project, 10 are in the middle of doing one, 13 plan to do one and 4 have had applications turned down.

The Work Experience projects usually provide CHCs with office help for 30 weeks. The Job Creation schemes are being used for a variety of purposes. Some CHCs have obtained sufficient workers for several months to conduct large-scale surveys. Others are compiling handbooks of local services, or doing research into specific problems.

QUESTION 7 asked about CHC representation on health care planning teams (HCPT), district planning teams (DPT), joint care planning teams (JCPT), joint consultative committees (JCC) and family practitioner committees (FPC). The table shows the replies as percentages of 180. (The totals do not add up to 100% because of multiple answers).

	HCPT %	DPT %	JCPT %	JCC %	FPC %
CHC represented — speak + vote	16	13	2	10	*
CHC represented — speak, not vote	21	10	6	18	18
CHC represented — not speak + not vote	*	0	1	3	10
CHC wants representation but AHA/Local authority/ FPC opposed	19	12	23	31	34
CHC does not want representation	15	9	14	12	10
HCPT/DPT/JCPT/JCC not set up	7	23	16	1	*

*less than 1%

QUESTION 8 covered other bodies on which CHCs are represented. Over 60 different organisations, are mentioned by CHCs, including local voluntary bodies concerned with health and social services, committees dealing with health education, environmental health, addiction and community development. Of special note, 16 CHCs send members to ethical committees, 14 are represented on councils of voluntary service and 4 on safety committees.

Hospital services	53
Mentally ill + handicapped + physically disabled	37
Transport + access	35
General attitudes/priorities	33
Family practitioner services	30
Maternity services	25
Specific issues (incl. abortion, fluoride, smoking, etc)	22
Elderly	14
Community services	12
Child health services	11
Other	15
Total	287

QUESTION 9 asked for CHCs' experience in helping complainants at the Service Committee hearings of family practitioner committees. The secretaries of 41 CHCs have helped complainants present their cases. For 14 CHCs members have performed this role. 12 CHCs say their representative was allowed to cross-examine witnesses, 15 were allowed to address the committee and 35 were restricted to advising the complainant and were not permitted otherwise to speak. A greater number of CHCs have not yet had the experience of being involved at a hearing. 75 do not know whether the FPC would agree to their participation and 24 CHCs have not themselves decided whether they would be prepared to take part if the opportunity arose. 13 CHCs report that the FPC has not agreed to their request to be involved, while 21 CHCs have obtained the FPC's approval but have yet to be involved in a case.

QUESTION 10 asked for details of survey work being undertaken or planned. The wealth of information this prompted cannot be reported in full here, although fuller details will be published in the near future. As a broad indication, the topics of the surveys have been grouped under a number of headings.

QUESTIONS 11-15 asked for suggestions about improvements and additions to *CHC NEWS* and the information service. These cannot be quantified in the same way as earlier questions, but the many interesting and imaginative ideas will be a great help to us. We hope to report some of the points in the near future.

FINALLY we would like to thank all the secretaries and members who took so much trouble to complete the questionnaire. We hope you will feel that the effort was worthwhile, and please contact us if you have any particular questions arising from this report.

Many thanks to Candace Barker, of Pitzer College, California, for analysing the completed questionnaires.


Health Council 'on right lines'

'High-handed move forced resignation'

by PETER HASLAM

IMPACT OF HEALTH — EDUCATION ON SMOKING

WATCHDOG GROUP SAY HEALTH CENTRE PLAN 'DEAD DUCK'

BOOK REVIEWS

HEALTH, THE MASS MEDIA AND THE NATIONAL HEALTH SERVICE;
from Unit for the Study of Health Policy, 8 Newcomen Street, London SE1 1YR, price £2.00 inc post

The Unit for the Study of Health policy has over the last two years been developing some very stimulating and refreshing ideas. Through a series of publications Peter Draper, Gordon Best and John Dennis, the principal staff of the Unit, have been setting out their thoughts. In 1976 there was *Health, Money and the National Health Service* (reviewed in *CHC NEWS 8),* and *Economic Policy and Health.* Both presented challenging perspectives on the debate about resources and values in the NHS.

This latest volume (146 pages) is a welcome exploration of the mass media. Specifically, the authors analyse the general ways of reporting policy matters and take a close look at the coverage of health topics. They conclude that the newspapers and TV and radio devote little enough space to health, and adopt a particular slant throughout their coverage.

This slant or bias assumes that better health is equal to consumption of more and more health services. It assumes that the effectiveness of modern medicine has been proven, that striking advances have been made in technological medicine. It also plays down the environmental influences on people's well-being.

The authors suggest that it would be more accurate to regard health as "... a process of dynamic interaction between people and their environment". They say that since most of us rely on the mass media to tell us about what is happening in the world, it is very important to recognise what interpretations are being put on events before we learn about them. Current coverage of health "portrays reality in such a way that it is likely to act as an obstacle to more open and informed public discussion".

The authors would like to see a genuine diversity in reporting, a more open and participative approach to news coverage and independent access to the means of mass communication.

PHYSICAL IMPAIRMENT: SOCIAL HANDICAP
Office of Health Economics, 1977. Price 70p from OHE, 162 Regent Street, London W1R 6DD.

This booklet is a compact review of physical handicap from the social and medical points of view. The author identifies the 1970 Chronically Sick and Disabled Persons Act as a milestone in attempts to improve patterns of care for the disabled. Local authority social services departments have increasingly had to recognise the special needs of the disabled and make provision for them; the quality and effectiveness of aids has come under greater scrutiny; several new social security benefits have been introduced; and more comprehensive approaches to housing and mobility provision are being made.

A particular feature of the problem in the future is that more and more people will suffer from physical handicaps as they reach middle and old age. The consequences of strokes, arthritis, Parkinsons disease and many other conditions will require 'maintenance rehabilitation' quite different from the acute treatment needed for people impaired by injury. Public and professional attitudes to physical disability also need to change. The author argues that the state of being handicapped should no longer be regarded as rare since most individuals will eventually suffer it in some form.

The booklet has useful diagrams, many references and a good summary of income support schemes and benefits.

Shared Care—the GP and the Hospital Doctor

The relationship between GPs and hospital doctors in sharing the care of patients is reviewed in a recent issue of 'Drug and Therapeutics Bulletin' (published for doctors, by *Which?*), no. 20, 30 September 1977.

Patients have *direct* access to a GP, the first person to whom most medical problems are brought. The GP is responsible for the care of patients when they are not in hospital, decides when a specialist's advice is needed and maintains medical records.

Patients have access to a specialist only by *referral*. The specialist gives advice on diagnosis and treatment on consultation and is totally responsible for the patient while she or he is in hospital.

The smooth operation of this system of medical care is threatened when there is poor communication between the GP and the specialist. It can lead to confusion about who is responsible for the patient's care and about the role of the GP and the specialist.

Surveys have shown that fewer than half hospital case notes contained a GP's referral letter. When a GP's letter was included, it often omitted important clinical history, or what the GP wanted of the specialist, or was barely legible. The problem of hospital specialists having to act on incomplete information is made worse when patients by-pass the GP and go directly to the accident and emergency department. They may prefer not to wait for a GP appointment, or may think they will get more expert treatment. A lack of confidence in deputising services may also contribute to this.

Discharge letters or reports from specialists to referring GPs are often delayed for as long as four weeks after discharge following emergency admission. Delays may be due to lack of secretarial staff or the failure of those responsible to appreciate the importance of being prompt.

Confusion about the role of the GP and the specialist is especially common in outpatient referral and treatment. In 1973 and 1974 more than three quarters of all outpatient attendances were repeat attendances, and it is possible that some patients are continuing to come for outpatient treatment, even though the GP is competent to care for them. Such unnecessary attendance blocks up the clinics and means long waiting lists. Repeated appointments may be due to the specialist's personal research interests or, more commonly, the result of the GP's failure to state whether specialist care is required, or simply a consultation. A clearer record of the treatment policy in the hospital notes would ease this problem.

However, long term specialised outpatient treatment sometimes is necessary, and in such cases sharing of responsibility is especially important. Patients may need to consult their GP for problems related to the treatment, and the GP may not have been told what is happening, or what to do if there are setbacks. Who is responsible for prescribing and for issuing certificates must also be clearly established.

The article suggests that communication between GPs and hospital specialists should be more rapid and explicit. GPs' referral letters should give more detail and the use of 'problem lists', similar to problem oriented medical records would improve both referral and discharge letters and help to ensure that all essential information is included.

Finally, specialists should only retain outpatients for long term care for specific reason, and should give the GP detailed information on the treatment and how to monitor it. In the interests of patient care, doctors must have clearly defined areas of responsibility and there must be clear and prompt communication between the two levels of medical care.

Signed and Delivered

CHCs often receive petitions from various interest and pressure groups, but in recent months some have also begun to organise their own petitions and deputations to the DHSS, over issues where local management has failed to give satisfaction.

The longest list of signatures yet to arrive at the Elephant and Castle has come from Rotherham CHC, which at one stage in its campaign had people queueing up to sign.

The issue in Rotherham was the failure to open the town's brand-new District General Hospital — an opening originally scheduled for early 1977, twice postponed, and not even guaranteed for inclusion in the 1978/79 programme.

In a press release in May, the CHC set the issue firmly in context: "For too long Rotherham has been one of the lowest funded areas in the country. Largely due to the skill and dedication of the medical and nursing staff a health service has been maintained, but the problems of providing 20th century medicine in a 19th century environment have no doubt caused many of the Rotherham community to seek medical care elsewhere. . . .

"In its discussions with many community groups, the CHC has been made aware of public disquiet in this matter. Such disquiet was often tempered by the hope that improvements would come with the opening of the DGH. It now appears that the needs and wants of the Rotherham community are to be further denied, and that by so doing Rotherham will continue to remain the Cinderella of the NHS. This intolerable situation must not continue.

"The Rotherham CHC therefore invites all members of the community to make their voices heard by using every possible means, including that of making representations to those responsible for the provision of health services. Such action will be totally supported by the CHC, by providing support at public meetings or the raising of public petitions".

Making the most of press publicity surrounding this statement, the CHC launched its petition, in conjunction with the Rotherham Trades Council and local MPs. In six weeks over 30,000 signatures were collected — a rate of about 1,000 a day. The word was spread not only through the press and public meetings, but also via a circular letter sent by the CHC to a wide range of local societies and voluntary organisations.

Even before the CHC's deputation left for London, the Trent RHA had announced a special allocation so that the DGH could open in January 1978, and the Rotherham AHA had begun to press the region to guarantee further money, to cover the hospital's running costs in the 1978/79 financial year.

In July a deputation arrived at the DHSS' London offices, to present the petition to David Ennals. Included in the party were CHC chairman and deputy mayor Coun. Charles Brett, CHC secretary Bob Payne, three local MPs, and representatives of the trades council and the Rotherham branch of the British Medical Association. No specific commitment was obtained from Mr Ennals, but the deputation left satisfied that it had presented Rotherham's case to the Secretary of State in a forceful way, leaving him in no doubt of the urgent need for action.

Three London CHCs have been involved in collecting and presenting public petitions. In Newham a petition opposing the closure of Plaistow Maternity Hospital was launched in July, following a CHC public meeting attended by about 70 people. Nearly 9,000 signatures were collected in ten days, by local people who volunteered to canvass their own roads. In August Roland Moyle met twice with a CHC/borough council deputation, including the borough's chief executive and the director of the Newham Voluntary Agencies Council. Between these two meetings the petition was presented to the House of Commons by a local MP. Mr Moyle, however, was unable to give a firm commitment to providing a replacement maternity unit in Newham.

Islington CHC has presented its RHA with a 4,000-signature petition calling for the return of a neurosurgery unit, which was "temporarily" moved out of the health district in mid-1975. The CHC has also found an ingenious use for the names and addresses of local people who signed its petition — it has sent as many of them as possible a copy of its recent annual report, to help build up a network of local people who know the CHC exists and understand something of what it is trying to do.

Also in London, Barking CHC has presented Roland Moyle with a petition requesting that local treatment for long-stay elderly patients be made available within the borough. Some 8,000 signatures were collected over about eight weeks, by leaving petition forms in the town hall and other public buildings.

In Southend, about 18,000 people signed a CHC petition opposing the closure of two wards at Southend Hospital. Some 8,000 of these signatures came via the local paper, the *Evening Echo*, which ran a strong "Save the Wards" campaign. Following a public meeting, a deputation of CHC representatives, councillors and local medical representatives presented the petition to David Ennals. He told them it would not be right for him to intervene in a local management decision, but added that DHSS officials would be discussing the underfunding of Essex AHA with the RHA.

Rotherham CHC secretary Bob Payne sums up the lessons of Rotherham's campaign as follows:

Some people say that the public are only interested in their health service when they have a need to use it, but our experience has shown that if a CHC is prepared to go out and sell itself it will get the support it needs.

But this won't happen by sitting behind a desk. Writing articles for the press and going on the radio is all very good, but success will always come in the end if the CHC secretary is prepared to stand up and be seen — to go out amongst the community he represents. The support we got from the community was magnificent.

There are several specific points which I see as most important:

1 There must be a clearly defined reason for the petition.
2 The aim, or what it is hoped to achieve, must be made adequately known by using all forms of publicity available, ie press, radio, TV, public meetings, etc.
3 Publicity must be continuous throughout the whole period of the exercise (get yourself a good PR man).
4 The community must be made aware of the part they have to play, and must be kept informed.
5 Support from all and any source is essential, ie press and radio, local authority members, trades councils, MPs, etc. All these are important to have the total support of the community.
6 Having delivered the petition, make the outcome publicly known as soon as possible.
7 A letter of thanks to all concerned.

INTO THE LIMELIGHT

by Chris Mackwood, Secretary of Worthing CHC

The Worthing District CHC's survey report, "Concern for the Elderly" hit local headlines after its release in May. It established the shortfall in local services for the elderly. It showed that 28% of the 63,000 persons over the age of 65 lived alone and 11% had infrequent contact with friends or neighbours. 6% had not seen a GP within the last 10 years (some obviously had no need), 96% had no contact with health visitors, 93% with district nurses, and 97% with social workers. 12% had financial problems with heating, 14% had unsatisfactory teeth and glasses and 25% had trouble with hearing.

The next day the telephone rang continually with calls from national newspapers, and from two TV stations requesting I await further calls as they wanted to arrange programme space, camera crews and locations. By midday I realised both programmes would clash — impossible to be in London and Southampton within an hour! I accepted Southampton, allowing time to liaise with Chairman, eat sandwich and change blouse for colour TV. Did I do wrong by missing a wider audience? I shall never know. The interview went well and has been repeated with wider viewing. German TV rapidly followed by filming an interview on Worthing beach. Thinking it was to be filmed in the office, I wore high heels and found myself slowly sinking into the shingle. Interviews for radio followed.

Members of the Area Health Authority received the report, and our CHC asked for it to be officially discusssed as an item on their agenda. Congratulations were given to the CHC at their July meeting. It was promptly passed to the DMT. The first meeting of the District Planning Team for the Care of the Elderly was held in September when it was stated due consideration would be given to the report. We feel, as a Council, that immediate action could have been taken in planning at least one day centre combining a voluntary bureau providing a central telephone number to assist the elderly.

As the survey figures obtained appear to be of interest to a wide number of people, known by the continual requests for copies of the report whenever a meeting is held on the elderly either locally or nationally, we submitted another project, accepted on 5th October 1977, to be completed in six months. We shall print another report — as we are convinced continued and constant pressure is needed to achieve results.

I doubt whether our CHC will ever receive formal notification as to whether the findings of our report were instrumental in changing the care of the elderly but we do know it is being used as proof that changes are required. A query remains in my mind. We had the opportunity with one TV programme to film an elderly person from the survey in distressing circumstances and highlight the case throughout the country. We refused to break the confidentiality we had promised.

Perhaps if we had NOT refused the services for the elderly in our District would by this time thave been improved and the threat of financial cuts, due to take effect in our District in 1978, would have been averted. Is it only the Maria Colwell type of publicity that prompts action? We have tested the media one way and action, though far too slow, appears to be progressing — the alternative way is, of course, still available if necessary. The lessons to remember are, "know your subject inside out and upside down, think fast, be accurate in replies, and make rapid decisions" — if you don't you have lost the publicity, because what is news today is history tomorrow.

Access for disabled

by Joe Hennessy, Secretary of Durham CHC

One of the important provisions of the Chronically Sick and Disabled Persons Act was that access to and within public buildings or premises should be provided for disabled people but although the Act has been operative since 1970 there is still much concern that not sufficient notice is being taken of it.

The main sponsor of the 1970 Act was Alf Morris MP, who is now Minister for the Disabled and he has established a Committee, to be responsible, in Silver Jubilee Year, for considering ways of improving access for disabled people and to recommend changes to those responsible, as well as drawing the problems of access and egress for the disabled to wider public attention. The Committee, to which I have been appointed by the Association of CHCs, is embarking on a number of initiatives and it would be extremely valuable if CHCs could take a special interest in whether suitable facilities are available for disabled people in health services premises in their areas.

But what should these facilities be? The answers can be found in "Designing for the Disabled" by Selwyn Goldsmith, published by the Royal Institute of British Architects. At £20 it is probably too costly to be on the book shelf of every CHC but could be readily borrowed from the library. It contains a section on health and welfare buildings which CHCs will find particularly useful when assessing the situation in hospitals, health centres and clinics.

CHCs which assume that the health service is meeting its legal obligations under the Act may be in for a shock when they check for themselves. Darlington and Newcastle upon Tyne CHCs have made studies of newly completed major hospital developments in their areas and found them to be severely wanting in respect of facilities for disabled people.

Faults included inadequate car parking; inaccessible toilets; public telephones positioned too high for people in wheel chairs; inadequate facilities in changing rooms; inaccessible shower rooms; poor facilities at the hydrotherapy pool. Additionally, at Darlington, the control panels in the lifts were too high for wheelchair users, with the alarm switch being even higher and, to cap it all, the main entrance has a step.

None of these errors should have occurred. There are lessons to be learnt from this sorry state of affairs by the DHSS, Health Authorities and CHCs. The DHSS should be directing RHAs and CHCs to comply with the Act; the Health Authorities should ensure that appropriate design briefs are available to architects and engineers; CHCs should be healthily sceptical that either of these proposals will materialise and should, therefore, insist on seeing plans and accommodation schedules right at the beginning of new developments.

So much for new buildings. What about existing ones? Using the checklist in "Designing for the Disabled" (1976 edition), CHCs should visit their health service premises particularly the major ones, to vet their accessibility to disabled people. Deficiencies should be noted, prioritised and then discussed with the AHAs.

In assessing what needs to be done, CHCs can use the expertise of those of their members who are disabled or co-operate with local voluntary organisations covering such handicaps as deafness, blindness, and physical disabilities which impair mobility.

One final thought on access for the disabled. How do CHC premises themselves match up to the requirements of the Act?

The plight of the blind

by Fred Reid, Lecturer in the School of History, Warwick University

Unemployment, low incomes and lack of helpful, practical advice — these are the social levers which enforce isolation on blind people. Between 1920 and 1960, it could have been said that they were being progressively removed. Today, there is a good case for arguing that they are rapidly getting worse. There are about 120,000 people registered as blind in the United Kingdom. Three quarters of them are over the age of 65. There are about 25,000 blind people of working age in England and Wales. Of these, less than 10,000 are in gainful employment. Many blind people, potentially employable, are thus left unproductive.

The reasons for this low rate of employment are numerous. One is the lack of ordinarily attractive employment opportunities. Too many jobs offered to blind people are boring, dead-end, low paid or involve high risk of unemployment. Another reason is the inadequate staffing of the Blind Persons' Resettlement Service. But the largest single factor is lack of suitable work for those blind people who are handicapped by factors additional to blindness. Such other factors may be an additional clinical condition, such as diabetes, or the slowing up that comes with advancing years (most blind people lose their sight between the ages of 40 and 60), or there may be particular problems such as very poor memory.

Sheltered workshops have never provided employment for more than a tiny handful of these slow, irregular workers. Since the early 'sixties, moreover, sheltered workshops for the blind have been modernising. Basket making and other traditional crafts are out. Modern production processes in furniture making, toilet commodities, etc., are in. These require workers with little skill, but with a relatively high rate of consistent performance. Slow and irregular workers are being squeezed out and blind people fit for open employment are being encouraged to escape from current high rates of unemployment in industry by accepting jobs in the special factories for the blind. Thus, while some 7,000 blind people are registered as "not capable of work", the factories for the blind employ less than 3,000 blind people.

The "unemployable" are sometimes employed in the productive units run by some local authority day centres. This at least proves that they are capable of socially useful labour, since these units produce goods under contract to industrial firms. Current policy, however, prohibits them from paying their workers for the work they do, since that would breach the earnings rule applied by supplementary benefit rules. Examples are recorded of payments of as low as 10p for a morning's work to people producing parts for cars.

What of the remaining blind, too old or too young to work? The lives of the former are often impoverished by low social security payments and isolation: Nearly half of the 70,000 over retirement age live on supplementary pensions. To compensate them for the many extra expenses of blindness, these receive the quite inadequate weekly sum of £1.25. It was 15 shillings when introduced in 1948. The rest of the blind receive no help with the extra expenses of their disability unless they are lucky enough to pay income tax, in which case a mere £180 of their income is relieved of taxation.

The reorganisation of the social services in the early 'sixties has meant, nearly everywhere, the disappearance of the blind person's one sure point of contact with the wider world, the home teacher. He (or she) regularly visited the blind person in his own home. Such visiting was an obligation laid upon the local authorities by legislation between 1920 and 1948, which has never been repealed. The home teacher could keep the blind person up-to-date with new aids, with changing welfare benefits, and provide sympathetic understanding of the blind person's point of view. In addition, he was trained to teach braille, typing and the other skills of daily living.

Today most of this structure has disappeared. Social workers (even those rare ones specialising in the blind), do not visit regularly, but have to be contacted in a breakdown situation. A few local authorities provide officers to teach mobility, fewer still provide classes in braille or daily living skills. None tries any longer to offer a range of such training to everyone who goes blind.

For most blind people of school age, the only practical form of education is the residential special school. This has been criticised for segregating the blind child from family and community. Yet all agree that integrated education of the blind would require a high level of supporting services to teachers and pupils. Considerable advances have been made in providing these for deaf children in ordinary primary schools, but similar provision for the blind child is only now receiving systematic consideration.

YOUR LETTERS

continued from page 2

the 13 year old sister of this boy can be easily imagined.

At the request of my Council therefore I am asking through your columns if anyone knows of a vacant bed in their health district which could be allocated to this case, then we would be very pleased to know about it.

VOLUNTEERS

Gl Davies, Pontypool, Gwent

I recently read in *CHC NEWS* of the need of volunteers in the health service as some of the work carried out by volunteers is worthwhile, i.e. visiting patients who have no relatives or the old and infirm while they are in hospital — that, of course, is ideal. But there is a far more important issue which, as a health service employee, I am concerned about. At a time of high unemployment, a lot of work in some hospitals is carried out by volunteers — mostly married women whose husbands are working or some retired persons who are doing it for something to do — but it's work that should be done by full time staff. Health authorities should stop using cheap labour and employ people from the dole queues.

There is, too, the case of training nurses who, after training, find there is no work available for them. There is also the case of industrial disputes brought about by low rates of pay and conditions, e.g. an ambulance service recently had a dispute about manning levels, and what did the authority do? It tried to bring in volunteers to man the ambulances.

Would these same people volunteer to man the mines, the car factory, the docks or the bakery — NO — most of these same people, if they are working, are in trade unions. How would they react to hospital and ambulance staff doing their work?

We must protect our jobs as not everyone in the health service agrees to volunteers. It is an issue that our trade unions must look at in the interests of their members.

VISITING LONG STAY HOSPITALS

David Downham, Kings Fund Centre

A number of CHC members have approached the Kings Fund Centre about the possibility of organising workships on the skills required in visiting long-stay hospitals and other residential establishments. MIND has produced an excellent checklist on what to look for and what questions to ask, but what about such matters as: how to ask the right questions; initial contacts — establishing good relationships with staff; asking about written ward policies; learning about general services — e.g. laundry, meals; frequency of visits; writing reports.

The Long Term Care Team at the Centre would be pleased to hear from anyone who is interested in pursuing these and other questions further. Please write to us at 126 Albert Street, London NW1.

NOTES.....

SMOKING AND PROFESSIONAL PEOPLE
This is the report of a DHSS survey on the smoking habits of health professionals and teachers and their attitudes to anti smoking education. Except for hospital nurses, all in the survey smoked much less than the general population. TV advertising was considered the most useful method of anti-smoking education, although most people felt that they could also help through their work. The report will be available from HMSO.

DEFENCE AND PROTECTION OF DOCTORS
The annual reports of the Medical Defence Union and the Medical Protection Society include legal cases which the MDU and MPS have fought on doctors' behalf. The MPS report, under the heading, 'FPC Problems', argues strongly that a CHC Secretary is a 'paid advocate' for the purposes of a Service Committee Hearing (see *CHC NEWS 17, p.5*). Medical Defence Union, 3 Devonshire Place, London W1N 2EA. Medical Protection Society, 50 Hallam Street, London W1N 6DE.

SOCIAL SECURITY BENEFITS FOR HOSPITAL PATIENTS
DHSS leaflet NI9 explains the conditions under which certain social security benefits may be reduced or stopped altogether if the recipient or a dependant is in hospital. The benefits affected include supplementary benefit, attendance allowances, sickness benefit, widow's benefit, invalidity benefit and retirement pensions. A resettlement benefit is available in some cases, to assist people discharged from hospital after a stay of more than one year.

LAW CENTRES DIRECTORY
Legal Action Group have published a new edition of the Directory of Legal Advice and Law Centres. It covers England, Wales, Scotland and N. Ireland. 50p. (incl. post), from 28a Highgate Road, London NW5 1NS.

HELP WITH FARES
A revised version of DHSS leaflet H 11 gives details of help with travelling expenses for those attending hospital as a patient, or accompanying a patient. It takes account of the increase in supplementary benefit rates, and anyone on a low income is eligible to apply.

ENVIRONMENTAL HEALTH OFFICERS
A new leaflet, 'The EHO', explains simply how the environmental health officer can help with everyday environmental problems. Single copies free from EHA, 19 Grosvenor Place, London SW1X 7HU.

DEPUTISING SERVICES
A new code of practice on GP deputising services is expected from the DHSS soon. It will deal with 'the number of doctors on duty and their competence; their supporting staff and transport; their communications; the priority of and response to calls; the continuity of care; and the records to be kept and information available from them'.

HELP WITH HEATING COSTS
DHSS leaflet OC 2 explains how and when supplementary benefit claimants may be entitled to extra help with fuel costs, either as an extra weekly allowance or in a lump sum for special items like draughtproofing materials, repairs to appliances.

SELF-HELP CLEARING HOUSE
This is a project aiming to provide links between self help groups. The first issue of its bi-monthly newsletter sets out details of the project and a wide range of groups, many of which are involved in health and social services. ('Self Help Spotlight', £5 a year from SHCH, Kingston Road, Merton Park, London SW19 3NX).

HC(77)38: EEC DOCTORS' KNOWLEDGE OF ENGLISH
All appropriately qualified EEC doctors will, on application, be given immediate registration to practise in the UK. Within six months of registration they must satisfy the General Medical Council that they have adequate knowledge of English. If a doctor fails the language tests run by the GMC, his registration will lapse. (See *CHC NEWS 21, Notes*).

HN(77)115: VIOLENCE TO CHILDREN
The DHSS has invited professional bodies, voluntary organisations and others to submit their views on Volume 1 of the First Report of the Select Committee on Violence in the Family (HMSO £1.35). The Committee's recommendations cover a wide area of personal social services, the legal system and health services. They stress the importance of health workers taking heed of the social and emotional well-being of parent and child during the birth and new born period.

HN(77)154: COSTS OF AHA STAFF WORKING WITH GPS; HELP FOR GPS WITHOUT SURGERIES
Discusses the allocation of extra costs incurred by GPs when AHA employees working as part of a primary health care team also undertake other duties, eg nurses working in AHA sponsored clinics. Rent and rates for accommodation used by attached staff will in any case normally be met by the AHA, but by local agreement GPs may also be reimbursed for extra heating, lighting, telephone costs, etc. Also asks AHAs with surplus premises to assist GPs who are finding it difficult to acquire property suitable for surgery use.

Directory of CHCs

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

DIRECTORY OF CHCs
Page 5: Grimsby CHC
Chairman: Rev. N. C. Fisher
Page 9: South Lincolnshire CHC
Secretary: Miss E. E. Wood
Page 10: Central Nottinghamshire CHC
Address: 49 West Hill Drive, Mansfield, Notts NG18 1PL.
Page 13: Bury St Edmunds CHC
Address: 77 Whiting Street, Bury St Edmunds, Suffolk.
Page 19: South Camden CHC
Secretary: Mrs Jacqueline Kelly
Page 34: East Somerset CHC
Chairman: Count Charles de Salis
Page 38: Coventry CHC
Address: Room 222, 2nd Floor, Broadgate House, Coventry CV1 1NG
Page 43: Bury CHC
Chairman: Mrs J. Blunt
Page 45: Salford CHC
Chairman: Mr L. Martin
Page 47: Aberconwy CHC
Address: 3 Trinity Square, Llandudno, Gwynedd LL30 2PY
Telephone Llandudno 78840
Page 51: Yorkshire Regional Council of CHCs
Chairman: Mr J. L. Rosen
Page 51: Trent Regional Association of CHCs
c/o North Derbyshire CHC, 87 New Square, Chesterfield.
Chairman: Basil Barker
Secretary: Keith Swann
Telephone: Chesterfield 33042
Page 56: Trent Regional Association of Secretaries
c/o Barnsley CHC, Jordan House, 41 Gawber Road, Barnsley S75 2PY, South Yorkshire.
Chairman: G. G. Callaghan
Secretary: Alan Hicks
Telephone: Barnsley 203112

A tankful of trouble

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proposed EEC standard of 0.40 g/litre by 1981. In West Germany a limit of 0.15 g/litre was introduced last year. In the USA the average lead content of gasoline will be reduced to 0.13 g/litre by January 1979. In the Soviet Union, petrol sold in major cities has been lead-free since 1959.

*Information about the Campaign Against Lead in Petrol can be obtained from 168 Dora Road, London SW19.

FURTHER READING

1. Environmental Health Criteria 3: Lead, UNEP/WHO, 1977, HMSO £4.48.
2. Lead in drinking water, DoE Pollution Paper No 12, 1977, HMSO £1.15.
3. Lead in the environment and its significance to man, DoE Pollution Paper No 2, 1974, HMSO 90p.

HAS Report

The Health Advisory Service's Annual Report for 1976 was published in November. It raises several important points about deficiencies in facilities for long term care of children, the elderly and mentally ill, and we will be writing about it in next month's issue.