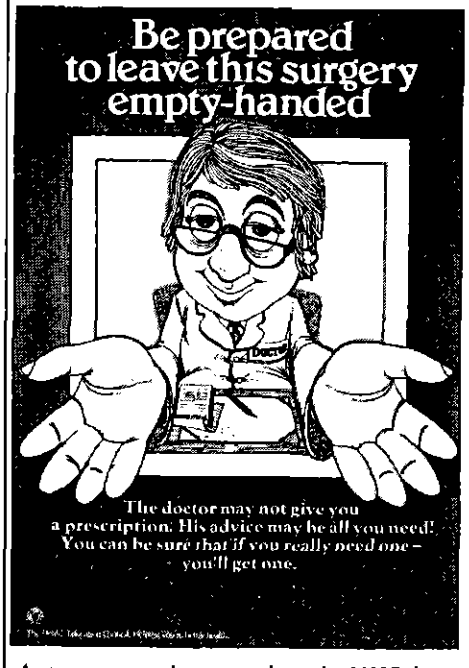
CHC NEWS

For Community Health Councils

June 1978 No 32

Keeping an eye on the growth of private hospitals

Reports in the press suggest that around a hundred new private hospitals may eventually be built in Britain, in response to the phasing out of private medicine from the NHS. This figure may well turn out to be an overestimate, but a trend is certainly under way. Last year the Health Services Board was notified of 12 proposals to build small private hospitals, and by last month this year's total had already reached 10.



A statement on how to reduce the NHS drugs bill has been issued jointly by the UK health departments and the British Medical Association, with circular HN(78)51. It expresses "growing anxiety about rising patient expectations and consumption of NHS facilities including pharmaceutical products", and coincides with the issue of new Health Education Council publicity material on the subject. Leaflets and posters (see above) tell patients not to expect a prescription every time they visit their GP, and explain that advice on treating many minor illnesses can be obtained direct from the staff of chemists shops. HEC, 78 New Oxford Street, London WC1.

The Health Services Act 1976 gives the board powers to control private hospital developments only where they would exceed 74 beds (99 in Greater London). Recently the board held its first public hearing into such a development, and its decision may be of some interest to CHCs.

The hearing considered plans by American Medical (Europe) Ltd to build a 150-bed hospital at Cheadle, Manchester, within Stockport AHA. The board had already approved an expansion plan from BUPA Hospitals Ltd for another Manchester hospital, St Joseph's.

Objectors to the proposal included two AHAs (Manchester and Trafford) and three CHCs (Crewe, Manchester Central and Manchester North). Supporters and "non-objectors" included the DHSS, three AHAs (Cheshire, Stockport and Tameside) and eight CHCs (Chester, Halton, Macclesfield, Manchester South, Stockport, Tameside, Trafford and Warrington).

Manchester AHA claimed the plan could interfere with work at the nearby regional centre for heart surgery, and could hinder the recruitment of nurses in its central and southern health districts. This was supported by Manchester Central CHC, which pointed out that an adjacent geriatric unit due to be completed in 1980 would "not be able to attract the highest quality staff". Trafford AHA also foresaw recruiting problems, "particularly if the controlling companies (at Cheadle and St Joseph's) pay rates higher than Whitley Council rates". CHCs supporting the application argued that effects on NHS services would not be "significant", and some added that more private medical facilities were desirable.

The board decided the Cheadle plan would not significantly interfere with NHS recruitment, though interference "to a small extent" was possible. Unemployed nurses and auxiliaries, and staff brought in from overseas by American Medical, would meet the company's demand. The decision stresses that "the onus of proof to satisfy the board on the balance of probabilities was firmly placed on the objectors".

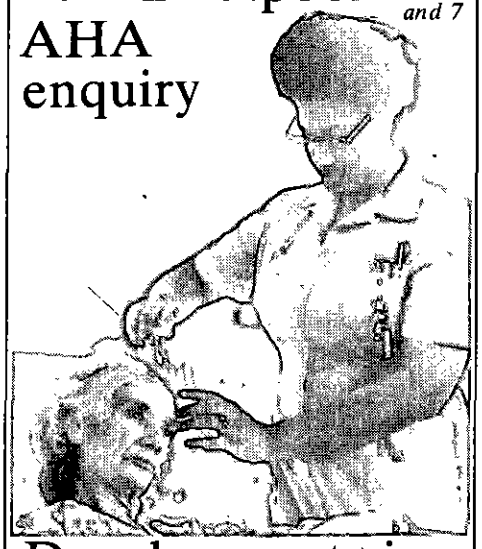
INSIDE . . .

Ideas in action *page 3*

The Liverpool AHA enquiry *pages 6 and 7*

Developments in the Eraldin campaign *page 8*

Deputising: South Birmingham's response *page 11*



Vivian Sanders

Vivian Sanders has been appointed as the new editor of *CHC NEWS*. Vivian is 32 years old and since 1971 has worked for the medical journal *The Lancet*, where she was a senior assistant editor. Before that she was with the scientific journal *Nature*.

OUR DIRECTORY AND INDEX

Several CHCs have asked when we shall be publishing updated versions of the Directory of CHCs and the Index of *CHC NEWS* contents. We had intended to have both these ready by now, but staff changes have made this impossible. Work on these publications is now in progress, and as soon as they are available one copy of each will be sent *automatically to every CHC. Further* single copies will be available free, but please send a stamped addressed envelope with your request.

Comment

On 13 April Rick Rogers resigned as editor of CHC NEWS, following a disagreement with the magazine's editorial board. Rick wanted to aim the magazine at a broader readership, whereas the board preferred the existing approach. In this column the chairman of the editorial board, Dr Rod Griffiths, comments on these events.

Should the magazine be addressed to a wider audience? Are CHC members and secretaries the most effective contributors? Broadly speaking, the policy of the editorial board is "News of CHCs, by CHCs and for CHCs", and recently this has had to be firmly stated. The resignation of an editor is a good chance to stop and reflect.

The questions are legion and there are no certain answers. Change is an essential part of progress, but the pressure for new directions must come from CHCs, not the editorial board or the staff of ACHCEW. On the other hand the skill and innovative spark of our team can highlight and increase the effectiveness of CHCs.

Already we can see that CHCs' interests are widening and deepening, and as membership changes there is an overspill of CHC experience into the community. Some councils already cultivate contacts inside and outside the health service with extra copies of *CHC NEWS*. Knowledge of our growing and changing readership is only gained through feedback, and neither CHCs nor the magazine and information service can take each other for granted. We need a continuous flow of criticism and suggestions. With that we can continue to develop the magazine, and we hope that you will continue to find that *CHC NEWS* is good news.

CHC NEWS

JUNE 1978 **No 32**

126 Albert Street, London NW1
01-267 6111

CHC NEWS and Information Service Staff:
VIVIAN SANDERS (EDITOR)
DAVE BRADNEY, JANET HADLEY

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

Published by the Association of Community Health Councils for England and Wales, designed by Ray Eden and printed by The Chesham Press Ltd., 16 Germain Street, Chesham HP5 1LJ.

Your letters

Our April issue

Drew Kimber, Secretary Sunderland CHC

Can I say how very disappointed I am with the new front cover of *CHC NEWS*. The April issue has taken on the appearance of a standard magazine, and unfortunately will never compete with the many others already on the market. The previous format of having a "bitty" front page was much more eye-catching, and more likely to be read both by CHC members and by outsiders. I do hope you will be able to revert to the previous pattern.

John Stevens, Secretary West Berkshire CHC

I should be interested to know why two full pages out of 12 in April's *CHC NEWS* were devoted to fume sniffing — scarcely a topic likely to be of major, if any, interest to CHCs. If this is part of the attempt to extend the scope of the magazine I hope you will reconsider your policy, since I have previously found *CHC NEWS* extremely interesting and helpful.

Ed: Other comments made verbally and on the phone to CHC NEWS staff have mainly been similar to the above, though there have also been some more favourable views expressed.

Campaign for lead-free petrol

Juliet Mattinson, Secretary East Berkshire CHC

A high intake of lead is a serious health hazard, particularly to very young children, and significant quantities of lead are emitted from car exhausts. This CHC has resolved to press the Government to legislate for the introduction of lead-free petrol as soon as possible, and in the interim to restrict the maximum lead content to 0.15 grams per litre, the present legal limit in West Germany.

The usual argument against this measure is that, although desirable, it would increase petrol prices, but there is evidence from an expert source quoting a figure of 0.06 pence per gallon. This is minimal, and in any case it is stated that wear and tear on petrol engines is reduced if lead is not added.

We would be glad to hear from any other CHCs willing to add their names to our campaign.

Ed: For background to the lead issue, see last December's CHC NEWS.

Need for more health visitors

Miss E. Gough, Hon. Secretary, Standing Conference of Representatives of Health Visitor Training Centres, Dept of Community Medicine, University of Leeds, 32 Hyde Terrace, Leeds.

The SCRHVTC wishes to alert CHCs to the fact that recruitment to health visitor training fell by 5.8% between 1975/76 and 1976/77, and by a further 5.4% in the following year, an overall drop of 10.8% during this period (figures relate to one-year post-registration courses).

If this situation does not improve, it will be impossible to implement the recommendations contained in the *Priorities* consultative document, which recommended a target national increase in expenditure on health visiting of 6% per annum. With existing ratios of health visitors to population it is impossible to give more than lip service to such important aspects of prevention as safer pregnancy and childbirth, nutrition, alcoholism, heart disease, early detection of abnormalities, screening programmes and health education. An increase is also necessary if health visitors are to meet some of the areas of need outlined in the Court report on child health services.

We ask all CHCs to urge their health authorities to increase their establishment of health visitors, to meet the recommended target. In some cases AHAs have money to spend on health visitor training, but find themselves unable to second or sponsor students because their health districts are not always able to offer employment to trained health visitors.

Waiting times in ante-natal clinics

Jean Coupe, Secretary Tunbridge Wells CHC

Members of our Maternity Services Group have been concerned at the long waiting times mothers spend in our ante-natal clinics. We are given many reasons why this happens, and so far have been unable to come up with an adequate solution. One of our problems in a rural area is transport to the clinic. Buses are infrequent, which means that mothers all tend to arrive at the same time. I am sure our problem is far from unique, and we would like very much to hear from other CHCs who know of a system that works.

Dental treatment for the handicapped

Alan Potts, Secretary Preston CHC

A new concept in providing dental care for patients with severe physical and mental handicaps is being developed at Whittingham Hospital, Preston.

Before being given an appointment for the hospital's special theatre unit, patients will be assessed by a consultant oral surgeon from Preston Royal Infirmary. Treatment will be provided by an assistant dental surgeon experienced in treating handicapped people. Initially, one session is being held per week, with no age limit on accepting patients.

The idea for the scheme came three years ago from Lancashire's Area Dental Officer, Mr D. M. Dodd, and was supported by the oral surgeon concerned, the AHA, the DMT, and other interested parties. The unit has been provided by adapting a disused operating theatre, at a cost of £7,500 for alterations and £9,500 for equipment. Revenue costs for 1978/79 are expected to be about £4,600. The scheme is funded by the AHA as an area function.

Community bus

by John Kitchen, Secretary of Worksop and Retford CHC

The CHC has always been acutely aware of rural transport difficulties, one of the many deprivations in this health district, which is co-terminous with Bassetlaw District Council. Public transport services are inadequate or even non-existent. For example, it is impossible for patients and visitors to travel by public transport to Saxondale, a mental illness hospital some 43 miles from the North Eastern sector, and return within a day. This prompted the CHC to do a survey in the North Eastern part of the district, to obtain accurate information on access to hospitals, doctors' surgeries and clinics.

By co-incidence, Nottinghamshire County Council's Planning and Transportation department was doing its own rural transport survey and offered to deal with the CHC's survey at the same time. The results would be fed through the County Council's computer. This was accepted and the results highlighted the expected deficiency. A group was formed to find ways of easing the problem. Its members were drawn from the health authorities, the County Council, the Council for Voluntary Service, the rural community council and the CHC. A whole range of ideas was considered, from mini-buses run on a voluntary basis to ordinary service buses.

Eventually a plan was put to the County Council suggesting a "midi-bus" with a custom-built body and side-chair lift, to accommodate 19 seated persons and two wheel-chairs. A comprehensive timetable was also submitted. £12,000 was allocated for a one year trial period, and the contract was eventually awarded to a local private company with considerable experience of rural transport operations.

The Bassetlaw Community Bus differs from other schemes in the way it is administered. A Local Management Committee was formed from among representatives of the parish councils, the AHA, the County Council and of course the CHC. A local co-ordinator will deal with day-to-day telephone bookings from individuals. One great advantage is that the bus can be used in the same way as a normal fare-stage service. Also an intending passenger may stop the bus anywhere along its route, which means a very flexible, almost door-to-door service. The timetable can be adjusted by the Local Management Committee in the light of experience. There are regular journeys to hospitals in Worksop and Saxondale. Soon the service is to be extended to carry patients and visitors from this district to Sheffield hospitals.

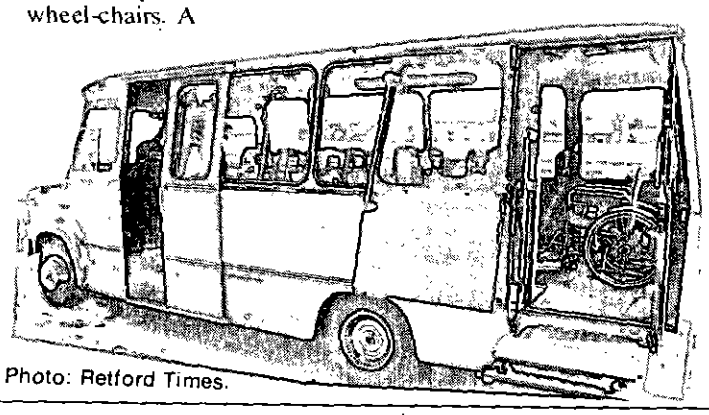


Photo: Retford Times.

The bus can carry groups who regularly attend day centres, and evening journeys will also be included in the timetable. The community bus fares are cheaper than service buses, over the longer journeys. The revenue will offset the running costs. The intention is not to compete with existing public transport but to complement it.

The CHC can claim the credit for having highlighted the considerable transport problems and for its involvement in the scheme. The project began on 2nd May. Whether or not it is a success will be clear after the first few months. Only regular patronage by the communities it serves will ensure its survival. The message is clear — "USE IT OR LOSE IT".

Day centre for the elderly mentally ill

by Harry Trent, Secretary of Sheffield Southern CHC

Early last year the Area Health Authority set up a joint working party to look into the needs of the elderly mentally infirm. This followed pressure from the CHCs and other bodies in Sheffield and some startling newspaper headlines which followed a couple of unfortunate incidents in the city.

The working party produced a long-term plan, but nothing was done about present urgent needs. The Sheffield CHCs contacted every GP in the city in a quick survey, and it became clear that there were hundreds of elderly people known to GPs, who were confused and demented. They needed daily supervision or care, though not necessarily in hospital.

The CHCs pressed the working party to consider alternative forms of care, but in the end decided that the best way to convince them was to set up a pilot scheme. This presented us with a dilemma, CHCs are not in business to provide services. We convened a "workshop" last December, of GPs, social and community workers and representatives of voluntary bodies.

The idea was to launch in 1978, a day centre where the elderly confused, at present in the community and often living alone, could go perhaps two or three times a week. They would get social stimulation, and it would relieve their neighbours and relatives of the constant pressures of care. Mid-day meals could be provided by using meals on wheels facilities and luncheon clubs. Relatives would be encouraged to help run the centre for one day a week in return for two or three days when they would be free of the care of their relatives.

It was agreed that the local branch of MIND would sponsor the project, thus avoiding the problem of CHCs providing any services. The workshop group would advise and also supply a Job Creation Programme worker.

We now have our JCP worker and a site for the pilot scheme. We have made contact with GPs, social workers and others and we are recruiting volunteers for the centre. Local GPs have agreed to supply any medical care needed at the centre. Several training agencies have enquired about using the centre for student placements.

Work has not yet started on the night care scheme, in which we aim to use the empty wards of some local hospitals. The St. John Ambulance Brigade, who are represented in the workshop, have expressed an interest in setting up a home-nursing course for volunteers and relatives, with special emphasis on caring for the elderly. The Brigade is also keen on a community nursing venture which would be different from the first-aid image for which it is so well known. Both these schemes could help to answer the nursing problems of any night care scheme.

The AHA are again convening the joint working party on the elderly mentally infirm and perhaps we shall now be able to press ahead with a contribution from the statutory bodies.

DIETING TO DEATH

Anorexia is a mystery and a growing problem. Its sufferers — mostly girls in their teens and early twenties — are obsessed with slimness and refuse to eat normally. Up to 5 per cent die, from self-starvation, suicide or infections such as pneumonia.

It is difficult to assess the size of the problem, partly because most anorexics insist that there is nothing wrong and are unwilling to seek help. A recent study of nine London secondary schools found that 1 per cent of female sixth-formers was anorexic. A survey of 100 students registered with Bristol University's Student Health Service found two anorexics. The "typical" anorexic is an exam-taking girl or young woman from a middle-class home.

The simplest explanation says anorexia is just dieting that got out of hand. "The hungrier they feel, the more inviting food looks, the more important it becomes not to eat," as one sufferer put it. It has also been suggested that self-starvation is a subconscious refusal to face up to the problems of becoming a woman, by keeping body weight below the level at which menstruation occurs.

Another theory suggests that anorexia is a rejection of family pressures. Anorexics tend to have domineering over-protective parents whose own ambitions in life have not been fulfilled. Many anorexics were formerly "model children", but at puberty success for girls becomes more closely linked with looking "right" and being popular. In this explanation, anorexics refuse food both as a confused gesture of independence and in an attempt to lose weight as the answer to their "success" problems. According to one study: "The connection between the attempt to lead a life of one's own and a refusal to eat at the family table is obvious. To reject a mother's food is to reject her".

A 30-minute film called "Sharon: an anorexia nervosa case history" can be hired for £10 plus VAT from Farley Health Products Ltd, Torr Lane, Plymouth. A free booklet is also available.

Other possible causes that have been suggested are glandular disturbances and examination stress. Types of treatment currently being used with some success are equally varied, ranging from drug therapy and enforced bed-rest to psychotherapy and "family therapy" sessions.

Anorexics are very difficult to live with. Usually they cannot see that they have already become unfashionably thin, even when this is pointed out to them. Outside meal-times they often indulge in eating "binges" which leave them feeling intensely guilty and occasionally suicidal. Some deliberately make themselves sick after such binges, and after a while vomiting up food can become automatic. Many dose themselves heavily with laxatives. Other symptoms can include lying about food and withdrawal from family life generally. Families of anorexics are usually depressed and in need of support themselves.

In 1974 a self-help organisation called Anorexic Aid was formed to support and advise anorexics, their families and their friends. AA emphasises that although hospital treatment gets anorexics out of physical danger, they are often discharged "fattened up" but no better equipped to cope with their feelings. AA's local groups may be able to help by arranging counselling. Anorexics often lack the confidence to attend meetings where they would be complete strangers, so a visit by an AA member can usually be arranged as the first contact. AA's national address is Gravel House, Copthall Corner, Chalfont St Peter, Bucks.

Further reading

☐ *Anorexia nervosa*, in *Spare Rib* magazine no 28, pages 6-10

☐ *Anorexia nervosa — the patient's view*, by Renee Kauffer, Nursing Mirror 6 April 1978, pages 26-7.

☐ *Eating Disorders*, by Hilde Bruch, Routledge and Kegan Paul, 1974.

☐ *The Golden Cage*, by Hilde Bruch, Open Books, 1978, £5.50.

WINDOW INTO THE HEALTH SERVICE

Personal View

by Gordon Lambert, Chairman of Sutton and West Merton CHC.

If CHCs were disbanded tomorrow, would it matter? Are we wasting our time and valuable public money? Are we just a collection of "carping amateurs"?

True we are not democratically elected, but even so the present system does provide a very valuable cross-section of members, with much experience and a very special interest in our NHS. True we have no "teeth", in the sense that we have no executive power. But this is the very strength of a CHC, for we have to work extremely hard to influence those who have such power. CHCs are also the public's "window" into the NHS, and it is of vital concern that the public has a clear view and gets the NHS it wants — not necessarily what the planners think it should have.

The concept of a voice to represent the interests of the public in the NHS was unique, and it is taking time for the importance of this role to be widely accepted. There have been complaints that some health authorities pay nothing but lip service to the consultative procedure. It would be naive not to believe that to some extent this has been true — not necessarily intentionally, but simply because the authorities themselves are new and are still uncertain. They are under constant criticism and constraints, and the task before them is great.

Over the past three years my CHC has tried to build a bridge of trust between itself and the authorities. Militancy is no substitute for reasoning and persuasion. We are now invited to stay for the "confidential" part of the agenda at AHA meetings, which shows that trust exists and is growing. CHCs have been encouraged by the DHSS to send an observer to FPC meetings, and my CHC is already represented on Joint Consultative Committees and other bodies. We also enjoy informal meetings with our DMT.

All this means that our views are heard "on the ground floor" — in the making of decisions which have not yet become firm matters of policy. But this is not to say that agreement will always be reached, and should we consider that the interests of the public in the NHS are in jeopardy we shall not hesitate to use our real teeth — which are set firmly in the power of public opinion.

CHCs should fight strenuously to preserve what belongs to the community, if it is right for it to be retained. Before closures are made there is still a great need to make further economies within the service. For example my own CHC has successfully opposed the closure of Wimbledon Hospital, which provides an excellent service and does so economically. The proposed transfer to St. Helier Hospital will not now take place — a rare event in the history of CHCs.

We must not allow a "Beeching" situation to develop — outer areas have been stripped of rail links, and the same must not be allowed to happen to health services in the outer parts of the larger health districts. Every effort should be made to increase the services we receive from such outer hospitals, to encourage them to fulfil their potential and to provide a service from which their local populations will benefit.

News from CHCs

☐Cumbria AHA has agreed to inform its CHCs about cases in which mentally ill or mentally handicapped hospital patients might wish to make a complaint but have no close relatives to assist them. **West Cumbria CHC**, through the AHA, has obtained DHSS advice that this extension of the "patient's friend" role would be in order, provided the patient welcomes the CHC's help and investigating officers do not object.

☐ A joint working party is being set up between **Crewe CHC** and its AHA and FPC, to discuss the council's report on family practitioner services, *I like my doctor, but . . .* (see *CHC NEWS April 1978, p4).*

Isle of Wight CHC *has persuaded the Southern Vectis bus company to introduce a new route, and to produce this pamphlet to publicise it. The other side of the pamphlet gives timetable details.*

☐ Subscriptions to *CHC NEWS* on behalf of two local weekly newspapers have been taken out by **Dewsbury CHC**.

☐The idea that local referenda run by AHAs are needed to justify the fluoridation of water supplies has been rejected by **West Birmingham CHC**, following the Severn-Trent Water Authority's decision to withdraw fluoride unless it can be shown that a majority of people want it to be continued. The CHC has written to the authority reminding it that CHCs are the statutory representatives of the public in health matters, and that West Birmingham supports fluoridation "as a necessary part of preventive dentistry".

☐An interesting style of public participation has been adopted by **Pembrokeshire CHC**. At every council meeting, business is suspended at 8 pm, to allow members of the public to take part in a health service "open forum".

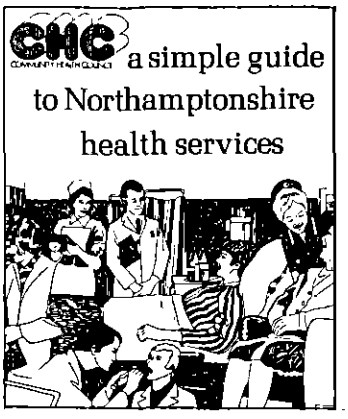
☐ **Tameside CHC** is asking David Ennals to resolve the legal dispute over menstrual aspiration. A local consultant has been using this technique as a successful way of providing outpatient abortions, but has discontinued this service following a complaint made to the Director of Public Prosecutions. The consultant has been advised by police that his use of the technique may contravene the Abortion Act 1967, and could lead to prosecution.

☐ A year of "bitter disillusionment" is described in **Brent CHC's** annual report for 1977, which focuses on the so-far unsuccessful campaign to keep Willesden General Hospital open as a community hospital (see also *CHC NEWS March 1977, page 9*). The CHC concludes that "the consultation procedure (ie circular HSC(IS)207) does not embody any real mechanism for making health service decision-makers publicly accountable".

☐ **Sheffield's** three CHCs are to be merged into two, in line with the proposed new two-district structure for the city's AHA. The existing councils are pressing Trent RHA to retain all present CHC staff, some of whom could specialise in public relations, research and handling complaints.

☐ A visit to an ante-natal clinic in a local maternity hospital, by **North Staffordshire CHC** members, identified the need for a regular playgroup — and this is now being provided by the North Staffs branch of the Pre-School Playgroups Association. CHC member Mrs Philomena Gray helped set up a demonstration playgroup in the clinic, which proved the worth of the idea to all concerned.

☐ Members of **Solihull CHC's** Visits Working Party spent a whole day and night at a local purpose-built geriatric unit, to gain a better understanding of the difficulties in caring for the needs of the elderly.



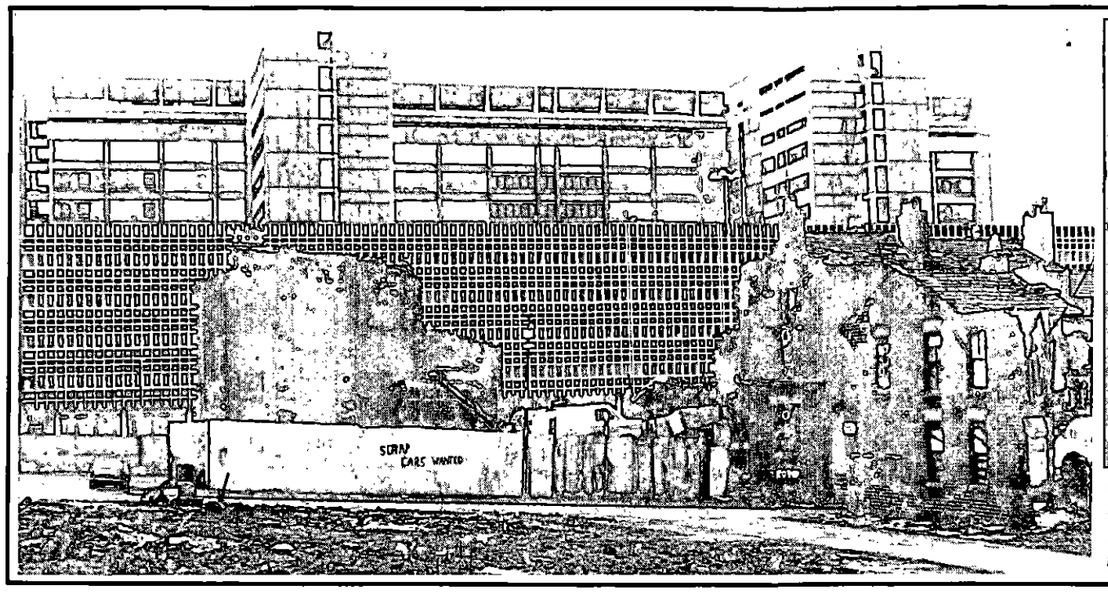
Another consumer's guide to local health services has been produced – this time a joint venture by Kettering and Northampton CHCs. *In 32 pages it gives detailed but uncomplicated information on family practitioner, hospital and community health services. The booklet is being widely distributed locally, and copies are available free from either CHC.*

☐ Correspondence between **Weston CHC** and the Pharmaceutical Society of GB has confirmed that the society will be issuing its members with a notice, for display to the public, on the subject of child-proof containers. The notice will advise that medicines can still be dispensed in old-style containers if requested.

☐ **Sunderland CHC** has complained to the Health Service Commissioner that the Northern RHA's methods of inviting membership nominations from voluntary organisations may "reduce the level of community participation through CHCs". The CHC feels there should be a definite closing date for the list of appointing voluntary organisations. RHA ads in local papers have included the phrase "by the latest within one month of the (first) appearance of this advertisement", and these ads have appeared up to 12 days apart. The CHC also argues that if the Washington new town development corporation is to nominate members its seats should come from the local authority or RHA sectors of the council, not the voluntary side.

☐ Representatives of the **Association of Welsh CHCs** attended a recent meeting of the British Medical Association's Welsh General Services Medical Committee, to exchange views on patient transport problems. Idris Davies, chairman of the Welsh Association, suggested that the BMA and CHCs should be consulted when county councils are drawing up transport plans.

Barking CHC *has pulled out all the stops to halt a proposal which would have converted Rush Green Hospital from acute to geriatric use, as part of the Barking District Plan. The CHC collected over 17,000 signatures on a public petition, organised interviews and "adverts" on* Radio London, *and got the local press to print free posters and car-stickers. The London Coop agreed to have posters and petition forms in 12 local shops. All seven local MPs gave support, and the borough council agreed to call a public meeting if needed. The RHA has now postponed change of use for at least a year, and the CHC is urging its DMT to upgrade the hospital. The picture above was taken in an outpatient clinic at Rush Green.*



Patients queuing in the corridor of a Liverpool GP's surgery.

The Royal Liverpool Hospital – 17 years in the building. **Photos: Derek Massey**

Protecting patient care *and* jobs in Liverpool

by Jane Leighton, Secretary of Liverpool Central and Southern CHC

"It was clear by the summer of 1977 that the Area Health Authority was no longer able to guarantee the provision of its health services". In these words an independent inquiry into Liverpool AHA confirmed the fears of health service staff and consumers, who last year saw that service on the verge of collapse.

In 12 months two-thirds of Liverpool's hospitals had come under threat of closure, partial closure or change of use. Finally a dramatic £1m programme of cuts, involving the closure of wards in 14 hospitals, the possible loss of 500 jobs and a reduction in the number of people treated for kidney, heart and blood disease brought an explosion of protest. Opposition to this vicious programme of cuts resulted in the Minister of State for Health, Roland Moyle, announcing a committee of enquiry into the working of Liverpool AHA — the first official enquiry into the operation of the health service at local level since the 1974 reorganisation.

Organised resistance to deterioration in the NHS is growing. This article discusses the question of united action between CHCs and staff interests — a question of policy for all CHCs facing cutbacks in service. But first a brief outline of the crisis facing the NHS in Liverpool — a city with some unique problems, but sharing others with health areas all over the country.

Resources — Liverpool is supposedly "overprovided" with beds for its dwindling population. But insufficient account is taken of patients coming in from other areas — the "cross-boundary flow". Consequently, the pace at which resources were withdrawn for reallocation elsewhere was too swift for the city to cope with.

The Royal Liverpool Hospital was first becoming a national scandal. Built to replace five old hospitals it was still unfinished after 17 years of building and the cost had risen from £12m to £56m. "An appalling fiasco", said the chairman of the House of Commons' Committee of Public Accounts.

Primary Care Services were in desperate need of development. The legacy of concentrating on a hospital-based service had left Liverpool trailing behind other areas of the country in health centre building.

Industrial relations had degenerated to "guerilla warfare", according to the report of the committee of enquiry (the Dyson report*). The report attributed this to a militant ancillary leadership pitched against paternalistic management. With uneasy cooperation from the trade unions, the AHA vigorously employed a policy of not filling staff vacancies, which between August 1976 and December 1977 resulted in the loss of 230 nursing and 119 ancillary jobs.

Public relations were appalling, with the AHA isolated from staff and excessively cautious in its cooperation with the media.

Members of the AHA should have taken a stronger hand in the authority's affairs. Few attended meetings, and those who did in the main were mesmerised by the treasurer's balance sheet — at the expense of the standard of health care for the local population.

Overspending resulted in panic measures to claw back revenue. A drastic and premature "rationalisation" of hospital facilities was proposed to find extra cash for the new hospital, and fund developments in primary care services.

The single-district area proposal introduced by the AHA was a totally self-inflicted problem and "disastrous" for the city, said the Dyson report. Hospital staff, already unsettled by the 1974 reorganisation, became increasingly discontented and suspicious at the prospect of yet more change. A large number of senior managers fled the city for more settled posts. The Dyson report warned that "the Liverpool approach to single-districting should stand as a warning to other AHAs contemplating similar structural changes."

This then was the background to the unprecedented outburst of abuse and opposition which greeted the AHA's £1m cuts announcement in May 1977.

The CHC and ancillary, nursing and medical staff were unanimous in deploring the cuts. The protests were unanimous but separate, and based on potentially divisive arguments. Some consultants heralded the collapse of the NHS by pointing to their long waiting lists and calling for more resources. Other campaigners illustrated waste and bad medical and administrative management as the causes of the problems. Some of us, while recognising the scope for economy and the need to evaluate medical practice, also felt that underfinancing was pivotal to Liverpool's — and the NHS's — complex difficulties. But we were all agreed that the AHA's panic measures would ultimately compound Liverpool's problems.

The CHC's primary responsibility was to inform local people of the crisis. Most people's knowledge was very low and mainly gleaned from information "leaked" to newspapers. They were demoralised and lacked organisation. The CHC organised a series of meetings with residents' associations and action groups, and struggled to get local publicity for patients' views. The council was also faced with the dilemma of whether to plough its own furrow of opposition to the cuts, or share its views and experience with staff interests. Members had always considered that if CHCs care about the service to patients, they must be concerned about staff morale and welfare.

While retaining the right to make individual representation to the AHA, the council decided to join with the staff side in urging the authority to make a united protest to the Secretary of State and request additional funds for Liverpool during an exceptionally difficult period. This decision to join with staff associations and trade unions was strongly criticised by other CHCs, by the AHA, and prompted a rebuke from the Dyson committee itself.

The argument against joint discussion and representation was that CHCs would lose their "independence" if seen to speak with the staff side. The AHA adopted a strict interpretation of "representation separate from management responsibility." The committee of enquiry, while "impressed by the imaginative work" of the Liverpool CHCs, and "despite general support" for the way in which we had worked nevertheless was not "fully confident" that we had explored the full implications of our attitude toward industrial relations.

In retrospect it seems that one of the most valuable actions taken by Liverpool Central and Southern CHC was its involvement with staff organisations. It is regrettable that, because medical representatives were unwilling to share a public platform with staff and patient representatives, the debates were limited to nursing and ancillary staff. Involvement in discussion and debate resulted in the CHC being taken seriously by large numbers of health service staff, who had previously thought that CHCs had little relevance for them. Staff understandably were mainly concerned with redundancy. The CHC ensured that on public platforms and in the press "quality of care" was as much an issue as job security. For the first time many workers in the health service were introduced to a positive position on changing patterns of care. The CHC remains steadfastly opposed to any cuts or changes which would lead to a diminution of service. But we *are* thinking about changes which could be made in any future period of NHS growth. Consequently we were able to broaden discussions from the narrow "no change, no cuts" position.

Photos: Liz Heron

The CHC proposed a joint approach to the Minister, and a joint working party of staff, management and CHCs, but these initiatives were not taken up by the AHA. Finally there was little alternative but to seek an official enquiry into the working of the authority. Spearheaded by the trade unions, the campaign achieved its end when Roland Moyle announced the enquiry on 26 July 1977. The relief which followed Roland Moyle's statement turned to anger and frustration when we learned that the enquiry was to be conducted by the Regional Health Authority. There was widespread suspicion and hostility towards health service management, and it was clear that an RHA committee investigating one of its own areas would enjoy no public credibility. After negotiations with staff side and CHCs, agreement was reached on an independent committee, chaired by Professor Roger Dyson of Keele University and reporting to the RHA.

During its three months' investigation the committee considered 250 items of evidence, held 11 oral hearings and visited local health facilities. Its findings vindicated the demand for an enquiry into the AHA. The report's 36 recommendations range from quarterly informal meetings between the AHA and the CHCs to more resources for Liverpool.

The most alarming paragraph concerns primary care — which should have been the "key to Liverpool's success". "Present plans offer no way out of the Liverpool dilemma within the next ten years," said Dyson. Serious deficiencies in the authority's industrial relations were pinpointed. Training of AHA members was called for, and a major shock for the authority was the committee's attack on its "baffling" plans to close one local hospital. The report also called for a no-redundancy guarantee for staff in hospitals which will close when the Royal Liverpool Hospital opens.

The sting in the tail of the report was its proposal to create a single CHC for Liverpool, in line with the merging of its two districts. This was a curious decision from a committee which had roundly condemned

continued on page 10

Report of a Committee of Inquiry, Mersey RHA, January 1978.

Book reviews

Mental handicap — ways forward

Office of Health Economics 35p.

For someone needing a brief overall view of the problems of mental handicap and the structure of services, this is the book. In less than 50 pages, it describes what mental handicap is, what is known about its causes, and the ways in which it may be prevented.

In recent years, a policy of community care has been accepted, but this has also coincided with the economic restrictions. Health authorities have reduced hospital places, without linking up properly with local authorities in planning the shift to community based services. (The booklet summarises the hospital versus community debate and is worth reading for this alone.)

Although joint funding may influence local authorities to comply with national development targets, the booklet has a warning. "In the mid-1970s, 24 (local) authorities made no residential provision for mentally handicapped children whilst more successful ones had between three and four times the national average level of places available. Findings like these suggest that . . . unless consumer bodies like the CHCs become more aware of local authority failings in NHS/LA overlaps the targets of *Better Services for the Mentally Handicapped* may not be achieved in some parts of the country by the 1990s."

A depressing picture, but with the help of this stimulating booklet, CHCs could help to transform it.

Restructuring the health service

by Tom Heller, Croom Helm, £5.95.

This book is small but beautiful — an ideal introduction to the fierce debates now in progress in and around the NHS. Its central theme is power — the battle for it between the medical professions and the administrators, the relative lack of it amongst other health service workers and consumers, and the inappropriate patterns of health care produced by these distortions.

The author draws on his own experiences as a CHC member to show how consultation between management and CHCs can be so perfunctory as to be almost an afterthought. He prefers the "community advocate" stance to the "two-way link" approach, but either way he feels that CHCs at present have little ability to influence events:

"Either function requires methods of finding out what the community does want, continuous monitoring of the decisions that are taken by the management and an effective method of communicating with the general public . . . in practice none of these basic tools are available to the majority of CHCs. The budgets of the CHCs are so small that surveying of public opinion becomes impossible, and access to the information systems that the councils need for monitoring the management is entirely dependent on local management of the service whose performance they wish to monitor or criticise".

This should be taken as a challenge, not a reason for despondency. Tom Heller himself accepts that "terrific opportunities" do exist for CHCs if they "can be seen by the community itself to be involved in furthering the interests of that community".

As a book to keep in the CHC office and lend out to members, these 114 pages are a good six quid's-worth.

Books received

Infectious diseases by A. Melvin Ramsay, from Family Doctor Publications, BMA House, Tavistock Square, London WC1H 9JP (30p plus 8p post).

Children living in long-stay hospitals by Maureen Oswin (Spastics International Medical Publications £5).

Dictionary of social services by Joan Clegg (Bedford Square Press of the National Council for Social Service £2.95).

Health services in Britain prepared by the Central Office of Information (HMSO £1.75).

Medicine under capitalism by Vicente Navarro (Croom Helm £7.95).

ERALDIN CAMPAIGN PICKS UP SPEED

by Bryn Williams, Secretary of Merthyr and Cynon Valley CHC

It is now several months since Mrs Thea James, a young mother with three children, wrote to Merthyr CHC asking for help. She had suffered appalling side effects from the heart drug Eraldin. Our own inquiries into Eraldin so alarmed us that we decided to launch a major campaign, calling on all health councils in England, Wales and Scotland to help us. The front page of *CHC NEWS* in December 1977 gave the full details.

Many CHCs responded with enthusiasm — they publicised Eraldin and asked people to come forward. In many areas the publicity was extensive, but it is clear that Eraldin has not been prescribed so much in some areas as in others. But many people are having difficulties even establishing that they have been prescribed Eraldin, as some GPs have been unwilling to give details of treatment.

Although ICI, which produced and marketed Eraldin, has only accepted a limited range of side-effects as attributable to the drug, we are finding that other ailments such as skin disorders, swelling in the joints, numbness in limbs and severe depression are also very common, and there may well be a case to answer here.

In the past Eraldin sufferers were isolated and many let the case fall rather than go through the bother of a legal battle with a massive drug company. However, forming themselves into groups has bolstered their determination and they have given each other new hope. A single solicitor has often been chosen to act for all group members and the lawyers have exchanged information among themselves.

In the short term we are interested in the patients receiving adequate compensation for the ruination of their lives. In the long term however, we are determined to see a major upheaval in the system of issuing and monitoring new drugs.

We recognise that the initial identification of Eraldin side-effects was difficult because of their similarity to other illnesses. But some adverse reactions showed up very early on, but went unrecognised by doctors. In some cases, even after warnings from ICI, several GPs carried on prescribing.

The yellow card system, used by doctors to inform the Committee on the Safety of Medicines of suspected side-effects has proved completely inadequate. There has recently been considerable debate and publicity on this issue and the Committee on the Safety of Medicines is proposing improvements to the procedures. This "recorded release scheme" would mean that patients and prescribers would be closely monitored. This is a step in the right direction, but we are concerned that unless there is an obligation on doctors to make reports, the new scheme may turn out to be similar in practice to the present arrangements.

Merthyr CHC and many of the other CHCs which have become involved in the Eraldin campaign, consider that drugs should only be allowed to come onto the market through the health authorities, who would be approached by the drug companies. This would stop the sales pressure on GPs. The health authorities would then be responsible for monitoring.

We have made some progress in our campaign, but the fight for compensation, for treatment of Eraldin side-effects and for reforms to ensure better drug safeguards is still only at the beginning. Action groups are forming of patients and their supporters, and for many patients just the relief of knowing what has been causing so many illnesses has been a massive release. This has spurred us on to challenge the monitoring system which purports to be among the finest in the world.

WHICH WAY FOR SECRETARIES?

On March 17 a meeting of English CHC secretaries, held in London, voted 58 to 7 in favour of setting up a new organisation — the Society of CHC Secretaries (SCHCS).

The formation of SCHCS caused quite a stir — both during and after its founding meeting. On this page we publish comments from opponents of the new body, and a reply from its chairman Ron Brewer.

SCHCS has three main aims:

1 The development of good practices,
2 The exchange of views and information amongst members, and
3 The representation of concerns and interests of members to appropriate bodies (but not to act as a trades union).

The founding meeting elected an 11-person executive committee, which in turn elected the following officers:
Chairman: Ron Brewer, Tower Hamlets,
Vice-chairman: Mary Merricks, Cambridge,
Secretary: Paul Reynolds,Bury,
Treasurer: Mike Mannall, Hounslow.

Annual subscription was set at £5, and the first annual conference will be held in the autumn.

From: Caroline Langridge, Hilary Blumer and Jeanette Mitchell. Secretaries of Wandsworth and E Merton, Roehampton and Brent CHCs.

We cannot support in any way the foundation of the SCHCS.

The society's first objective was originally "The development of good *professional* practices". To secretaries such as ourselves, with a strong interest in community work, the concept of professionalism is anathema — implying the creation of a barrier between us and the people we are supposed to serve. After criticism from several delegates, who pointed out that CHC secretaries bring a diverse range of skills to bear on their respective jobs, the word *professional* was dropped.

However we are still concerned at the implication that there is such a thing as "good practice". CHCs are all different, and we strongly resent any attempt to set up an idealised model of "the good CHC secretary" for the rest of us to follow. What is "good" or "bad" practice depends on the age, experience, class background, politics, education, etc, of the individual presuming to make this judgement.

As regards SCHCS's second objective, we feel that views and information are already exchanged through *CHC NEWS* and by personal contact. Attempts to replace this existing informal network by a more rigid structure of workshops etc are likely to take CHC secretaries even further away from their day-to-day work than is already the case. We are already besieged with invitations to workshops on every conceivable aspect of community health. We feel the need to stop talking and start doing.

On the SCHCS's third objective, the platform stressed the need for a body to represent secretaries' interests to bodies such as the Association of CHCs (ACHCEW), the DHSS and the RHAs, on such matters as staff gradings. How SCHCS can do this without acting as a trade union is not clear. Matters such as staff grading and job evaluation are of direct concern to the appropriate trade union, and should not be subject to interference by an unrecognised body. We hope secretaries who share our views on this will make it very clear that the only organisation they will allow to negotiate for them on such matters is the appropriate trade union.

Finally, we were disappointed that SCHCS has made no attempt to include assistant secretaries and other staff, who make up the rest of the CHC team. Considering the overwhelming predominance of male secretaries at the meeting, perhaps it is not surprising that once again hierarchical structures reign supreme.

From: Drew Kimber Chairman, Northern Region Association of CHC Secretaries

The 17 secretaries in the Northern region cannot support in any way the foundation of the SCHCS. Secretaries should organise through ACHCEW rather than by creating a separate body.

SCHCS's second objective would seem to be a complete duplication of the existing information service and *CHC NEWS*, which of course are available to all CHCs whether or not they are members of the association. Most of the information submitted to the information service is sent in by secretaries, so if there are omissions in the type of information submitted these could easily be rectified by secretaries themselves. If the SCHCS intends to offer anything like a reasonable information service, it will soon find that it requires office premises, filing systems and full-time staff.

Northern region has four main questions to ask about the SCHCS's third objective:
1 How can the 58 secretaries who formed the SCHCS represent the views of Northern secretaries, who want nothing to do with the society?
2 Will anyone take any notice of a breakaway organisation representing only a quarter of what is in any case a very small group of people?
3 Will the SCHCS seek membership of various organisations in its own right — so undermining anything ACHCEW may be able to do as a larger body?
4 How can SCHCS avoid acting as a trade union, when at its foundation meeting its executive committee was asked to approach appropriate bodies about improving pay and conditions?

It is also difficult to see how SCHCS's executive committee can meet lawfully — the society's constitution states that the EC will consist of one representative from each English region, yet Northern, Trent and Wessex regions had no nominations at the foundation meeting. Yorkshire region was foisted with someone who at that time was not even working in the region.

We already have seven observer secretaries on the ACHCEW standing committee. Current arrangements in this committee may not be perfect, but could be developed to offer secretaries a national voice within the association, without the expense of setting up another bureaucracy.

The newly-elected executive committee of SCHCS has considered the points made by Drew Kimber, and by Caroline Langridge and her friends. The EC recalled that all of these critics put forward their views at the establishment conference, but they were thoroughly and soundly defeated.

The society is not a "breakaway" from anything. It would hope to work harmoniously with ACHCEW, and that some of its work would be complementary to the work done by the association.

One doesn't know how seriously to treat Caroline's implications of male chauvinism. One hopes that the old ploy of finding "reds under the bed" is not to be converted into a new scare, in which men are found under the bed instead! As far as we are aware, the society is entirely heterosexual.

From: Ron Brewer Chairman, SCHCS

Healthline

Job creation programme

What will happen when the Job Creation Programme ends in December 1978?

STEP is the successor to the Job Creation Programme. The Special Temporary Employment Programme will work in much the same way as JCP, providing jobs for up to one year. CHCs interested in getting extra staff this way should apply to the nearest Manpower Services Commission Area Office or to MSC, Selkirk House, 166 High Holborn, London WC1V 6PF.

Which Ombudsman?

My CHC is advising a woman who wants to complain to the Ombudsman about the way her husband was compulsorily admitted to a mental hospital under the Mental Health Act 1959, Section 25. The admission involved action by employees of the health authorities and the local authority. With whom should the complaint be lodged — the Commissioner for Local Administration or the Health Service Commissioner?

The two commissioners work closely together and may make a joint investigation. It is better to complain to both. The complainant should write to her own representative on the local council which employed the officials in question. She should ask for the complaint to be referred to the local government Ombudsman. If this is refused, she may then write direct to the Ombudsman, giving details of the complaint and the name of her councillor. A booklet with more details is available from: Commission for Local Administration, 21 Queen Anne's Gate, London SW1H 9BU (01-930 9333).

Abortions

Do health authorities have a statutory duty to make sure that consultant obstetricians and gynaecologists employed by them are willing to perform NHS abortions?

No. If authorities consider that in their area there is a demand for abortion which cannot otherwise be met and if patient care would otherwise suffer, they may include the termination of pregnancy as a duty, in job descriptions. In such cases, authorities would have to be sure that an applicant was prepared to perform NHS abortions. The DHSS has stated that this issue only arises in a minority of posts.

Regulations about withdrawing drugs from chemists' shops

When the supply of a drug to the market is stopped by a manufacturer because of potential hazard to users, what regulations are there which ensure that existing stocks in chemists' shops are withdrawn?

There are no regulations on this. The withdrawal of a product from the market by the manufacturer does not prevent retail pharmacies from continuing to supply it in accordance with a prescription. If the withdrawal is on grounds of safety, GPs are advised of the position and it is left to the GP to decide whether a particular product should be prescribed.

There is power under section 62 of the Medicines Act to make a statutory order totally prohibiting the sale or supply of a specified product on grounds of safety. It is illegal for a pharmacist to supply a product which has been so prohibited — even on a prescription.

No such order has ever been made in the case of a prescription product, as the requirement of a prescription is considered a sufficient safeguard.

The Healthline column publishes selections from the queries received by our information service. This service is for CHC members and secretaries, and for others interested in the NHS and the work of CHCs. To contact the information service, write to or ring CHC NEWS, 126 Albert Street, London NW1 7NF (01-267 6111 ext. 267).

Parliament

Association of Community Health Councils

Individual CHCs are fully entitled to take up matters direct with the DHSS and with Ministers. The objects of the Association of CHCs in England and Wales include providing a discussion forum for member councils and expressing views to the DHSS and other bodies. Mr Ennals does not consider any single function of ACHCEW as the primary one. (Patrick Jenkin MP: Redbridge, Wanstead and Woodford 17 March 1978)

Obstetric training for GPs

More than 10 per cent of all GPs volunteer for obstetrics refresher courses each year. No steps will be taken by the DHSS to compel all GPs on the obstetric list to take in-service training at regular intervals. (Lewis Carter Jones MP: Eccles 14 March 1978)

Long-stay hospitals for the mentally handicapped

The roles of the Health Advisory Service and the National Development Group for the Mentally Handicapped do not overlap. Though HAS still has responsibilities in relation to mental handicap services in Wales, it has none in England. In England, the National Development Group for the Mentally Handicapped advises the Minister on national policies. Health and social services authorities may request advice on the operation of local services, from the Development Team for the Mentally Handicapped. (Patrick Jenkin MP: Redbridge, Wanstead and Woodford 3 March 1978)

Breast cancer screening

Trials are being conducted to help the Government decide whether a national screening service for breast cancer would be justified, in terms of effectiveness and safety. (Betty Boothroyd MP: West Bromwich West 11 April 1978)

Cigarette Advertising

In evaluating the present voluntary restrictions on cigarette advertising and considering possible further measures, the Government will take account of evidence from other countries where advertising is restricted. (Ian Grist MP: Cardiff North 23 March 1978)

CHCs in Wales

A short debate, introduced by Donald Anderson MP (Swansea East) was held on 18 May. Mr Anderson said that the Welsh Office civil servants had shown a "complete lack of support" for CHCs with problems such as staffing and premises. Also CHCs had been under a "counter-attack by the professionals". The Under-Secretary of State for Wales, Mr Barry Jones, replied for the Government. (Hansard 19 May 1978, Vol. 950, No. 120)

LIVERPOOL

Continued

the single district decision as "premature." The single-CHC proposal is under consideration by the RHA at present. The two CHCs co-ordinated their lobbying against this proposal, circulating a 12-point letter to the city and county councils, and backing this up by personal interviews. These councils have now "strenuously recommended" the retention of separate CHCs. Elected representatives, at least, have accepted that the more remote the management structure the greater the need for CHCs with strong local roots.

As a result of the enquiry there is agreement between the AHA, the CHCs and the staff organisations on the nature of the problems affecting the city's health service. Some of the practical suggestions of Dyson are already being implemented, but the action taken so far has largely been cosmetic (for instance the appointment of a public relations consultant for six months). It is clear that the city still faces enormous problems. We have to live through the reality of single-districting, the Royal Liverpool Hospital has yet to open and there is an ominous note of resistance from the RHA towards the idea of extra finance.

But it is certain that if staff and patients had not made separate and collective protests, Liverpool would have been subjected to a savage reduction in the standard of its health care. The opposition undoubtedly had most impact, and engaged a wider public, when the protestors were united.

GP DEPUTISING

South Birmingham's response to the new code of practice

by Margaret Stanton, Secretary of South Birmingham CHC

South Birmingham CHC was naturally concerned when the death of Jason Bryant last summer raised questions about the efficiency and adequacy of the South Birmingham GP Deputising Service. Considerable discussion and investigation followed. The CHC pressed the Family Practitioner Committee for information about its procedures in relation to deputising services in Birmingham. The FPC recently published a report, presented to the Birmingham AHA, which included a schedule of "Conditions to be applied to the provision of a deputising service for doctors in the city of Birmingham."

Meantime there was the lengthy preparation by the DHSS of a code of practice. This has now been issued, under cover of circular HC(FP)(78)1, and is percolating through the CHCs. (See front page of last month's *CHC NEWS* for a brief summary.) We managed to obtain copies for our monthly meeting on 25 April. The circular is not a draft for consultation but a finalised document. We decided to write to the DHSS expressing disappointment that

We are disappointed that there has been no consultation on the code of practice with CHCs

there had been no consultation with patients' representatives, especially CHCs, in the production of the code of practice. We hope other CHCs will do likewise.

A code of practice is for guidance, and unlike a statutory instrument does not lay down mandatory regulations. Nevertheless it was welcomed by our members as an improvement on the present situation and a move in the right direction. For example, one of the major problems in Birmingham is that night calls may be scattered over great distances, and that the deputising doctor is often a stranger in some of the districts that have to be covered. We are therefore pleased to see that paragraph 2 of the code requires that transport be available, and that the doctor or driver must have knowledge of the area. But we are concerned about how such conditions could be met unless more personnel and resources are available than the commercially-based services are likely to provide.

We have been very concerned that a deputising doctor does not have access to patients' records, so that the medical background is not known. We have had cases brought to our attention where this has proved a grave problem: for example, a seriously ill patient sent to a different hospital from the one he had been attending as an out-patient for a long time, too ill in the night to give information himself and the hospital doctor not knowing his medical history. Paragraph 4(b), about consulting with the patient's own doctor, will meet this problem only if the GP is available to be contacted by the deputising doctor when needed.

We also welcome paragraph 6 — requiring the deputising doctor to report back to the patient's GP on action taken. This is most important. One of our local doctors wrote last year: "Working as a deputy myself, I have been able to feel for myself the frustration that occurs when cases cannot be handed over properly after a period of duty".

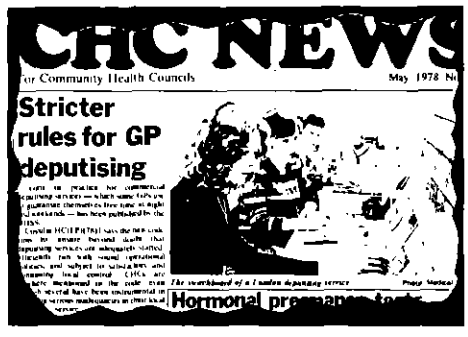
Members were particularly concerned that the proposed Professional Advisory Committees (PACs) are to be composed entirely of medically qualified people, except for the committee secretary. It is recognised that professionals may be in the best position to ensure that deputising doctors are adequately qualified. However it is not — in our experience — the level of medical competence of deputising doctors about which most complaints have been made in the past. Rather it is the management of the deputising services which is under scrutiny: for example, questions about the adequacy of numbers on duty, geographical distribution, and the lack of close supervision by and accountability to the FPC and AHA.

The code would require extra resources, which are unlikely to be provided by a commercial organisation

The CHC feels that these management and administrative functions could be at least as competently supervised by lay members as by medical members of a committee. It seems certain that one liaison officer (paragraph 3.7 under *Functions of PACs*) cannot adequately carry out such duties. The new PAC will be a more closed committee than the present Joint Medical Consultative Committee, which includes lay members from the FPC.

The circular starts by assuming that only one-third of all GPs now use deputising services. Here in Birmingham the FPC has given consent to more than two-thirds — 500 out of 669 — of the doctors on the Birmingham Medical List. We are concerned that the cover at night and at weekends is for very long hours. Many of the deputising doctors have done other work during the day, and it is regretted that this is accepted in the DHSS document (paragraphs 2.2 and 3.3). How can efficiency be expected in both daytime and "spare time" posts?

Our CHC resolved last July, when Jason Bryant's death brought the South


CHC NEWS
For Community Health Councils
May 1978
Stricter rules for GP deputising
Hormonal

Birmingham Deputising Service into the headlines, that it was unsatisfactory for such services to be provided on a commercial basis, and that a proper salaried relief service should be run by the NHS, through the AHA or FPC. This view is also expressed in a consultative document of the West Midlands RHA, *Towards a Strategy for Health, 1978-88*. The proposals in the new code of practice would require much greater expenditure in order to achieve the improved standards, and a commercial organisation is unlikely to provide the extra resources.

We believe, however, that group practices (or GPs grouped together for the purpose of out-of-hours cover) are the best answer. When four or more doctors are involved, an on-call rota should be possible without recourse to an outside organisation.

The CHC is undertaking a deeper study, and hopes to produce suggestions that might influence the DHSS and health authorities in future improvements to the code of practice, or in the organisation of alternative types of off-duty cover in general practice.

Scanner

Cutting the drugs bill

A scheme to encourage the prescription of cheaper drugs is outlined in *Drugs and Therapeutics Bulletin* (published for doctors by *Which?*), 14 April 1978. Many drugs marketed under brand names are also available in much cheaper forms. Under the proposed scheme there would be no prescription charge to patients for the cheaper drugs. The potential savings to the NHS might influence GPs to use the cheapest satisfactory drug. The GP's right to prescribe would not be affected. Schemes similar to this operate in other countries, e.g. Australia.

Contraception, sterilisation and fertility

The pill is the most common method of contraception from the family planning services. Use of contraception has expanded amongst single women. A survey by the Office of Population and Census Surveys for the DHSS also shows that at present rates, either the wife or the husband in more than a quarter of couples will be sterilised by the time the wife is 35. *The family planning services: changes and effects by Margaret Bone* (HMSO £5.25 net).

Using radio and TV

The Volunteer Centre have published a directory of radio and TV programmes which focus on topics such as volunteers, the handicapped and the elderly. It is hoped that the booklet will stimulate new programme ideas in other areas. *Directory of social action programmes*, from the Volunteer Centre, 29 Lower Kings Road, Berkhamsted, Herts HP4 2AB.

Crown immunity

Crown bodies such as health authorities should no longer be immune from liability to prosecution and other sanctions for breaches of health and safety legislation. This is stated in the *Health and Safety Commission Report 1976-1977* (HMSO £1.25 net).

Asian patients in hospitals and clinics

Is an 11 page booklet prepared by Barking Community Relations Council and the Health Education Panel of Barking and Havering AHA, for "members of the caring professions". Ethnic groups, cultural backgrounds and names are briefly described, as well as customs of dress, hygiene and diet. Free from Barking CRC, c/o Methodist Church, London Road, Barking, Essex (15p post).

Menopause problems

Hormone replacement therapy is widely over-rated as a treatment for post-menopausal problems of oestrogen deficiency. *Drugs and Therapeutics Bulletin* (published for doctors by *Which?*), 17 Feb 1978, reviewed 20 types of drug, varying greatly in cost. It points out that the treatment may also by risky, for women liable to diabetes, heart disease or certain kinds of cancer.

Down's Syndrome

Is the title of a booklet explaining the mental handicap often called mongolism. Two other leaflets, *Help your child to learn at home* and *Reading before talking* in which a father describes teaching his mongol daughter to read are also available. From National Society for Mentally Handicapped Children, Pembridge Hall, 17 Pembridge Square, London W2 4EP (30p each plus post).

High blood pressure

Hypertension, or high blood pressure, affects at least 8 per cent of the adult population in most countries. A World Health Organization committee has called for a world-wide drive against hypertension, a disease which is easily identified and can be effectively treated. More research and preventive measures are needed — such as weight control, exercise and regular blood pressure checks. *World Health*, the WHO magazine, devotes its entire Feb/March issue to hypertension. (HMSO 65p net).

Social security leaflets

DHSS leaflet NI 146 lists all the social security leaflets, which are available in local DHSS offices or by using the order form printed inside the leaflet.

Mobility allowance

An updated mobility allowance leaflet (NI 211) has been published by the DHSS, explaining how to qualify and when to claim.

War pensioners

The Royal British Legion is concerned about NHS treatment for war pensioners. Successive governments have confirmed that ex-servicemen, disabled in the war, should get priority in-patient and out-patient treatment, except for emergency cases. The RBL believes that present NHS staff need to be reminded of this commitment. And an increase in the rates of car maintenance allowances paid to disabled war pensioners was announced in April.

The budget and cash limits

Cash limits for 1978/79 have been increased in real terms on a scale from 0.6 per cent for N W Thames region to 4 per cent for Trent and for the North West. The DHSS will give guidance to health authorities on spending the £50m. budget boost. Getting new hospitals into full use, day surgery facilities, and improved staffing levels in mental and geriatric hospitals are among the priority items.

Violence to children

This White Paper gives the Government's response to the report from the Parliamentary Select Committee on Violence in the Family. It calls for closer co-operation between obstetric units and health visitors to identify "at risk" families and for sensitive care during the whole birth experience. *Violence to Children: Cmnd. 7123* (HMSO 75p).

Hearing therapists: HC(78)11

The DHSS will give special funds for each region to recruit and train two or three hearing therapists over the next four years. The aim is to help adults with acquired deafness and the scheme is the implementation of a recommendation of a sub-committee of the Advisory Committee on Services for Hearing Impaired People. Its report was published by the DHSS in 1975.

Community dental services extended: HC(78)14

The circular gives AHAs discretion to treat handicapped adults through the community dental services. Priority is still to be given to children and expectant or nursing mothers.

Thirtieth anniversary of the NHS: HN(78)47

Gives advice for health authorities, local authorities and CHCs as to how they might celebrate 30 years of the NHS on the 5th July. Some special posters are being produced and booklets will be available.

Essential small pharmacies: HN(FP)(78)22

Outlines revised qualifications for payment to small chemists' shops which are shown to be providing an essential community service. See *CHC NEWS 21 page 10* for article on the scheme.

Directory of CHCs: changes

A directory of CHCs in England and Wales is available from *CHC NEWS*. This was last updated in February 1977, and a revised version is now in preparation (see front page for details).

Changes are published monthly in *CHC NEWS* — please notify us of any alterations in address, telephone number, chairman or secretary.

Page 3: Northumberland CHC, Chairman: Mrs J. K. B. McCallum

Page 6: Airedale CHC, Secretary: Richard Bray

Page 20: City and Hackney CHC, Secretary: Mrs Fedelma Winkler

Page 23: Greenwich CHC, 23 Anglesea Road, London SE18 (01-317 9994)

Page 28: East Dorset CHC, Chairman Mr E. W. Nobbs

Page 31: Kettering CHC, Chairman: Mrs Jill Carter

Page 37: South Warwickshire CHC, Chairman: Mrs K. J. Hughes

Page 59: Association of CHC Secretaries in the West Midlands, Chairman: Jim Smy (Sandwell CHC), Secretary: Bob Townsend (Solihull CHC)