CHC NEWS

For Community Health Councils

October 1978 No 36

Mental health balancing act

The Government's long-awaited White Paper on the Mental Health Act of 1959 has finally appeared. Mr Ennals believes that it achieves the right balance between the need to increase and redefine the rights of patients, the demands of staff that their rights also are protected and clarified, and the fundamental right of the public to protection from serious harm.

MIND is concerned that the document does little to resolve apparent injustices. For example, mentally disordered offenders will still be subject to court orders detaining them in hospital for specified or unlimited periods which could well be longer than if they had been sentenced to imprisonment. And representatives of doctors, social workers and NHS trades unions, as well as MIND, have voiced disappointment that many of their recommendations on the consultative document on the Act (see *CHC NEWS* October 1976) have not been accepted.

The main topics covered in the White Paper are detention powers, the review procedures, mentally abnormal offenders, patients' rights and safeguards for staff. More details on page four.

Hard work at the AGM

Only 11 of the 30 policy motions on the agenda were decided at ACHCEW's AGM last month. This pressure of time should be eased next year by having a two-day meeting, in York in September.

The liveliest discussion was prompted by the motions on resource allocation. The meeting voted 85-54 to deplore the increasing concentration of NHS resources on the big teaching hospitals. But a motion asking for more money to ensure that no district should suffer cuts as a result of RAWP was lost 66-97.

Carried enthusiastically was a motion asking for wider consultation on the closure of specialist hospitals. Other motions carried were on simplifying NHS structure, earlier notification of regions' budgets, CHCs and Inner City Partnerships, and mentally handicapped children. Motions not reached were referred to the association's standing committee.

Secretary of State David Ennals was applauded for his promise to hold further talks with the Society of FPCs about accepting CHC observers at FPC meetings. He urged that CHCs should have a bigger role in planning services, including closure consultations, "at an early, informal stage". He wanted CHCs to act as a focus for debate about the future of the NHS when the Royal Commission reports next year.

Of the 228 CHCs in England and Wales 193 have now joined ACHCEW, and 189 came to the meeting. Four non-member CHCs sent observers.

Eating well

*Eating for health** is the latest in the series of DHSS booklets on aspects of prevention. It explains clearly what is known about the effects of food on health, and is aimed at lay readers and health education workers. It recommends that:

- Breast-feeding is best for babies.
- Children's intake of sugar and sweets should be restricted.
- Sufficient vitamin D is important.
- Food intake and energy expenditure should be matched, to avoid obesity.
- Many people should cut down on fats, other fatty foods and sugar.
- These people could re-balance their energy intake by eating more bread, fruit, vegetables and potatoes.
- Less salt might be beneficial.

The booklet points to the improvements in health which accompanied food rationing during the last war, but suggests no changes in social policy which could produce comparable effects today. There is no discussion of the pressures from the food industry which may persuade some people to eat unhealthily, and the role of advertising is not considered. On the other hand the booklet defends processed foods and the use of chemical additives.

**HMSO, 95p. The DHSS will be sending CHCs a free copy for every member.*

Photo: Bavaria-Verlag/O Poss

CHCs not consulted on GP complaints

Proposals to reform the procedure for investigating complaints about GPs are entering a second round of consultation — but the DHSS is not encouraging CHCs to take part. Following the first round of consultation in 1976 a second-stage document listing "major proposals" for change has been circulated to Family Practitioner Committees, professional bodies and the press. CHCs will not get a copy unless they specifically ask the department for one.

● **See page three for comment**

New Directory

An updated edition of the Directory of CHCs is now ready. One copy will be sent automatically to each CHC. Further single copies are available free — please send a large, stamped addressed envelope with orders.

INSIDE:

Your letters

CHC television contact with Asians

Geoffrey Johnson, Secretary, East Birmingham CHC

East Birmingham CHC has recently had the chance to contribute to a nation-wide Asian TV programme and it seems likely that our representative will soon be invited to make a number of further appearances to enlarge on the work of CHCs.

One of the main problems faced by CHCs in the West Midlands, and probably by most other CHCs representing a sizeable number of Asian NHS users, has been the diffidence of Asian patients in raising health care problems, either with CHCs or other bodies. Those CHCs which have tried to make contact with Asian minorities in their districts will appreciate the value of this new opportunity for contact and the importance of maintaining the quality of our input.

We would therefore like to hear from CHCs in other regions who have been involved with Asian patients and their families. The CHC's spokesperson on this programme is Mr M. U. Dard, an Asian with a full command of all the major Indian dialects, and a founder member of this CHC. Mr Dard may be contacted direct at his home, 50 The Broadway, Birmingham B20 3EA (021-356 7648) or through the CHC office at 203 Bordesley Green East, Birmingham B9 5SP (021-784 5388).

Clearing house for waiting times

Jean Franks, Secretary, Mid-Surrey CHC

I refer to Mr Baker's letter on this subject in the August issue of *CHC NEWS*. Sorry, but I do not subscribe to the idea, for the following reasons:

1. I doubt if many people would be willing to go to another part of the country to receive treatment. This would remove them from relatives and friends when they most needed support.
2. *If* many opted for this scheme, the waiting lists in districts providing a reasonable service would lengthen.
3. After-care would be more difficult to arrange, and travelling home from any distance could be exhausting and distressing for patients who had undergone surgery.
4. It would blunt attempts by CHCs to obtain a better deal for the public.

Stoke Mandeville Hospital

Philip V. Lowe, Secretary, Eastbourne CHC

On page 1 of your July issue you refer to the rejection of a part-closure proposal of beds in the Spinal Injuries Unit at Stoke Mandeville Hospital, Bucks. It is perhaps not appreciated that this was, at least in part, due to the vigorous opposition to the proposal made by Eastbourne CHC to the Secretary of State.

Those using the unit are mostly ex-service patients of the Chaseley Home in Eastbourne, who were rehabilitated at Stoke Mandeville, and who still look to it for quick action when they suffer a breakdown, mostly of the kidneys. There is no other unit south of the Wash with an equal knowledge of paraplegics, and, although most of us now take the war in Northern Ireland more or less for granted, nevertheless our soldiers are still being wounded there and there is a steady stream of servicemen with spinal injuries.

Whose job to inform the public?

J. W. Corbett, Secretary, Barnet/ Finchley CHC

I was interested to read Evelyn Roith's article on CHCs and information services (*CHC NEWS*, August, page 9), but I find myself forced to disagree. She states that providing information about health services is not the "life-blood contact" of CHCs with the public. I only wish that I had been given a pound for every time I have been asked how to change doctors, obtain support services, and so on.

It is crucial that we do not decide for the public what they want us to be. In my experience social workers tend to spend too much time agonising over what they should be doing and not enough actually doing what the community demands. CHCs must not fall into the same trap. The key to good community services of any sort is quick and relevant action. Of course health authorities can provide guides, but if they do not then the CHCs involved should move swiftly to fill the gap lest the public be unwilling witnesses to an argument between the CHC and the authority, and remain without the information they require.

Nurses and the trade unions

Michael McGeorge, Member, Tower Hamlets CHC

I noted that you had omitted a major union from your August centre page article on the trade unions — the Royal College of Nursing. The RCN has a membership of 110,000 nurses, of whom 80,000 have a statutory qualification. The remainder are student nurses who are studying for a statutory qualification. It is misleading for COHSE to say they have 150,000 nurses and for NUPE to say they represent 80,000 nurses and midwives, when the majority of these are in the Auxiliary Nurse/Nursing Assistant grade.

The unions' viewpoint

E. W. W. Double, Member, North Staffs CHC

I should like to make two related comments on the article on trade unions in your August issue. First, I would like to ask whether the leaders of these unions ever wonder if their policies could be partially responsible for many of the so-called ills of the health and social services, as well as for restrictions on current spending. For example, more homes and hostels are badly required for the mentally ill and handicapped, and dental services in mental hospitals need to be improved (I write as a CHC member nominated by Staffordshire Society for Mentally Handicapped Children). But it seems that finance and staff for these improvements will not be found until the unions have first secured their 10%-plus from available funds or from increased rates and taxation.

Secondly, I wish to express my support for the present system of appointing members to CHCs and health authorities — a system which has the advantage that minority groups with pressing needs like the mentally handicapped have a chance of securing direct representation and of making their needs known. The TUC request for the right to nominate half the membership of AHAs and RHAs (as well as proportional representation related to union size) could exclude many such minority groups.

Secrecy on BMA fees

Joan McGlennon, Secretary, North Surrey CHC

In the July issue of *CHC NEWS* I offered to send interested CHCs a copy of guidelines issued by the BMA in connection with fees charged by general practitioners for private certificates, cremation fees, vaccination certificates, etc. When I went to copy the document, in response to numerous requests, I observed the word "Copyright". Warning sirens sounded. I decided not to honour my offer in case of repercussions from the BMA.

I was not disappointed. Within three weeks of the publication of *CHC NEWS*, a solicitor's letter arrived by recorded delivery. Whilst I have to agree that circulation of the document would have been an infringement of the law, I feel that information of this nature should not be hidden beneath a veil of secrecy.

I hope all CHCs will ensure that members of the public are aware of the existence of the guidelines, and will join with this CHC in pressing for a more open approach.

Personal clothing

Leonora Elphick, Member, Guy's CHC

The difficulties of providing personal clothing for long-stay patients was mentioned by Marcia Saunders in your July issue (page 2). I suggest that there are three steps which must be taken if a successful system of personalised clothing is to be operated:

1. Everyone involved — including nursing, purchasing and laundry staff — must be motivated to achieve the objective.
2. Representatives of all the staff concerned must agree on how the scheme should be implemented, and should meet regularly to review progress and sort out problems. These representatives must include staff from the medical and nursing groups; purchasing, administrative and finance groups; and laundry and sewing-room groups. The clothes bought must be suitable for the patients and for the laundry process, and care must be taken to hang or store clothes properly on the wards.
3. A clothing manager should be appointed to liaise with all members of staff concerned in the scheme.

I am a member of the Clothing Panel of the Disabled Living Foundation, which can give helpful advice. Their address and exhibition centre is at 346 Kensington High Street, London W14 (01-602 2481).

Comment

By now readers will realise that an almighty row is going on over the investigation of complaints about GPs, dentists, chemists and opticians. Predictably the professions are making a fuss, though the new DHSS proposals seem reasonable enough.

Family Practitioner Committee service committees, which investigate complaints on behalf of the full FPC, would be slimmed from seven members to five, two lay and two professional, with the lay chairman being given full voting rights. The time limit for complaints would be considerably extended. Oral complaints, and complaints made to health authorities and CHCs, would be allowed. Complainants would normally have a right to an oral hearing. Service committees could order the production of medical records, for complainants to examine. Practitioners would be asked to have a "suggestions and complaints box". What's more, the argument that CHC secretaries cannot represent complainants because they would be acting as "paid advocates" would finally be laid to rest.

But CHC members have had to learn about all this in the press, because the department's approach to this second round of consultation has been clumsy and one-sided. When the first round was announced in 1976 all sides were asked for their views, but now only FPCs, the professional bodies and the medical defence societies are being re-consulted.

The DHSS says "bona fide" enquirers, including CHCs, will be sent the new document on application. When we asked whether further comments from CHCs would be accepted we were told that this could "lengthen the process enormously", and any further CHC comment should come through ACHCEW. ACHCEW however has not been sent the document either, and has complained about this.

The very composition of service committees reflects the need to balance lay and professional viewpoints, and it is essential that this balance be maintained within the consultation process itself until the decisions are finally taken. If the department really wants to implement its proposals, despite medical opposition, why is it trying to muzzle its strongest allies?

Health News

GP hospitals undervalued

The 350 general practitioner hospitals in England and Wales are bearing more than their fair share of hospital workload and operate more economically and conveniently than district general hospitals — yet they are often underfinanced and the GPs who work in them seriously underpaid. These are the conclusions of a survey (reported in the *British Medical Journal* for 1 July) which shows that GP hospitals provide initial hospital care for up to 20% of the population — coping with more than 13% of all casualties, 6% of operations and 4% of X-ray examinations. Twenty new DGHs would be needed to cope with such a workload. Many of the GPs questioned considered hospital work essential to their job satisfaction, and the morale in most of the hospitals is high, despite the lack of financial incentive to work in them.

Do we need means tests?

Means testing in local authority social services departments could be phased out at a cost of £9.1m — only 1% of total expenditure on personal social services in England — according to the report* of a workshop organised by the National Consumer Council.

A means test is an investigation into a person's financial circumstances, to decide how much help they are entitled to. The workshop agreed that the worrying low take-up of services was at least partly due to the use of means tests, which can be humiliating as well as administratively wasteful.

The vast differences in levels set for flat-rate charges and means testing also caused concern (with meals on wheels costing from 6½p to 30p), and the workshop suggested that national guidelines, with maximum charges, should be introduced.

* *Means tests in local authority social services – who needs them?* (NCC, 18 Queen Anne's Gate, London SW1).

Personal social services reorganised

Nine large non-metropolitan towns will once again get sole responsibility for the administration of personal social services, following government proposals for certain limited changes in the organisation of local government. Councils in Bristol, Derby, Hull, Leicester, Nottingham, Plymouth, Portsmouth, Southampton and Stoke-on-Trent lost their powers over social services, education, roads and traffic in the Local Government Act of 1972.

Although the transfer will mean that social services are reorganised yet again, the government considers it more important to place responsibility for decisions as close as possible to the people served. It will enable towns to deal with their "inner city" problems in their own way. Similar powers may in future be handed back to other district councils, with populations of more than 100,000.

Mental health review tribunals

There are about 6,000 patients compulsorily detained in mental hospitals in England and Wales for whom mental health review tribunals (MHRTs) provide a vital appeal mechanism. A few of these patients (mainly those detained on hospital orders made by a court) are subject to restricted discharge — and have to apply to the Home Secretary, who is responsible for their discharge or transfer, to have their cases reviewed.

A discussion paper from the Committee on Mental Health Review Tribunal Procedures* has recently proposed some changes in the rules governing MHRTs. Among the recommendations are that the rules should, with a few exceptions, apply to all patients (those subject to restricted discharge as well as direct applicants); that any written application for a review should be accepted, though simple forms could be used if preferred (and could be made available in CHC offices); that patients' representatives should have the right to see and hear all evidence put to the tribunal, provided they are legally qualified or approved by the tribunal; and that written evidence should only exceptionally be withheld from patients. MIND has objected to the proposals because they still largely ignore the *patient's* right to know all the facts of the case.

**The procedures of mental health review tribunals*, available from Room C501, Alexander Fleming House, Elephant and Castle, London SE1 6BY; comments on the proposals should be made by 30 November.

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Breastfeeding:

Breaking down the barriers

by Priscilla Alderson, member, Tunbridge Wells CHC

It is now DHSS policy to advise mothers to breastfeed for 4-6 months and to discourage the introduction of solid food before four months. Yet a survey commissioned by the DHSS in 1975 (1) found that only 51% of 1544 mothers attempted to breastfeed; by 6 weeks 4% of babies and by 4 months less than 1% were entirely breastfed. Mothers stop breastfeeding in the first few weeks mainly because of insufficient milk, discomfort, and sucking difficulties — and hospital routines often exacerbate these problems.

The sooner the baby is put to the breast, the better he or she will suck. Yet the DHSS survey shows that 52% of babies waited more than eight hours before being breastfed. The only way to produce more milk is to feed the baby more often, but only 6% of mothers who felt that they had too little milk were told this. Many hospitals have set feeding times, keep the babies in nurseries, and discourage feeding on demand. Mothers are told to feed for a few minutes at four-hourly intervals, as this is supposed to prevent sore nipples. However, in the survey more women complained of soreness, and gave up breastfeeding, if they followed this rigid schedule, than if they fed on demand. Breastfed babies need to be fed more often than bottlefed babies, but many mothers were not told this. When the baby cried well before the prescribed feed time, and then, having waited, was too tired to feed, they assumed that their milk was inadequate in quality or quantity. The survey concludes that health professionals could do much more to encourage breastfeeding.

A small study in our district found similar results to the national findings, and feeding emerged as the aspect of post-natal care that worried mothers most. We received comments such as: "They had to pick Fiona up, shake her and slap her feet at feed times. She woke between feeds and they would say, 'no, wait for two more hours' "; "Your mother instinct is cramped by hospital routine. It's panic, panic, panic"; "They pulled me about so much I couldn't stand it. I said, 'just leave me alone, I'll manage', but they wouldn't". Mothers were upset about complementary bottle feeding: "When they said, 'it's time for the babies to go back', she'd hardly had anything, so they bunged a whole bottle of glucose down her".

Photo: La Leche League

There are many ways in which CHCs can help to change attitudes of staff and new parents. They can ask what is achieved by antenatal care and teaching, and whether there is enough time in crowded clinics to discuss feeding. Is anything arranged for mothers who do not attend classes or clinics? CHCs might look at the booklets given out at surgeries and hospitals. These tend to be inaccurate and discouraging — for example: "It is not worthwhile persisting in the attempt to breastfeed your baby if you have not enough milk when perfectly good artificial ways exist" (2).

Are mothers encouraged to hold and feed their baby as soon after the birth as possible and whenever they wish? In the DHSS survey 29% of women felt unable to sit comfortably while breastfeeding, and were more likely to give up. Do your wards have soft beds and chairs, air-ring cushions, and warm rooms? Does the atmosphere in the wards help each mother to feel relaxed and confident as a new parent, or are they intimidated by routine? They need the right amount of personal encouragement and help from nurses. Do expectant and new mothers meet women who have enjoyed breastfeeding and can offer advice and support? Half the mothers in the national survey were given a free sample of cow's milk to take home from hospital. What are mothers in your district given at discharge? Do the hospital and primary care staff and voluntary organisations work together to give consistent advice?

These are just a few of the questions that need to be asked by CHCs, which are uniquely well placed to investigate maternity services and their effect on families.

(1) *Infant feeding 1975 – attitudes and practice in England and Wales*, HMSO, 1978, £7.
(2) *You and your baby*. Family Doctor publications, British Medical Association, latest edition 1977.

MENTAL HEALTH ACT WHITE PAPER

(Continued from page 1)

The scope of the Mental Health Act 1959 is now largely limited to compulsory powers of admission to and detention in hospital, and to safeguards for patients subject to such powers. But the new White Paper concerns voluntary (informal) patients as well as detained (formal) patients and those subject to restriction orders, which are usually imposed by a court and mean that patients can only be discharged with the Home Secretary's consent.

The White Paper recommends that *all* patients must be given a clear written statement of their rights. They should also be given full information about any proposed treatment and its likely effects. No treatment can be imposed on informal patients, and the Government intends to clarify the right to impose treatment on detained patients in certain circumstances. Some treatments may be classified as irreversible, hazardous or not fully established (ie treatments not in general use, or whose safety and efficacy are unproven). These treatments would never be imposed against patients' wishes, except in an emergency to save life, and a second opinion would have to be sought from a multidisciplinary panel (with a lay member) even if the patient had given consent. Electroconvulsive therapy might be classified as "hazardous". The panel would be consulted if there was doubt about whether a treatment came within one of the special categories.

New safeguards are proposed for patients compulsorily admitted for short periods (in emergencies, and for short-term assessment and treatment lasting up to 28 days). For example, only the nearest relative, not any relative as at present, would be able to apply for an emergency admission.

The present periods of detention under the longer-term powers would be reduced by half, to six months followed by a further six months and then one year. Patients would be able to apply to mental health review tribunals (MHRTs) to have their cases reviewed, at similar intervals. Reviews would be made automatic for patients who did not avail themselves of this right.

The Government says existing powers to make restriction orders of indefinite duration should be retained, but the essential intention of such orders — the protection of the public, rather than punishment — should be made clear. The White Paper says compulsory powers should not begin or end at the hospital door, and invites comments on how such powers should be used in the community.

The section of the Act which allows correspondence to and from informal patients to be withheld should be repealed, the Government says. Detained patients should be largely free to receive and send mail, but in special hospitals and regional secure units mail might be withheld for security reasons — for example, where money might be sent to help the patient escape. But patients would have to be told if their mail was being inspected, and letters to MPs, MHRTs, CHCs, etc, would be free from interference.

The Government has turned down the idea of a legal advocacy system or a mental welfare commission to protect patients' interests. But it accepts that the idea of patients' advisers should be tried out in pilot schemes.

**Review of the Mental Health Act 1959, Command 7320, HMSO £2.*

DOGS AND DISEASES

*by Mike Crook**

Toxocara canis is a worm which lives in dogs but can also infect humans, causing various diseases. At worst it can damage your brains or eyesight. The worms are caught by accidentally eating some of their tiny eggs. This is not such an unlikely event because the eggs are excreted in very large numbers by many dogs, onto parks, pavements and other public places — where they can remain alive for several years. It has been estimated that at least one person in fifty picks up the parasite at some time in their lives, and we do not know how many people suffer illness as a result.

Toxocariasis — as infection with *Toxocara canis* is called — does not lead to a single illness with a clearly identifiable set of symptoms. If it did we might have recognised the risks long ago. Instead it can cause a variety of ailments, any of which can easily be put down to some other cause. Before 1952 it was not even known that the worm could live inside people. Then one was discovered in human tissue for the first time, more or less by accident, but at first it was assumed to be rare.

Toxocara has evolved to live and breed in dogs, where it can reach a length of four inches. Fortunately in humans it never reaches anything like this length and cannot breed. One way it spreads is by going straight from a bitch to her puppies before they are born — so it is advisable to be especially careful of young dogs. The worms' other way of passing from dog to dog is via their hosts' faeces, in the form of eggs. This is the route which most concerns humans, since we can inadvertently swallow the eggs too.

In the human intestine, *Toxocara* eggs hatch into small worms or *larvae*, which eat their way into the blood-stream. From there they can move to any part of the body. They are likely to head for the liver — their first port of call in the dog. Many will stay there, but some may end up in the lungs, kidneys, heart, muscles, brain or eyeball.

Wherever the worms stop they will lodge themselves in tiny blood vessels or lymph channels, and they will then be attacked by white blood cells as our bodies try to dispose of the intruders. But the worms may actually feed on white cells. They will not grow much longer than one hundredth of an inch but they may stay alive for months. Around each worm there will be an area of inflammation which can lead to disease. By the time the worm dies some of the surrounding tissue will have been permanently damaged. A tiny vein will also have been blocked, causing a small part of the organ that it supplied with blood to die.

Whether this will make you ill depends on the number of eggs swallowed and where they finish up. It is probably very rare for a worm to reach the eye, but if one does and the disease is not diagnosed in time, vision could be very seriously affected. The least damage can affect the way the eye works. On the other hand the liver, which is a more common place to find *Toxocara*, is also a more robust organ so a worm or two may be of little consequence. But because the eggs are deposited in very large numbers it is possible to consume many at a time, making an illness much more likely.

Toxocariasis has been found to be associated with serious liver disease, and with serious disorders in other organs. Compared with children who are healthy, children suffering from polio have been found to be over six times more likely to have had toxocariasis, and children with epilepsy are four times more likely to have been infected. A link with asthma has also been found. Even when toxocariasis has produced no obvious disease, it may still have damaged an organ enough to make it more likely to go wrong in the future.

Between one dog in ten and one in seven is busily excreting *Toxocara* eggs, which means that the British dog population of around seven million must be producing close on a million egg-bearing offerings every day. There can be as many as 15,000 eggs per gram of faeces, giving up to a million in a good-sized dropping. The eggs are amazingly durable, and long after the faeces in which they were excreted has been washed away or broken down by bacteria thousands of them will still be lying around, invisible to the naked eye.

Parks and pavements must be littered with eggs. Children are most at risk because they are more likely to get eggs on their fingers, and more likely to put dirty fingers into their mouths. Perhaps most people who get toxocariasis do so as children, but adults are also at risk — for instance, the eggs can be carried by flies.

Life cannot be lived without risks, but that is no reason to run risks which can easily be avoided — and nobody need suffer from toxocariasis. Dogs can be given pills to clear them of these worms for about 30p a time. Regular treatment — say once a year — is needed, but this is not too much to ask. Applicants for dog licence renewal could be required to produce proof that their dog has been de-wormed.

Dog owners could stop their animals fouling parks and pavements — and byelaws to make this illegal could be introduced. In 1976 the Working Party on Dogs recommended that local authorities make use of their existing powers to make byelaws prohibiting dogs from children's play areas and from other places in a park where they might cause inconvenience or discomfort to other users of the park". The working party also asked local authorities to consider employing dog wardens, part of whose job would be to educate the public about the care of dogs and the nuisance they can create.

It is now exactly 100 years since the cost of a dog licence was last increased — to 7s 6d (37½p). The working party recommended that the annual licence fee should be increased to £5, at 1975 prices, and this is the obvious source of revenue for the system of enforcement of doggy hygiene that is so clearly needed.

Further reading

Toxocariasis, by A. W. Woodruff, *British Medical Journal*, 19 September 1970, pages 663-669

Toxocariasis as a public health problem, by A. W. Woodruff, *Environmental Health*, February 1976, pages 29-31.

Domestic pets in urban society, by A. J. C. Scott, *London Topics*, August 1976, from GLC Intelligence Unit, County Hall, London SE1.

Report of the Working Party on Dogs, HMSO 1976, 65p.

**Mike Crook is a researcher working in local government.*

The long and short of waiting lists

by Lorna Wainwright, formerly Patient Services Officer for Ipswich Health District, and now Research Associate at the King's Fund College, London

On their way to a hospital bed patients may have to wait twice — first to be seen in outpatients, and second for a bed to become available. The purpose of this article is to set out how outpatient and inpatient waiting lists work and to describe some ways in which they can be managed most efficiently and the time a patient has to wait can be kept to a minimum.

Outpatient waiting list

Usually people are referred to an outpatient department by their general practitioner. All GPs have a list of consultants, with their clinic days and times, and they refer their patients by addressing an appointment request form to a consultant by name, or sometimes more generally to a clinical department such as general surgery. This "open" request is not popular with doctors or patients, who usually want to see a particular consultant.

The patient sends the form to the hospital, where the staff of the medical records department arrange an appointment and return a section of the form to the patient informing him of the date, time and place. Sometimes the forms are combined with the GP's letter of referral, but the doctor may send this separately to the hospital. The form usually includes a section for the GP to indicate how urgently he thinks the patient needs attention, using such terms as "urgent", "soon" and "non-urgent", and whether or not the hospital should arrange transport.

Although it is not yet standard practice, many health districts provide GPs with information, every three months, on outpatient and inpatient waiting times and on the numbers on the lists of each consultant and specialty. GPs who have this information can tell their patients how long they may expect to wait before seeing a consultant. Some outpatient clinics provide treatment as well as consultation, and the waiting time for appointments may be longer than for consultation only.

Inpatient waiting lists

If the consultant decides to place a patient on his inpatient waiting list, he usually makes out a waiting list card and writes in the patient's case notes, the diagnosis and the degree of urgency, and whether the patient, for example for domestic reasons, wishes to be admitted at a certain time. The consultant will write to the GP to let him know what has been decided.

What happens at the next stage will differ in detail from hospital to hospital. At some hospitals all patients put on the waiting list are asked to go to the admissions office, where information such as their home and work telephone numbers, willingness to come in at short notice, or, conversely, a need for three weeks' notice, holiday dates and so on, are entered on the waiting list card. At others, the consultant may ask for this sort of information. The efficiency of the clerical procedures at these early stages helps to determine the effectiveness with which the waiting list can be managed. In my opinion, although a waiting list can be computerised, it is more easily maintained on a visible-edge card system. The cards are filed for each consultant separately in fixed metal trays or individual metal books. The advantage of the books is that they can be taken to an outpatients' clinic or ward or theatre; this is particularly useful when the admissions officer is trying, for instance, to replace a late cancellation.

The inpatient waiting list may be centralised or decentralised. A centralised waiting list is one that is operated from one office in the hospital. Where individual departments, wards, or consultants' secretaries keep their own waiting lists, this is known as a decentralised waiting list. Sometimes there may have to be a combination of both — where, for example, one department of a hospital is at some distance from the main building. The main advantage of the centralised waiting list is that it can be linked to the admissions office and the bed bureau. The bed bureau is where the centralised information on the hospital's bed state is kept. It consists of some kind of chart showing — often with the use of coloured flags — the number of empty and occupied beds, and of beds due to be occupied, in each ward. It is usually updated three times a day.

There are other advantages of a centralised waiting list:

- **It provides a central point for all enquiries — for example, from GPs and relatives.**
- **With an ex-directory telephone installed there, GPs can have easy direct access to up-to-date information (patients can of course still make contact through the hospital switchboard).**
- **The staff can be trained to a high standard, thus giving a personal service to the patient and doctor.**
- **All emergency admissions and deaths can be checked daily against the waiting list.**
- **It helps to ensure reliable statistics.**

Examples of good practice

Except in emergencies, some wait for a hospital bed is clearly inevitable. It is therefore important that patients should have confidence in the way the waiting list is managed and should know how it works. Systems vary from hospital to hospital, but some examples of good practice are given below, in order to help CHCs know what to look for and ask about when investigating waiting lists.

Good practices in the *administration* of waiting lists include:

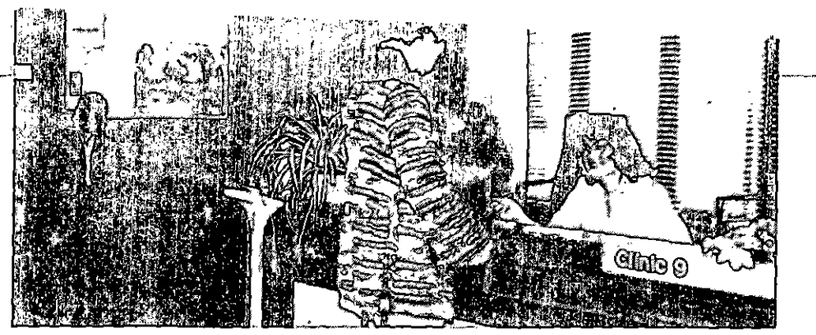
- **A coloured signal attached to waiting list cards to denote those patients willing to come in at short notice.**
- **Coloured metal tags to indicate degree of urgency, and also to signify patients whom the GP has enquired about.**
- ***Ex-directory telephone lines for GPs in the admissions office (inpatient waiting list) and also at the outpatient appointment desk save time otherwise spent trying to get through on the hospital's busy open lines.***
- **The waiting times and numbers for each consultant and specialty can be circulated to GPs — at no extra cost — via the family practitioner committee.**
- **Some GPs advise the consultant or medical records officer of those patients who no longer need an operation, have moved away, have changed their mind, or for any other reason, should have their names taken off the waiting list.**

A number of systems can be used by consultants, when deciding on the *clinical* aspects of a patient's treatment, that can help to reduce waiting times.

The diary system (also known as the **book** or **booking** system). This is a system where the consultant gives an admission date to a patient at the time consultation takes place. It allows the patient to make work or family arrangements and it can mean that fewer waiting list patients fail to come in.

Pre-admission investigation or treatment. For example, patients can be referred to anaesthetic assessment clinics if they have cardiorespiratory or other anaesthetically significant problems. This practice helps to prevent operations from being postponed and so avoids wastage of beds and operating time. Where drug treatment is necessary before an operation, the GP may be asked to start therapy.

Pre-booking of inpatient investigations. When a patient needs a special investigation such as arteriography, this can be booked by the admissions office staff with the X-ray department before admission.



Patients and receptionist in an outpatient clinic area.

Surgical and medical day care. There are medical treatments and investigations and certain operations that are suitable for day admission, preferably in a day care ward.

Programmed investigation and treatment unit. Such a unit operates a five-day working week with patients scheduled for one, two or three day stays. Admission dates can be arranged to suit a patient's domestic circumstances, or the availability of facilities for special investigations.

Planned early discharge. Patients are assessed in outpatient clinics by the consultant and with mutual agreement are put into the planned early discharge system. The date of admission is booked and the GP and the community nursing service are told both the date and the anticipated length of stay. GPs are asked to tell consultants if they consider any patients are not suitable for the scheme.

Admission wards. These are for the admission of patients with serious illnesses or who have been involved in accidents, and help surgeons to plan their routine work in the main wards and thus admit patients from their waiting lists.

Flexible use of beds. Fluctuations in the emergency work-load, leave of colleagues, and so on, will inevitably sometimes result in empty beds. Temporary arrangements can be made for beds to be reallocated to another specialty and, providing there are theatre sessions available, some reduction of the waiting list is possible.

Consultant with house officer and admissions officer selecting patients from the inpatient waiting list.

Points to discuss

In HSC(IS)181 the DHSS suggested that consultants within the major surgical specialties could agree to draw patients from a common waiting list, since a high proportion of patients on the non-urgent waiting list relates to only a few diagnostic conditions and procedures. This would help to prevent the build-up of large numbers on one consultant's waiting list and give more equitable waiting times. This system may work for a very few selected operations and procedures, but the *patient* is more concerned with the availability of the skill of a particular consultant. Quite often this consultant will be a specialist *within* a specialty. For instance, a general surgeon may also specialise in rectal surgery.

The term common waiting lists now usually means placing private patients on the same list as NHS patients, in order to prevent queue-jumping by private patients. The Health Services Board reported in May 1977 on its proposals for the phasing in of common waiting lists over a one-year period. The Secretary of State for Social Services announced at the beginning of August this year that he has now put proposals to the medical profession for the early introduction of common waiting lists. Private patients may in fact find themselves waiting longer than NHS patients if common waiting lists are introduced, particularly as more pay-beds are phased out from NHS hospitals, since no pay bed may be available when the private patient reaches the top of the common waiting list.

Another suggestion is that patients could travel to a hospital where the facilities they need are available. Some patients would do this, but from my experience these would be few, perhaps understandably so. What in hospital terms is a routine procedure, is for the patients a major event in their lives, and they welcome the assurance of familiar faces and places around them at such times.

Not infrequently, discussions on waiting lists concentrate on the patient, the surgeon and the bed. But what about the availability of the nurse, the anaesthetist, the theatre and the porter? It is the bringing together of these seven requirements *at the same time* that helps to determine the number of patients that can be admitted.

Administrative and secretarial support for consultants must be of the highest calibre. For example, when a consultant selects a patient for "short-stay" he sets in motion a whole chain of events all of which must be effectively coordinated. At no time should a patient feel lost within the system.

What can CHCs do?

First, they should visit the hospital's medical records department. I know of one CHC that has done this, and members saw for themselves the type of systems in operation and how they work. Second, they can also make informal visits to the hospital and show the administrative, nursing and medical staff that they are interested in the management of waiting lists, by talking to them and finding out what the local problems are. Third, they can encourage patients on waiting lists to inform the medical records officer at the hospital of changes in personal circumstances like new address, change of name and so on.

Fourth, even the holiday dates of patients waiting for a "non-urgent" admission matter, particularly if they are aware that they are reaching the head of the list. Patients are not moved back on the list because for personal reasons they are unable to accept an admission date when offered. Indeed, it is important that patients should not be intimidated by the hospital's bureaucracy, but should feel able to approach the medical records department to discuss any problems over their admission date.

Some waiting lists are long because resources are lacking; but even with more resources the answers are not simple — better facilities and more staff may create more demand. What matters is not the number of patients waiting for admission, but the length of time they wait and the reason for this wait.

FURTHER READING

1. *Day care surgery*, by J. E. P. Simpson, British Journal of Hospital Medicine, December 1976.
2. *The social and economic implications of planned early discharge*, by H. Brendan Devlin, Update, July 1977.
3. *Programmed investigations and treatment unit*. DHSS Abstracts of Efficiency Studies, no 175.
4. *Waiting list statistics*, by John Yates, CHC NEWS, February 1978.

The growing threat of Lead Pollution

Last December *CHC NEWS* reported on the harmful effects of lead pollution, and since then there have been several important developments. This updates the December article, and should be read in conjunction with it.

Currently the Government says a blood lead level of 36 µg/100ml (micrograms per 100 millilitres) is "the upper limit of normality in people not occupationally exposed to lead", but four new pieces of research now suggest that a downward revision of this "safety level" is needed.

Drs R.O. Pihl and **M. Parkes** (1), of McGill University, Montreal, studied lead levels in the hair of "learning disabled" (LD) children — children with academic difficulties but no obvious illness or emotional disturbance. The average level in the LD children's hair was six times that in normal children. This hair lead level suggests the LD children had an average blood lead level of about 30 µg/100ml.

Dr Oliver David (2), of the Downstate Medical Center, Brooklyn, measured blood lead in children who had been referred to his clinic for reasons unrelated to behaviour and learning problems. Yet when he checked with teachers, parents and child guidance counsellors, he found these problems were significantly more common in the children with higher blood levels. The group's average blood lead level was 18.3 µg/100ml.

Dr Herbert Needleman (3), of the Harvard Medical School, Boston, used lead levels in the teeth of healthy school-children to give an indication of long-term exposure to lead. Dividing the children into "high lead" and "low lead" groups on this basis, he assessed them using 37 IQ, learning and other psychological tests. In 14 of the tests the "high lead" children scored significantly lower than the "low lead" group, and in no test did they score significantly higher. Average blood lead levels were 35 µg/100ml in the "high lead" and 24 µg/100ml in the "low lead" children.

Dr Gerhard Winneke (4), of the University of Dusseldorf, has confirmed Needleman's findings at lower tooth lead levels.

A further disturbing report has come from Prof. D. G. Wibberley (2), of Aston University in Birmingham. He has been measuring lead levels in the placenta — the organ which links the mother to the foetus, enabling it to take in food and oxygen. On average, placental lead was 59% above normal in cases of stillbirth and neonatal death in which the child was malformed. In neonatal deaths not involving malformation, placental lead was 86% above normal.

In May the Department of the Environment issued its report *Lead Pollution in Birmingham* (5). This was presented as "reassuring" and not giving "any cause for concern" — despite its findings that pre-school children and male adults had blood lead levels in excess of the limits laid down by the EEC's *Directive on biological screening of the population for lead*. Dr Robert Stephens of Birmingham University was a member of the working party which produced the report, and is now one of its harshest critics. Applying Needleman's results to an existing survey of tooth lead levels in Birmingham children, Dr Stephens concludes that lead could be causing psychological impairment in one fifth of all Birmingham children under 13 years old. In June the TV series *This Week* asked environment minister Denis Howell to appear on its programme *Poisoned minds* to answer these criticisms. But no-one from the DoE would agree to do this.

Lead in air is not the only major source of human lead absorption, but it is the simplest and cheapest to control. The Government's intention to reduce the level of lead in petrol from 0.45 grams per litre to 0.40 in 1981 now seems inadequate. A growing body of public and expert opinion is anxious to see fresh action from the DoE and DHSS.

Further Reading

1. *Science*, 14 October 1977, pages 204-6.
2. In *Lead pollution – health effects*, proceedings of a symposium held in April 1978, £2.50 inc post from the Campaign Against Lead in Petrol, 168 Dora Road, London SW19.
3. Paper presented to a meeting of the American Paediatric Society, 27 April 1978. Photocopies available from CALIP.
4. Not yet published.
5. DoE Pollution Paper No. 14, HMSO, £3.75.

Book reviews

In the service of old age: the welfare of psychogeriatric patients

by Tony Whitehead, HM+M Publishers Ltd, Milton Road, Aylesbury, Bucks, £3.

"It will of course be claimed that day hospitals cannot be conjured out of thin air, but in fact they can" is a typically forthright statement from this book. Also typical is the description of how one hospital actually created and ran such a day hospital. Strongly worded indictments of bad practice in the treatment of the elderly mentally ill are there, but they go hand in hand with information on realistic schemes for improved care.

Tony Whitehead inveighs against authoritarian regimes in long-stay hospitals, against over-protectiveness of the elderly and insistence on nursing for nursing's sake, which he says create "bedridden ex-people", against hasty diagnosis and placement of the elderly, against admitting people to hospital because of "academic interest, to allay a doctor's anxiety or as a quick solution to a difficult social problem".

One of the insistent themes of the book is that wherever inpatient care for the elderly mentally ill is provided — in the long-stay psychiatric hospital or, ideally, in units within the general hospital complex — the closest possible links should be maintained between geriatric psychiatry and geriatric medicine. A fitting close to a thought-provoking book is the idea that psychiatric hospitals should be subject to an annual self-audit and as a result be assigned a position on a hospital league table.

Health rights handbook

by Gerry and Carol Stimson, Prism Press, Stable Court, Chalmington, Dorchester, Dorset £3.95 plus 40p post.

There are so many books we would be glad to commend to readers — they all have to compete for space in the books section. This book claims to be a "completely up-to-date consumer's guide to medical facilities in Britain". Because it fails to do this, we make an exception to our rule of not writing about books which we cannot recommend. It is sad to have to warn people off a book when there is such a dearth of health rights knowledge. If you want to read a trenchant argument about the politics of health care, written in a patronising tone — then this *is* the book for you. But although this book does contain some rights information it has tried to be much more than a handbook, with the result that it is much less.

Books received

Old and cold — hypothermia and social policy by Malcolm Wicks (Heinemann Educational £8)

In worlds apart — professionals and their clients in the welfare state by Tim Robinson (Bedford Square Press £1.95)

Take six children by Maureen Oswin (National Society for Mentally Handicapped Children £1.50)

Initially speaking — a glossary of NHS terminology by Fred Hawley (National Assoc. of Health Authorities, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT 60p + 10p post)

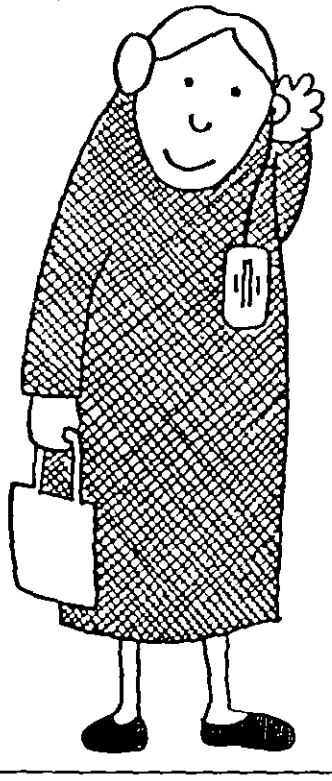
A SOUND SERVICE

by Susan Nattrass, formerly Deputy Organising Secretary, Age Concern, Greater London

About one third of elderly people have some form of hearing impairment. Many are reluctant to seek help. They feel that the deterioration in their hearing is an unavoidable part of ageing, and unfortunately some professionals share this view.

Identifying and helping the elderly is made more difficult by the hidden nature of the handicap. CHC members and all in contact with the elderly should be aware of this so that some action can be taken before social contact is lost. Age Concern have produced a leaflet (1) outlining the warning signs. This should be available in CHC offices and checks made on old people's clubs. People should be encouraged to discuss their problem with their GP and not accept as an answer "what can you expect at your age?". The doctor may find that wax is the problem and drops and syringing may help.

If a hearing test is necessary there is often a long wait for an appointment (sometimes up to a year). There is a danger the elderly person may become resigned to the loss and take no further action. Although behind the ear aids are available, the body-worn aids have more manageable controls and many elderly people prefer them. All NHS aids, batteries and cords are issued free of charge.



A survey by Kensington, Chelsea and Westminster (South) CHC showed that the difficulty people have in adjusting to using an aid could have been alleviated by some home-based training (2). Some audiology units have developed follow-up schemes, using volunteers, and a few local Age Concern groups have similar plans. The DHSS has acknowledged such a need and have earmarked funds for a small-scale hearing therapy service. The Age Concern leaflet describes a number of devices which can help the hard of hearing cope at home. The British Association for the Hard of Hearing (3) has a network of clubs throughout the country.
Check the services in your area.

Assessment for a hearing aid

1 Where are patients in your district referred to for a hearing assessment and the fitting and issuing of an aid? (It is usually the same centre that does both, but not always.)
2 Is the procedure for getting an assessment clearly set out and circulated to GPs?
3 How long do elderly people have to wait for a hospital appointment once they have been referred by a GP?
4 Can transport to the hearing aid centre be arranged for the housebound?

The issue of an aid

5 When a hearing aid is recommended, how long is it between the time an impression of an ear is taken and the earmould is issued to the patient (the average time is 2-3 weeks)?
6 What instruction is given in how to use the aid — eg, how to use the controls, where and when to use the aid and what to expect of its performance?
7 Is the DHSS booklet *Guidance for hearing aid users (HA1 (Rev))* issued routinely to all new patients?
8 Is information given (preferably in writing) as to where to get replacement leads and batteries and where to get the aid repaired?
9 Is information given about local lipreading instruction and aids such as flashing doorbells, TV and radio adaptors?

Follow-up services

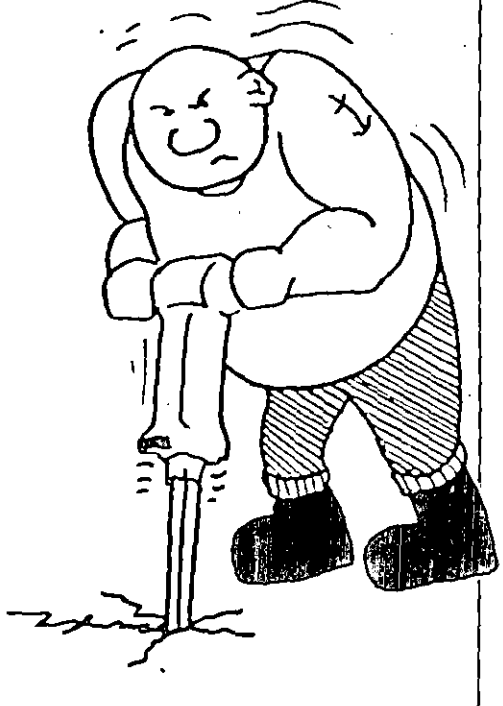
10 If an aid has to be repaired, does it mean that the patient has to wait for a few days without an aid? (Some centres issue a replacement aid.)
11 Do health visitors and district nurses and social workers have supplies of batteries and leads for those they visit? Are they able to help patients with the simple problems they have with their aids?

Future planning

12 Are there any plans to expand the staffing level of the hearing aid departments? Has the employment of hearing therapists been discussed?
13 What are the physical conditions of the department, eg a room may be acoustically unsuitable? Are several people issuing aids in one room?
14 Could day-centres, health centres be used more extensively as a base for issuing batteries and for help with routine problems?
15 What training is available for staff in hospitals and residential homes so that they understand the problems and the help available to the hard of hearing?
16 Is there a specialist social worker with the deaf and hard of hearing on the local authority staff?
17 Could a voluntary visiting scheme be organised to help the elderly get used to their aids and persevere with wearing them?
18 Could CHCs seek out those who have been recently issued with an aid and ask them what sort of help they would have liked, in addition to the help that they received?
19 Have CHC members visited the hearing aid department and talked to the staff about the service and how they wish it to be improved?

Further information:

1 *Why do people mumble so much?* from Age Concern, 60 Pitcairn Road, Mitcham, Surrey (single copies free).
2 *What did you say? – the use and misuse of hearing aids by the elderly* from Kensington, Chelsea and Westminster (South) CHC, 89 Sydney Street, London SW3 6NP.
3 British Association of the Hard of Hearing, 16 Park Street, Windsor, Berks.



Cartoon: SIAD Alternative Design Group, from a booklet produced by Kensington, Chelsea and Westminster (South) CHC

Healthline

When can we get rid of our chairman?

The chairman of my CHC is sometimes rude and off-putting to members of the public when they ask questions at our meetings. How often does a chairman have to stand for re-election, and can he or she be re-elected indefinitely?

The relevant authority on this is Statutory Instrument 1973 No. 2217, *The NHS (Community Health Councils) Regulations 1973* (HMSO, 11p). Section 12 says that CHCs shall elect a chairman "for such period as the council may determine", provided that period is not longer than the remainder of the chairman's current term of office as a CHC member. Section 8 says that after two consecutive terms of office as CHC members people become ineligible for the next four years — so in theory someone could be chairman of a CHC for as long as eight years. The same goes for vice-chairmen.

BUT — if other members share your view of your chairman's behaviour, perhaps some straight talking now would be better than waiting till your next elections.

Joint consultative committees

Which CHCs are represented on joint consultative committees with both speaking and voting rights?

Our survey *CHCs at work*, in the December 1977 issue, suggested that 18 CHCs were in this position, but further checking has revealed this to be incorrect. Some CHCs do have members who sit and vote on JCCs in their capacity as local councillors, but no *CHC representative* has voting rights.

Consultation on closures

ONE: Do CHCs have a right to be consulted about closures and changes of use of NHS buildings which are not used directly for delivering patient care, eg offices, laboratories and nurses' homes?

TWO: Are CHCs entitled to be consulted when the buildings concerned are leased to the NHS rather than owned by health authorities?

The closures circular — HSC(IS)207 — only refers generally to "health buildings", so we asked the DHSS for some clarification. The department says that CHCs only have a formal right to be consulted when a proposed closure or change of use would affect an "identifiable unit, known and accepted to be providing patient care". In other cases there is no formal obligation to consult, but the DHSS hopes AHAs will keep CHCs fully informed. The obligation to consult also extends to buildings under lease, where patient care is being provided from them, but if the owner of a building does not wish to extend a lease CHC objections are unlikely to have much effect.

Courses for new members

Do you know of any courses designed to introduce new members to the work of CHCs?

We know of three places which run seminars for new members: The Nuffield Centre for Health Service Studies (Clarendon Road, Leeds), the Polytechnic of North London (Department of Management Studies, Marlborough Building, 383 Holloway Road, London N7), and the School for Advanced Urban Studies (Grange Road, Bristol).

Food allergy testing

A member of the public has asked us where he can go to be tested for "food allergies". Can you suggest a hospital or clinic we could contact about this?

Yes. Try Park Prewett hospital in Basingstoke (Basingstoke 3202), or the Royal Southern Hospital in Liverpool (051-709 6841).

The Healthline column publishes selections from 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, *362 Euston Road, London NW1 3BL. (01-388 4943.)*

Parliament

Failure in diagnosis

The tragic and alarming story of three children in a Rotherham family was debated in the House of Commons on 6 July. The family had called for help from the secretary of Rotherham CHC, who had prepared a detailed account of the case and had brought it to the attention of the MP for Rother Valley, Peter Hardy; he is pressing the AHA to hold an inquiry. The children, born in 1961, 1963 and 1965, all had extra digits at birth, and had received attention for visual difficulty (later diagnosed as retinitis pigmentosa) almost since infancy. They also suffered from obesity, deafness, and some mental retardation, and all had been classified as educationally backward and attended a special school. But it was not until last year (when the parents were told that all three children were going to be totally blind) that the rare genetic condition, Lawrence-Moon-Biedl syndrome, was finally diagnosed. Somehow, Mr Hardy said, the children had escaped the diagnostic and registration net. In his reply to the debate Mr Eric Deakins said that when all the known medical information on the children had been assembled the AHA would decide whether or not to hold a formal inquiry. The children were now attending a school for the blind. (Hansard 6 July 1978, Cols. 842—858)

Preventive health services for children

A draft document proposing that health authorities should ensure that a basic programme of health surveillance should be offered to all children has been prepared by the DHSS; consultations are in progress and it is hoped to issue the document in its final form later this year. (Patrick Jenkin MP: Redbridge, Wanstead and Woodford 13 July 1978.)

One-parent families

The Registrar General's latest estimate is that the number of one-parent families in Great Britain has increased from 570,000 in 1971 to around 750,000 in 1976 — a 32% increase. An account of changes in the numbers and family characteristics of one-parent families in Great Britain is given in the September issue of *Population Trends*. (Helene Hayman MP: Welwyn and Hatfield 13 July 1978.)

Cost of NHS administration

In 1976/77 4.36% of expenditure incurred by health authorities in England was attributable to headquarters administration. (Bryan Davies MP: Enfield North 11 July 1978.)

Adverse drug reactions

When asked if he would consult the BMA, the Pharmaceutical Society and CHCs on new methods of ensuring that yellow warning notices (Adverse Reactions Warnings) are not ignored by doctors, Mr Moyle said that whether or not to prescribe a product for a particular purpose (such as a hormonal pregnancy testing drug) was a matter for the doctor's professional judgement. But the Department would be seeking advice from the relevant professional bodies about new measures to ensure that the warnings issued by the Committee on Safety of Medicines received doctors' full attention. (Jack Ashley MP: Stoke-on-Trent South 21 June 1978.)

Death and social class

In England and Wales in 1970–72 the death rate for infants under 1 year of age in Social Class V was approximately 2½ times as high as in Social Class I, and for children 1–14 years old it was twice as high. For adults aged 15–64 the male rate was approximately 80% higher for Social Class V than for Social Class I, and for married females (classified by their husband's social class) approximately 70% higher. (Ronald Atkins MP: Preston North 11 July 1978.)

Scanner

Discrimination against former psychiatric patients

Many employers, both in the public and private sector, operate blanket policies of exclusion for anyone with any form of psychiatric history. MIND has published* details of 40 such cases received by its office in a 2-month period. Fear of discrimination may lead people to falsify histories or even not to ask for treatment in the first place. MIND would like to see reform along the lines of recent US legislation which protects former psychiatric patients from the need to disclose their medical histories if a consultant psychiatrist regards them as mentally fit. **Nobody wants you (50p from 22 Harley Street, London W1M 2ED).*

Found dead

Is the title of a study by Dr Jonathan Bradshaw of the incidence of old people found dead or dying in their own homes in York from 1960 to 1977. The report (available from Age Concern England, 60 Pitcairn Road, Mitcham, price 50p plus 15p post) shows that though the numbers found dead are rising, the length of time between death and discovery is decreasing. There are more elderly people living alone than formerly but most old people do not lack contacts. Many refuse help and prefer death at home to dying in hospital. But regular medical screening of elderly people would alert friends and relatives to the risk of sudden collapse.

Decline of the village

Doctors' surgeries and pharmacies, along with shops, schools and pubs, are disappearing at an alarming rate from Britain's villages. The problems of village life are most acute for the elderly, the very young, those without cars, and the less affluent. These conclusions come from a survey reported in *Decline of rural services* (from the Standing Conference of Rural Community Councils, 26 Bedford Square, London WC1B 3HU — send an A4 envelope with 18½p stamp). Ideas for halting the decline include combining different delivery, collection and transport services, early warning of closures, and more part-time services.

Mental illness hospitals

The working group on the organisation and management of mental illness hospitals (which is to report to Mr Ennals by the end of the year) has found that the circumstances of many hospitals are so complex that additional resources will be needed to solve some of the problems. The group would like to have details of succesful local arrangements, which should be sent to Room C424, DHSS, Alexander Fleming House, Elephant and Castle, London SE1 6BY.

Identification of the handicapped

Outset is a national charity which believes that 100% identification of the disabled, through comprehensive surveys, is imperative for full implementation of the Chronically Sick and Disabled Persons Act. It has sent a prospectus* to all CHCs setting out the ways in which its Disabled Information Unit can advise on, provide training in, or actually carry out identification surveys. **Action on handicap, Outset, 30 Craven Street, London WC2.*

New dental fees and charges

The new fees, which came into force on 1 October, represent an overall increase of 23.76% over 1976, and follow the Health Ministers' acceptance of the report of the Dental Rates Study Group. Charges to patients have also increased — for example, to £1.70 from £1.40 for a simple filling and £2 from £1.60 for a scale and polish. Check-ups are free, as before, and the maximum charges for routine treatment (£5) and for crowns and dentures remain unchanged.

Occupational illness

A *Draft document on the notification of occupational ill health*, which has recently been published by the Health and Safety Commission (HMSO, 50p), suggests that, as far as possible, there should be a single reporting system for accidents, dangerous occurrences, and diseases. It proposes, for example, that employers should notify the Health and Safety Executive of cases of ill health believed to be caused by a pathogen (such as infections contracted in biological laboratories). And a review of the occupational deafness provision of the industrial injuries scheme (*Occupational deafness*, Command no 7266, HMSO, 70p) recommends that it should be extended to include, for example, workers who supervise or assist in the use of pneumatic percussive tools.

Private medical care

A report to the DHSS on provident scheme statistics for 1977 (*UK private medical care*, £1 from Lee Donaldson Associates, Consultant Economists, 21-24 Bury Street, London SW1Y 6AL) shows that the number of subscribers (about 4% of the population) did not change during the year, but that subscription income and benefits paid both rose by almost a quarter. The increases mainly reflect inflation, but also indicate that more people with a choice are favouring private over NHS treatment.

And the booklet *Private and national health services* (£2.20 plus 15p post from Policy Studies Institute, 12 Upper Belgrave Street, London SW1X 8BB) by Michael Lee (of Lee Donaldson Associates) describes the continuing growth of private health services outside the NHS. He argues that the existence of a separate private service will provide an indication of the efficiency of the NHS, offer greater flexibility in resource allocation, and permit the development of a broadly-based occupational health service.

Physiotherapy in the community

Copies of this report by C. J. Partridge and M. D. Warren are not available free of charge, as we said in our August issue (page 11). They cost £2.50 (inc. post) from the Health Services Research Unit, Cornwallis Buildings, University of Kent, Canterbury CT2 7NF.

Cycling: the healthy alternative

Contains a digest of ten reports on the physical, psychological, social and environmental benefits of cycling, and is available, free of charge, from the British Cycling Bureau, Stanhope House, Stanhope Place, London W2 2HH.

Fluoride preparations

Certain sodium fluoride preparations — tablets, drops and mouth rinses — for use in preventing tooth decay in areas where the water supply is not fluoridated, are to remain on sale over the counter, but only in pharmacies and under the supervision of the pharmacist. This change of plan is given effect in a statutory instrument — the Medicines (Prescription Only) Amendment (no. 2) Order 1978.

New tar and nicotine tables HN(78)98

Revised posters and leaflets prepared by the DHSS show the tar and nicotine yields of 125 brands of cigarettes. The percentage of brands falling in the low and low-to-middle tar range has increased from 5 to 21 between 1972 and 1977.

Directory of CHCs: changes

An updated version of the Directory of CHCs is now out, and each CHC has been sent a copy. Further single copies are available free from the *CHC NEWS* office — please send a large, stamped addressed envelope with orders.

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

NB: Some recent changes in addition to the ones listed below have already been incorporated into the new directory.

Page 4: North West Leicestershire CHC Secretary: Mrs Jane Buggy.

Page 9: Canterbury and Thanet CHC Secretary: Philip Topham

Page 11: Worthing CHC Chairman: Mr A. F. Mason

Page 19: Arfon-Dwyfor CHC Chairman: Mr Tudwal Jones-Humphreys

News from CHCs

☐ *Aspects of health care for deaf children in Stockport* is a report compiled by **Stockport CHC.** It makes practical recommendations for improvements in detecting hearing impairment among young children, in the system for supplying aids and batteries and in the network of guidance and support for parents.

☐ The working of the 1967 Abortion Act is being monitored by **Basingstoke and North Hampshire** CHC. The council has compared services in the district with other Hampshire areas and with the national statistics. It concludes that the NHS is failing in its duty under the Act and that far too many women are being referred for NHS terminations outside the district, or are being forced to seek help privately. A day care unit and better contraceptive advice for the young are among the CHC's recommendations.

☐ **Central Birmingham CHC** has a representative on the project team planning a new health centre in Balsall Heath. As a result of its contacts with community groups, the council is pressing for services which local residents want the centre to offer, such as circumcision facilities and a creche for the children of staff and patients. The CHC have also endorsed a demand for *resident* involvement in the management of the centre.

☐ Thanks to **North Staffordshire CHC,** it will now be much easier to phone up the VD clinic. In the current phone book it is not listed among the clinics run by the AHA, but under "Special Treatment Centre". Now the AHA has agreed to place it as "VD Clinic" in the new phone book.

☐ **South Camden CHC** has shop-front offices and belongs to an advice agencies group which aims to promote good working relations and coordination between advice agencies in the Borough of Camden. The offices are owned by a hospital, and when the hospital threatened to block up the shop-front as part of an improvement scheme, the group gave valuable support to the CHC's opposition to the plan.

☐ Births should not be induced without the signed consent of the mother — this is the view which **Anglesey CHC** will put to the AHA at the next joint meeting. Members of the council have likened induction of labour to an operation and say that if a patient's signature were required, it would help ensure that staff gave patients an adequate explanation of the procedure.

☐ A team of six volunteers has been recruited by **Eastbourne CHC** as an interim solution to the shortage of NHS chiropodists. The team has been trained by the Area Chiropodist to cut toe-nails and will work in health centres under supervision. The local Women's Institute is now giving publicity to the scheme and it is hoped that a second team can be trained to give simple foot-care to the elderly.

The CHC has also been pressing for a school of chiropody to be set up in a small disused local hospital. The Ministry of Education has given its agreement, in principle.

☐ The health and safety officer of ASTMS, Sheila McKechnie, was the guest speaker at a meeting of **City and Hackney CHC.** She explained the new Health and Safety at Work Act which becomes law this month, and the limitations on its usefulness for hospital workers. Among examples given of hazards faced by workers in hospitals, Ms McKechnie cited the risks of infection to porters and orderlies in emptying waste bins and improper storage of gas containers and other unsafe equipment in corridors. She called for the removal of Crown immunity from prosecution and stressed the need for the DHSS to recognise that hazards to workers are hazards to patients.

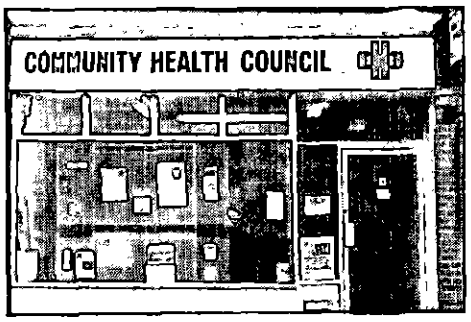


Photo: West Surrey and N.E. Hants CHC

☐ *In its first two years,* ***West Surrey and North East Hampshire CHC*** *had just 60 visitors to its office. It has now moved to a shop-front, very near to a shopping centre, and has had 600 visitors in the first twelve months.*

☐ Plans for a younger disabled unit have been amended by the Brent and Harrow AHA, after members of **Harrow CHC** visited the Willesden Hospital site and put forward suggestions. The AHA has accepted proposals for ceiling hoists above beds, for laundry facilities for residents to do their own laundry if they wish and for re-charging units for electric wheel-chairs to be provided in bedrooms. Also, if finances allow, windows will have catches which can be opened by disabled people.

☐ Mentally handicapped children will be the topic of a public meeting later this month organised by **Cambridge CHC.** The council has voted to reduce its business meetings from ten to six per year and to have four meetings which will be more attractive to the public. At the discussion meetings, members will be able to discuss any business which cannot wait.

☐ Blackpool health district has a population of 316,000 and is one of six districts in Lancashire AHA. **Blackpool CHC** considers the district should be given AHA functions without delay — ie prior to any recommendations by the Royal Commission on the NHS. At the request of the CHC the regional health authority invited views on reorganisation of services in Lancashire. But now the RHA's working-party has been disbanded on advice from the DHSS that "there is no point at this stage in going ahead with consultations". Lancashire AHA has stated that any reorganisation now would be "unnecessarily disruptive". The council want the working-party to make public its information so that it can be compared with the Royal Commission's views. The regional administrator has refused and the CHC plans to take up the issue with the Chairman of the RHA.

Photo: Manchester Evening News

☐ *Three CHCs combined to take part in the three-day Manchester show, which was attended by roughly 70,000 people.* ***Central, North and South Manchester CHCs*** *hired a marquee, which contained a static bicycle and rowing machine, an area for floor exercises and an exhibition. Dieticians were on hand with nutritional advice and a physical education student answered the question "How fat are you?" by taking skinfold measurements of people's fat. Each visitor to the tent was handed a wallet of leaflets about the CHCs' work and the "Look After Yourself" campaign. Sports and radio personalities attracted visitors' attention and generated publicity. The picture shows the Lord Mayor of Manchester, Cllr. Trevor Thomas, with the float which toured Manchester to publicise the stand. The event cost each CHC £650.*