CHC NEWS
For Community Health Councils
November 1978 No 37

International support for children's unit

The World Health Organization has given "strong endorsement" to a campaign to keep a cancer unit at a Salford children's hospital. Salford CHC, together with an action committee of staff at the Royal Manchester Children's Hospital, Pendlebury, considers that the North Western RHA's proposals for the transfer of the regional speciality to the Christie Institute of cancer in Manchester, have been badly handled, and there is even talk of "double-dealing" by the RHA.

The original decision was made in 1972, before the arrival of CHCs, with the reluctant agreement of the paediatricians. They were led to believe that the DHSS had earmarked £1m for a children's unit at Christie and that if the money was not spent there, it would be lost to the region.

But early this year the paediatricians asked the DHSS about the £1m allocation, and the department replied that the money had not been earmarked, but was allocated for the region as a whole. Also for the first time the region's own paediatric advisory committee considered the issue. It agreed that it is in the best interests of children for the unit to remain within a children's hospital.

Since 1972, the treatment of cancer has changed. One of the main arguments in favour of the transfer was the need for access to Christie's radiotherapy facilities, at that time considered a very important part of cancer treatment. However, radiotherapy is now considered far less important.

Photo: Salford CHC

Royal Manchester Children's Hospital, Pendlebury.

But the RHA still intends to make the transfer. Salford CHC has the support of many other CHCs in the region, local MPs and CHCs in Cheshire. Salford AHA has warned that it will not allow the transfer of any child to the Christie Institute until it is satisfied about the adult hospital's provision of paediatric support services such as play and educational facilities.

In a letter to doctors at the Pendlebury hospital, the World Health Organization says "Even if a child is suffering from cancer, a child continues to need all of the educational and psychological and social support systems for proper growth and development . . . This is only to be found in children's hospitals".

Health Minister Roland Moyle has visited both hospitals this autumn. At the children's hospital he met the action committee. CHC secretary Colin Clews says the meeting "opened the minister's eyes". The CHC and the committee are now awaiting Mr Moyle's response to their demand for a public enquiry.

Moyle rebukes AHA

Roland Moyle has agreed with West Birmingham CHC that consultation on the closure of Romsley Hill Hospital was not properly handled by Birmingham AHA(T). In a letter to the AHA chairman Mr Moyle says that the authority was wrong not to undertake early informal consultations. Answers to letters seeking information were inadequate — CHCs "could reasonably have expected better service", he says — and discussion meetings should have been offered to staff and CHCs. The West Midlands RHA showed little interest in CHC complaints about lack of consultation; indeed, the question was never taken to RHA members.

The Secretary of State confirmed in August that Romsley Hill should be closed as a geriatric hospital at the end of three months, though there will be at least a further six months' consultation period to discuss alternative plans. Mr Moyle has asked the RHA to see that further consideration is given to proposals for short-stay accommodation at the hospital, using joint funding. Or there might be a unit for younger chronic sick patients.

West Birmingham CHC says it was led to believe, by area officers, that a feasibility study on alternative uses for the hospital had in fact been carried out. The AHA denies this. One of the lessons learnt by West Birmingham is that CHCs should make sure that important matters are brought before the whole AHA, and not dealt with behind the scenes by officers.

INSIDE.....

Photo: Age Concern

Your letters

Private hospitals and "bias"

Judith Beattie, former Member and Vice-chairman of Airedale CHC

I cannot agree with David Blackmore (*CHC NEWS 35*) that your articles should be "unbiased" when it comes to discussing the private sector of medicine. CHCs represent NHS patients, and it can be argued that private hospitals compete with the NHS rather than complement it. If *CHC NEWS* interprets the situation as threatening the welfare of NHS patients it might feel that its readers might be more interested in those who object to a new private hospital than in those who support the development.

However, a good proportion of CHC readers will agree with Councillor Blackmore. During my four years on a CHC I was amazed and disturbed to find how many CHC and AHA members advocated extension of the private sector, even within the NHS. Far too often in committee work collectivist philosophies are labelled "biased", while the individualistic viewpoint is accepted as "unbiased". In certain matters — private medicine and race being two — it is surely impossible for a thinking person to be "unbiased".

Michael Silver, 64 Wentworth Road, London NW11.

Councillor Blackmore fails to answer the critics of private hospital development. It is just because the NHS is being cut back by deliberate Whitehall actions that the private sector has to be prevented from expanding. In fact it should be phased out — both inside and outside the NHS.

Every worker in the private medical sector has been trained at the nation's expense, and then for the worst motives sells on the open market to people whose natural anxiety about their health care has been compounded by the fact that the NHS is being cut back by deliberate Government action. Luckily there are CHC members around the country who will not be "conned" into aiding the growth of private medical care.

Help needed

Audrey Davies, Assistant Secretary, Croydon CHC

Croydon CHC is planning some local research on services for the elderly, and would be interested to hear from CHCs which have undertaken such projects.

Joan Harries, Stoke Women's Action, 15 Heath Street, Newcastle, Staffs.

One of our group has just been appointed to our local CHC. We would be interested to hear from any women's action, feminist or Working Women's Charter group with experience of working on a CHC.

Kettering outmanoeuvred?

Christopher Lewis, Member, Oxfordshire CHC

I was amazed to read in *CHC NEWS 34* about Kettering CHC's production of an NHS guide — not only did they do the AHA's work for them, they were even manoeuvred into paying for it!

The point at issue seems to be "How does the CHC become known for what it really is?". It is easy for CHCs to be NHS publicity bodies or, worse, an extension of the Health Education Council — distributing literature praising press-ups. The very name tends to mislead people — perhaps CHCs are an arm of the community physicians.

The ease with which CHCs can slip into the role of being another voluntary body plugging a gap in the service makes it all the more important that they try to keep to the hard task of learning the ropes and representing the views and experiences of consumers.

Fighting closures with a writ

Mr E. M. Cohen, Member, Southend District CHC

In *CHC NEWS 32* Brent CHC report their unsuccessful campaign to keep a hospital open, and their "disillusionment" seems to derive from circular HSC(IS)207. However impressively worded these circulars are, they only represent advice, guidance and information. They can be most useful, but they are not the *law*.

When involved in such issues — as we were in Southend regarding consultation about two closed wards — CHCs should concern themselves with "their" Statutory Instrument, *1973 No 2217*, which sets out their duties, responsibilities and powers. CHCs can then take legal advice, if necessary counsel's opinion, relating thereto. A satisfactory legal opinion, and the mention of a high court writ, can produce smart results.

Hazards of ear piercing

Irene Watson, Secretary, Hull CHC

We have become concerned about the practice of ear piercing. At present this minor surgical operation can be performed by any lay person, and there is a real risk of health problems arising. ACHCEW is being asked to consider the matter, and it is hoped that appropriate controlling legislation will result. CHCs should be aware of this health hazard, which can cause infective hepatitis, redness, swelling, irritation and ear-stud embedding. I would be pleased to send further details to other CHC secretaries.

"Yes, we're against screening"

Debby Sanders, Secretary, Women for Life, 47 Westbourne Gardens, London W2

I wish David Flint would get his facts right (*CHC NEWS 34*). At no time has *Women for Life* ever "sought public support for our counselling activities" or for our "homes for unmarried mothers". We have no such homes.

We are opposed to spina bifida screening partly because, as Mr Flint says, we are against abortion. We are opposed to lethal eugenics and the relegation of handicapped children to the status of "useless eaters" who we are too mean to look after. We are also against it because we respect the view of experienced gynaecologists who regard the procedure as too risky, notwithstanding your culpable evasion of the whole issue of risk. Even if only 1% of amniocenteses resulted in the miscarriage of a "normal" baby this would still be a very serious matter, which would involve a great number of babies if screening was widely implemented. Widespread screening would also be a disincentive to provide long-term care for handicapped people. They would regard themselves as a burden, as people who have survived by mistake. Their guilt feelings would be intense.

Bell's Palsy

Mary Dines, Assistant, NW Kensington, Chelsea and Westminster CHC

We were recently approached by a person who had suffered from Bell's Palsy for 17 years. He had had treatment from various hospitals, but no improvement had occurred. He wanted to know what further treatment was available, and if there were organisations which helped people like himself. The disease is fairly common, but most people recover from it in a fairly short time. Paralysis is seldom permanent. We could not discover any groups which could assist our client. Has any other CHC come across this problem?

Secretaries' training course

Barbara Steele, Registrar, King's Fund College, 2 Palace Court, London W2 4HS.

The King's Fund College is to mount a short induction course for new and recently appointed CHC secretaries, on 12-14 February 1979. This will be a residential course, with accommodation provided within the college at Palace Court.

Tuition and accommodation fees will be met from DHSS central funds, but CHCs will be responsible for travelling and incidental expenses.

Applications should be submitted not later than 8 January, and application forms together with a handout giving further information about the course are available from me at the above address, or by phoning 01-229 9361.

Receptionists' training

Anne Plumley, General Secretary, The Association of Medical Secretaries, Tavistock House North, Tavistock Square, London WC1H 9LN.

Two months ago the Association of Scottish Local Health Councils called for better training of GPs' receptionists. The problem is to get GPs to release their staff to attend courses, and to appreciate that special skills need appropriate financial reward. This is where CHCs and LHCs could help.

The AMS has introduced a certificate for doctors' receptionists. Our courses teach receptionists how to recognise the limits of their authority, and how to behave towards patients.

We welcome letters and other contributions, but we would like letters to be as short as possible. We reserve the right to shorten any contribution.

Comment

We have no choice but to keep on complaining about food hygiene in the NHS. Despite circular HC(77)24, which emphasised the need to give Environmental Health Officers "open access" to NHS kitchens, the latest annual survey from the EHOs' Association shows little improvement. Out of 1627 hospitals 125 "would have warranted prosecution" had not Crown immunity barred the way (we explained about the legal nonsense of Crown immunity in our July 1977 issue, on page seven).

A follow-up survey six months later found that 43 of the 125 were still in the "prosecutable" category, and 14 of this 43 appeared to be disputing the need for improvements.

An arrangement exists through which such cases are reported to the DHSS, but how this arrangement actually works is unclear. The EHOA says EHOs talk directly to the department, and that the 14 miscreants have already been reported. The DHSS says that in theory cases are relayed to it by the EHOA, but it has not yet received any. If it does ever receive any details it can consult and persuade, but it appears to have no powers of compulsion.

There is clearly no substitute for proper legal sanctions. What is needed is the removal of Crown immunity from the NHS, so that the Food and Drugs Act 1955 and the Health and Safety at Work Act 1974 can both have their intended effects. The EHOA and the Health and Safety Commission already support this, and it is time the DHSS came off the fence.

As we said last July: "Why should people be subject to less stringent hygiene standards just because they happen to be in hospital?"

Health News

Breast cancer screening

In 1976 over 13,000 women in the United Kingdom died from cancer of the breast. Two controlled experiments have been set up by the DHSS to assess methods of screening for the disease. The results will influence the kind of national screening service which may be set up in the future. In Guildford and Edinburgh every woman between 45 and 64 will be invited to be examined annually and will have an X-ray every two years. Women of the same age in Huddersfield and Nottingham will be taught to examine themselves. The trial will last eight years.

More choice in maternity care

The idea of childbirth as an illness and its management as a hospital-based and doctor-controlled event is increasingly being challenged. In a scheme described in the August edition of the *Journal of the Royal College of General Practitioners* (page 455) antenatal sessions are run weekly by GPs and health visitors in a group practice and attended every fortnight by the obstetrician from St. Thomas' Hospital. The history of the pregnancy goes on a hospital record card which the mother keeps and takes with her to hospital on admission in labour. The GP thus provides continuous care before and after birth, and the mother also gets to know the obstetrician in familiar surroundings.

Another article in the same issue of the journal (page 460) reports a comparative study of hospital and home deliveries. Advantages of home delivery included shorter labour, and more mothers who had their babies at home said they found the birth a happy experience, especially in respect of relationship with professionals, presence of husband, and contact with the baby. The report concludes, however, that in order to ensure that high-risk women still have hospital deliveries the policy should be to make hospitals more homely places to have a baby.

And an article in the *British Medical Journal* (26 August, page 591) reports that mothers who walked around during labour had shorter labours, needed fewer pain-killing drugs, and had babies which were in better condition than mothers who lay down. Ambulation during labour is therefore recommended as a means of making childbirth in hospital more natural and relaxed without losing the benefit of intensive supervision by continuous foetal and uterine monitoring.

How many doctors?

The fourth Royal Commission Research Paper is on doctor manpower*. Based on alternative (and largely speculative) assumptions regarding the future contribution of women and overseas doctors, choice of specialty, and the effects of career structures, the paper presents a number of possible manpower forecasts.

The "best guess" forecast gives a doctor stock of 89,765 in 2000, a growth rate (1975 to 2000) of 38%. There would be fewer foreign male doctors and more British women. This forecast would involve an increase in salary costs of 33% and of 47% for hospital expenditure. The report points to existing regional inequalities in doctor distribution and future age and geographical shifts in the population, and says that incentives will be needed to induce doctors to go where they are most needed.

As well as calling for more data the report asks that in future analysis of demand for doctors should be related to budget constraints and the agreed objectives of the NHS, and to the contribution made by all types of labour in providing health care.

**Doctor manpower 1975-2000: alternative forecasts and their resource implications.* HMSO, £1.50.

Another non-consultation situation

Sometimes you get the feeling that within the DHSS labyrinth there are people who have yet to hear of CHCs. The department, for instance, has decided that it wants to ban the pain-killer *phenacetin*, which is suspected of causing kidney damage (see page 11 for details). The professions and "consumer interests" are being consulted. "Consumer interests" consist of a long list of worthy bodies, including the Food Manufacturers' Association and the Agricultural Research Council. CHCs are not on the list, nor is ACHCEW.

When we reminded the DHSS what CHCs are supposed to be for, a spokesman told us there was "no particular reason" why ACHCEW was not on the list. The omission was not "sinister", but on the other hand it was not an oversight. He added that we should not expect CHCs to be consulted on everything. We did *mention* the 500,000 phenacetin-containing prescriptions dispensed annually through the NHS, and the possibility of damage to consumers' kidneys, but these points cut no ice. However, anyone can join in the consultation if they wish, and the person to contact is Mr H. Johnston, Committee on the Review of Medicines, Finsbury Square House, 33/37A Finsbury Square, London EC2A 1PP (Tel: 01-638 6020).

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Body Scanners —they are a temptation

by Rev Graham Cook, Member, Leeds West CHC

Have you or has your CHC ever been tempted to support one of the ever-growing number of public appeals for the purchase of a body scanner? These scanners — which combine X-ray and computer techniques to produce cross-sectional pictures of the head or body — are a temptation. Fund-raising events are advertised and supported on the grounds that "they save lives". Who can refuse such an invitation? Before you commit yourself, you and your CHC should ask some questions.

You should ask if it is true that such machines are life-savers. It is not true. Body scanners do not save lives. Only effective treatment can do that. Body scanners do not give treatment, they simply diagnose illness. That of course is a very significant contribution to the alleviation of distress, and this is especially true when, as in the case of scanners, the procedures replace difficult and often painful physical examinations. But does not early diagnosis lead to the saving of lives? Such studies as have been carried out in America report that "No benefit has yet been measured in terms of reduced morbidity or mortality" But you may still be tempted, for the right reasons rather than those presented by the media.

You should then ask yourself if your area has sufficient facilities for the treatment of such diseases if they were to be diagnosed. Because of recent public expenditure cuts some areas have reduced staff and closed wards, and so have less facilities for treatment than they once had. Ask youself also, and answer as honestly as you can, if in fact there are any treatments anywhere for some of the conditions that would be discovered.

Ask if the public appeal includes provision for running costs. If it does there is a stronger case for supporting it. If it does not then consider the consequences. The running costs are variously estimated anywhere between £50,000 pa and £250,000 pa. At a time when budgets are already stretched to the limits, money of that order would have to be taken from some other service within the area. It means less kidney machines, or less provision for the elderly, or fewer beds for children, or fewer community nurses, or less care for the mentally handicapped. Is it right that carefully and expensively worked out priorities should become distorted in this way?

Ask why the DHSS is so slow in giving advice on the subject. The answer is that they want to evaluate these machines and have not yet done so. Ask yourself if the making of public gifts is the way to get effective evaluation. We could end up with three or four machines in one region, with enough work to justify the use of only one. Neighbouring cities are already competing to see who can have one first! Is this sane? Should not the region be deciding where one should be sited, and then providing it and its running costs?

Ask if there might be cheaper ways of achieving the same results. American experience suggests that there are alternative ways of scanning the body which are up to seven times cheaper.

It might still be a temptation. If you have asked the questions and found satisfactory answers then give in to it. But otherwise it is a temptation which should be resisted.

● **See also book reviews, page 8.**

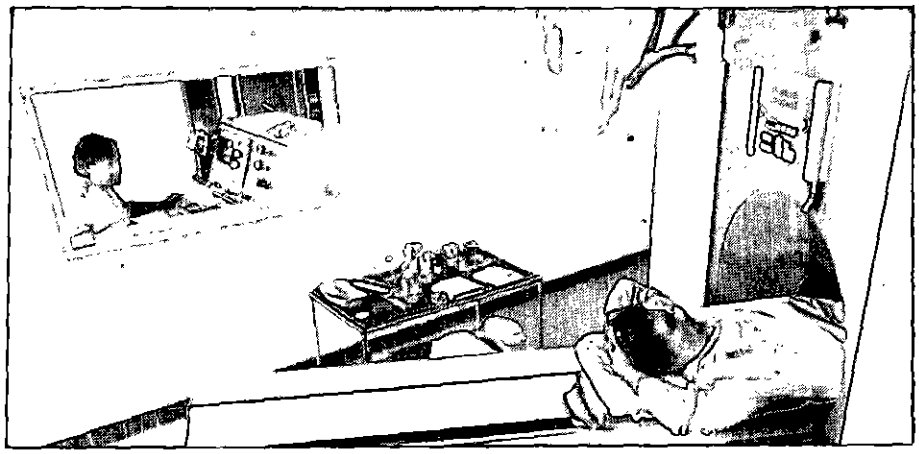
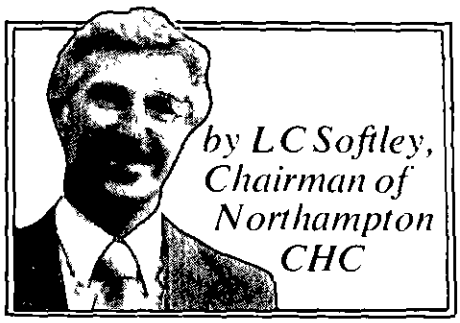


Photo: EMI Medical

The story of Steve



by L C Softley, Chairman of Northampton CHC

For many years now skin grafting has been used to heal the badly torn stump of a lower limb, severed in an accident. The surgeon produces an acceptable stump which has healed.

The patient is then referred to the limb fitter, whose task is to produce an artificial limb, a *prosthesis*, using which the amputee can lead a normal life. This is made more difficult when the stump has had skin grafting because inside a prosthesis the skin constantly breaks down and will not callous to take pressure. All the amputees I know who have this type of stump suffer from chronic stump trouble.

I know many who want to continue in sports, but because of the condition of their stumps have not been able to do so. I am delighted to say, however, that there is now the possibility of a cure for such people. I will tell you the story of Steve.

Steve, in his early twenties, lost one leg below the knee in a motor cycle accident. He was a sportsman and he joined my group of amputees playing volleyball at the Stoke Mandeville stadium. He seldom played for more than an hour and invariably, we would find him later with his prosthesis off, ruefully examining his very sore stump.

I had often wondered why skin grafts on stumps are carried out. I realised that when the accident happens, the limb is fleshy with muscle and if the flesh is badly torn it is impossible to pull the skin together to stitch it — hence the grafting. Then I realised that after three years inside a prosthesis, a stump is no longer fleshy and muscular — it would be easy to pull the slack skin together and make a simple, stitched scar. Would it be feasible to cut away all the grafted skin, and stitch the wound? This was the question Steve took to a surgeon, who agreed to try it, although he had not undertaken such an operation before.

Later, Steve wrote to me: "The surgeon did a fantastic job . . . all that remains of the skin graft scarring is a thin neat scar, also the skin is free to move, whereas the skin graft was adhered to the bone. All I wait for now is a remodelled prosthesis and I will be on the volleyball court with a good chance of lasting out a whole match without skinning my stump."

I am satisfied that my idea has proved successful and I am now trying to get maximum publicity so that others can obtain relief from a constantly sore stump.

One of the problems is that once the patient has been discharged from his care, a surgeon seldom hears how the patient is progressing. It would be much better if all amputees were re-examined after a period of time, with a view to eliminating the grafting. It is not good enough to leave as much of a stump as possible and heal it up by whatever means possible. The aim must be to produce a stump capable of withstanding wear and tear inside a prosthesis. The real answer is a re-think on our amputation and prosthetic service.

SCHIZOPHRENIA

Meeting the need for support in the community

by Peggy Pyke-Lees of the National Schizophrenia Fellowship

Schizophrenia is one of the major incapacitating disorders of mankind. It is quite different from mental subnormality and is absolutely nothing to do with the popular image of schizophrenia, which is usually portrayed as a 'split mind' or a Jekyll and Hyde complex.

In Europe, including Britain, almost 1% of the population will receive this diagnosis at some time in their lives. However, the disease particularly affects people in the 18–33 age group. Schizophrenia patients are among the largest users of hospital and other medical care, and they confront the health service and the local authorities with especially complicated problems.

There is still uncertainty about its causes, but it has been found that certain drugs, if take regularly, can often bring the disease under a fair measure of control. But there are often disturbing side-effects such as inability to concentrate on thoughts or carry out any occupation for any length of time. Family support and regular medical care are essential.

Common to all types of schizophrenia is the tendency to withdraw and an impairment or distortion of thought processes. Thinking becomes vague and illogical. Frequently there is emotional disturbance and hallucinations such as 'voices' or delusions. One of the most common symptoms is a falling-off of activity, both mental and physical. Moral standards and practices may alter too, for no obvious reason. Early diagnosis and the maintenance of any prescribed treatment are essential, and symptoms *can* be controlled, even when they are quite severe.

Even when it is untreated, schizophrenia may vary in its severity. Situations which provoke anxiety in the sufferer often heighten the symptoms, but there may also be long periods of remission. Symptoms may change from one bout to another and it is important to realise that schizophrenic symptoms may well shade into those of other mental illnesses, especially those of the 'manic-depressive' groups.

The lack of facilities for patients discharged from mental hospitals is probably all too well known by CHC members. It may not be realised, however, that many patients who do have families return to live with them. Families, often quite elderly parents, may find themselves confronted day and night with problems which they had not expected and which they do not know how to deal with. Often there is *no* communication between the hospital and the family. Often there is not even any liaison between the hospital consultant and the family doctor. Attempts by families and friends to get help meet with dismal failure.

An 18-year-old boy was acutely ill in a mental hospital. His parents had not been told what his illness was, nor how it was proposed to treat it. They had been refused an appointment with the consultant. The mother, in her distress, took a day off work and travelled 30 miles to the hospital and she sat outside the clinic where she knew the doctor would be. After she had waited some hours, the doctor came to her and said, "I understand you have been waiting to see me. There is nothing I can tell you. Your son will never be better than he is now" — and he walked away. With advice from the National Schizophrenia Fellowship, a second consultant opinion was arranged and it is good to report that the boy is now out of hospital and is doing well.

In addition to all other difficulties there is the fear and shame of having at home a relative who cannot work or take part in normal daily life. The inclination to hide the situation from neighbours, friends, and even the rest of the family, is often even stronger than the need to get support from the people in a position to help.

The National Schizophrenia Fellowship is a voluntary organisation, founded in 1972. It is a registered charity with a membership of 2,500 most of whom are relatives or friends of schizophrenics. Many doctors, nurses and social workers belong, and increasingly schizophrenics themselves are joining the Fellowship. From the beginning, one of the aims has been to give publicity to schizophrenia and to help people everywhere to understand the difficulties experienced by those who have had schizophrenia and by the families and friends who are caring for them.

The Fellowship is now organising seminars and conferences for employers and trade unionists as well as magistrates, lawyers and so on, all of whom may come across schizophrenics and may not have an appreciation of their problems. Increasingly, people who themselves have had schizophrenia are ready to talk about their experience.

In the last few years, Fellowship members have been forming local groups — there are now about 120 — where members can give each other advice and companionship, something which many have been without for years.

We are now training a small group of voluntary coordinators to give advice and information in response to requests from local people. These requests come from those who have schizophrenics at home and from professional workers who do not know where to turn for help for their patients or clients, once they have left hospital.

I hope that CHC members and secretaries will make themselves acquainted with the Fellowship's work and will ensure that members of the public are introduced to the help which the Fellowship can offer. Family doctors and psychiatrists could be encouraged to refer patients and their families to us: we are able to give practical advice and long-term support where it is needed — in the community.

Further reading

Schizophrenia at home (£1.15).
Schizophrenia — the family burden (22p).
Living with schizophrenia — by the relatives (65p).
Memorandum to the Royal Commission on the NHS by the National Schizophrenia Fellowship (25p).
All prices include postage and booklets are available from the National Schizophrenia Fellowship, 79 Victoria Road, Surbiton, Surrey KT6 4NS.

This man was once in a locked ward, but is now living at home with family and community support.

Photo: Yorkshire Television

MAKING RULES TO SUIT THE EXCEPTIONS

by Bernard Isaacs

I recently received a letter from a member of a Community Health Council which concluded: "I appreciate that you are very hard pressed, but I should be grateful if you would make an exception for this dear old lady who has . . . always tried to be independent but who is now very much in need". I might have replied (but did not) that our organisation, like his, had its rules. If the rules were right then there should be no need for exceptions. If an exception was necessary, as he believed it to be, we should be looking at the rules.

The rules are that, since there is not enough of anything to go round, we can only give something to one by taking away something from another. Rules like these have built-in hardship; and complaints are inevitable. Any CHC which has no file of complaints about the care of the elderly in its district must be concealing its address from the public. Most complaints are about delay in admission to hospital; premature discharge from hospital; difficulty of visiting patients in hospital; and unsatisfactory care in hospital. All but the last of these, and sometimes even that, are correctly attributed to shortage of resources.

I am well aware of the danger of using "shortage of resources" as a blanket excuse for all types of unsatisfactory practice. I am equally aware of the difficulty of making silk purses out of sows' ears. But the particular sow's ear which concerns me is that known as the DHSS "norm". This is the standard for the provision of NHS resources for the elderly. It was never intended to be a measure of need. Yet it determines the level at which our services are provided.

The DHSS norm for the provision of geriatric beds is ten beds per 1,000 of population aged 65 and over. (For the purpose of hospital statistics, a geriatric bed is a bed under the care of a consultant geriatrician.) This figure was arrived at in a curious way. Nearly ten years ago the civil service was asked to produce a planning norm. They counted all the geriatric beds in the country and divided this by the number of population aged 65 and over, arriving at the figure of 9.9. By an act of unparalleled ministerial generosity, possibly influenced by a yearning for mathematical simplicity, this figure was raised to 10. In the intervening years the old have become older, psychiatric bed provision has been reduced, much population movement has occurred, but the norm has remained 10. There would indeed be little point in raising it since the average level of provision throughout the country falls short of the norm.

It is difficult to define need, still more difficult to measure it; but some indication of the gap between the "norm" and the need may be derived from consideration of the elderly with mental infirmity. A community survey in Newcastle*, also done many years ago, showed that 5% of the elderly suffer from severe dementia, another 5% from less severe manifestations of the condition, and an additional 10% from other psychiatric illness. Now the norms for the main types of institutional provision are as follows (calculated as places per 1,000 of population aged 65 and over):

Geriatric beds	10
Acute services	10
Psychogeriatric beds	3
Residential home places	25

We could therefore just about get every old person with severe mental infirmity into a hospital or residential home (provided these were up to their norms which they are not), but we then would not have room for anybody else. None of these institutions wants to house large numbers of the elderly with severe mental infirmity. They feel they can do very little for this group of patients who are disturbing and disruptive, stress the staff and the other patients or residents, and prevent the organization from providing care for the group for whom it was provided. So the elderly with mental infirmity are advised to remain in the community.

Where is the community? It tends to be spoken of as though it was something which never existed before, but was recently invented by the Government, in which people receive every care and attention. GPs, nurses, social workers and others who work in the "community" know better. Being elderly with severe mental infirmity in the community means being at home, which is fine if there are relatives, neighbours, friends and domiciliary services covering the situation throughout the twenty-four hours. But that applies to few homes: most of those which house an old person with severe mental infirmity are characterised by fear and tension — fear that a dreadful accident will befall the patient and involve others; tension at the impossibility of communicating with one whose intellect has burned out.

A recent (unpublished) survey of GPs asked their views on the psychiatric services for the mentally infirm elderly. The commonest complaint was that this group of patients were shunted around from one service to another, while each sought an excuse for saying that the problem belonged elsewhere. Insofar as this is due to lack of co-operation it is to be deplored; but the main cause is lack of resources, attributable to the gap between norm and need.

The problem of the elderly with severe mental infirmity dominates the scene, but many other groups of old people in need have to compete for the limited services. These include the incontinent, of whom there may be 25 per 1,000 of population aged 65 and over; and those liable to fall, possibly an even larger number. The number of people aged 85 and over who live alone far exceeds the total provision of all forms of institutional care.

Figures like these are the facts of life for geriatricians. They have to operate a service with insufficient resources and they have to do it as efficiently as possible so as to bring some help in one form or another to as many as they can. They therefore try to use resources with maximum flexibility. This is a euphemism for aiming at high turnover; which is a euphemism for discharging patients from hospital a lot sooner than they might care to. Every patient retained excludes one who needs to be admitted. Few days pass without there being a patient urgently needing admission.

Geriatric medicine was for long an unpopular specialty which failed to attract junior doctors of good quality. Geriatric medicine departments which lack out-patient clinics, which have insufficient day hospital places, which are not located in general hospitals, and which have poor access to diagnostic facilities are excluded from participation in training programmes and have great difficulty in recruiting junior and indeed senior staff. As a result the service provided by such units falls behind, waiting lists accumulate and standards unavoidably fall.

The majority of geriatric medicine departments struggle on and even manage to enjoy the constant effort to meet the challenge. Many have proved highly inventive in devising effective systems of patient care which go far to meet the needs despite the resource shortages. For example, in the district in which I work, patients move freely into and out of hospital on a variety of programmes of intermittent care, designed to help them keep functioning at their optimum level and also give relief to families, thus preventing the accumulation of long-stay patients. Physiotherapy services go out from the hospital into the patient's home and reduce the burden on transport, while at the same time producing greater involvement of relatives in patient care. A psychogeriatric day centre plays its part in relieving some of the stress of caring for mentally infirm old people in their own homes. A specially trained nurse goes out into the community to advise on the management of incontinence. A variety of other innovative services is springing up all over the country, and there is much communication of good ideas through journals and society meetings.

The simplest advice that can be tendered to CHC members when faced with complaints about the care of the elderly in their district is "Don't shoot the geriatricians: they are doing their best". Find out first how the provision of services in the district is related to DHSS norms; and remember that norms are no measure of need. Geriatricians will always be pleased to meet community health council members and to describe their local situations.

When the whole system is working under such stress any little difficulty, like the breakdown of transport or of the hospital laundry or re-painting a ward or an influenza outbreak amongst nurses, can lead to awful things happening. CHC members, with their wide-ranging experience, may be able to suggest to the district management team ways which will help the geriatric services to meet their obligations. They may have contacts with the local community who might be encouraged to provide voluntary service to fill some of the many gaps.

All who work with and are concerned for the elderly will be happy when there is no need to have rules or to make exceptions. That day is unlikely to come soon. Meantime we have to look after the old people who have no one to write letters to call attention to their needs.

Bernard Isaacs is Professor of Geriatric Medicine at Queen Elizabeth Hospital, University of Birmingham.

He is one of the authors of Survival of the unfittest, *published by Routledge, 1972.*

*Kay, Beamish and Roth (1964), British Journal of Psychiatry, Vol 110, pages 46-58.

Photo above by Liz Heron. Others from Age Concern

MIND condemns White Paper

MIND, the National Association for Mental Health, has condemned the White Paper *Review of the mental health act 1959* as a "tidying-up operation in which patients' rights are again being swept under the carpet". Below is a shortened version of MIND's response to the White Paper (see October *CHC NEWS* for a summary of the Government's proposals).

MIND welcomes the proposals for removing the legal and other disabilities suffered by voluntary patients but is concerned that this will lead to more people being compulsorily detained and treated. Compulsory patients on short-term detention are not to have access to proper appeals machinery, as MIND recommended. Instead there will be an internal hospital review of their detention, "leaving them in a Kafkaesque world in which they can do nothing about their position".

Despite the fact that all major voluntary organisations in the field of mental handicap have recommended its removal from the scope of the Act, the White Paper proposes its retention. Indeed, it proposes to extend the definition of "treatment" to include "training, habilitative techniques . . . and other professional help". MIND says that mentally handicapped people do not require "medical treatment" and calls the proposals a "desperate attempt to justify the retention of mental handicap within the Act", which is against the spirit of current thinking which seeks to meet the needs of mentally handicapped people outside medical settings.

The White Paper's proposals for mentally abnormal offenders have also disappointed MIND, which takes the view that when a mentally disordered person has been convicted of a criminal offence, society is justified in protecting itself by detaining the patient only for a period proportional to the gravity of the offence. After that, the Home Secretary should not be involved. From the White Paper it is clear to MIND that the Home Secretary has won the battle to retain powers of detaining offender patients. It also regrets the White Paper's decision to continue censoring patients' mail in special hospitals.

Turning to community care, MIND welcomes the Government's support of the 24-hour crisis services, which, when widely available, will eliminate what is seen by MIND as the mis-use of Section 29 of the Act as a device to secure emergency treatment. (Section 29 allows for 72 hours' compulsory detention.) However, there is concern that in practice these proposals for a broader base of mental health care may be "sabotaged" by the slow or non-existent development by local authorities of these "plans of assessment". MIND will seek the urgent allocation of development funds through joint financing to the local authorities.

Photo: Tony Othen

MIND also regrets the White Paper's failure to commit itself to the idea that *any* patient has a right to give informed consent to any treatment he or she receives. Where it is impossible to secure this consent directly, MIND suggests that a "patient's friend" or nearest relative should be consulted. It is particularly concerned about the detained patient who will be "totally vulnerable" to receiving treatment against his (or her) will.

The new legislation should have laid down the legal framework for a modern community health service. Instead, says MIND, the White Paper reveals a shortsighted concern with the rights and safety of public and staff while making only minimal concessions to strengthen the rights and safeguard the liberties of mental patients.

Book reviews

Caring for elderly people

by Susan Hooker, Routledge and Kegan Paul Ltd, £1.95.

Caring at home for an elderly relative in failing health can be a daunting and lonely prospect. This book is not meant for cover-to-cover reading — it is a handbook for understanding and dealing with the problems involved in common complaints such as arthritis, broken limbs and strokes. There are chapters on caring for people in bed, on daily exercises, incontinence and constipation, and a good guide to gadgets and to outside services.

Community care need not mean the family of an infirm and elderly person battling on alone, unsure of whether or not they are doing the right thing. This book translates the notion of keeping old people out of institutions from pious thoughts into a practical day-to-day guide.

The image and the reality: a case-study of the impacts of medical technology

by Barbara Stocking and Stuart L. Morrison, Oxford University Press, £3.

This fascinating book describes the development and use of whole-body scanners and discusses the way the demand for them has been created, the commercial pressures for progress, the questionable benefits in terms of diagnostic effectiveness and treatment possibilities and the implications for the NHS.

The gift of a scanner may not be the boon it seems. Money for running costs may have to be diverted from other services. And the scanners may not be sited in the best places. The authors call for a central policy on the role of philanthropy in the NHS and closer scrutiny of advances in medical technology.

Books received

National health service — the first thirty years by Brian Abel-Smith (HMSO £1.95)

Sex and the mentally handicapped by Michael and Ann Craft (Routledge and Kegan Paul £3.95)

Social care research edited by Jack Barnes and Naomi Connelly — papers and report of a seminar held in 1977 (Bedford Square Press £3.50)

My mother said . . . the way young people learned about sex and birth control by Christine Farrell and Leonie Kellaher. Based on interviews with over 1500 young people aged 16-19, and 300 parents, this study examines the sexual knowledge, experience and attitudes of teenagers. (Institute for Social Studies in Medical Care: Routledge and Kegan Paul, £5.95).

Health care in big cities edited by Leslie H. W. Paine (Croom Helm £9.95).

Psychiatric provision drawing on large institutions (King's Fund Centre 75p).

Providing for the health services edited by Sir Douglas Black and G. P. Thomas (Croom Helm £8.50).

Subject index — of DHSS circulars, NHS Statutory Instruments, etc. (Institute of Health Service Administrators, 75 Portland Place, London W1, 70p).

Second class disabled — a report on the non-contributory invalidity pension for married women by Irene Loach and Ruth Lister (Equal Rights for Disabled Women Campaign, 5 Netherhall Gardens, London NW3, 65p).

Holes in the welfare net by Maureen Oswin (Bedford Square Press of the National Council for Social Service, £3.25 inc. post).

Birth impairments (Office of Health Economics, 162 Regent Street, London W1, 35p).

The realities of RAWP

Judie Langton-Lockton, secretary of King's CHC, describes the special claims on funds of a teaching district and gives her personal view of how RAWP will stunt the growth of community services.

King's health district is one of the three teaching districts in the Lambeth, Southwark and Lewisham Area Health Authority (Teaching). Of the three it has the largest resident and catchment populations but the smallest budget. It is already closer to its RAWP target than neighbouring districts, and is now struggling to maintain acute hospital-based services and hasn't the spare cash to expand community services. The hospitals are well placed to serve the local population. In addition, high cost specialties (liver unit and cardiothoracic and renal units) and outpatient clinics attract patients from far and wide.

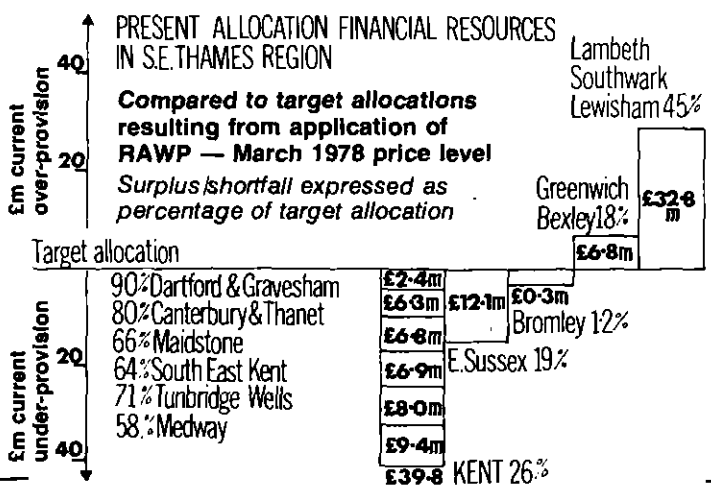
With the advent of RAWP local people are beginning to ask whether the district can afford to treat outsiders. There is a pressing demand for services. Inpatient numbers increased by around two thousand in two years, reaching 36,989 in 1977, outpatients were 406,923 compared to 384,891 in 1976, and there were 1,898 more attendances at the accident and emergency department in 1977 compared to 1976. Lengths of stay are shorter than formerly, bed numbers are falling, and bed occupancy is high. At the same time costs of inpatient care are low compared with those in neighbouring teaching districts. So long as the high level of demand remains and the district is committed to teaching not just medical, dental and nursing students, but also physiotherapists, radiographers, dieticians etc, there is no way that resources can be switched from the acute field to community and preventive medicine. Yet better health for the people of the King's district now depends on the growing effectiveness of the community services.

The district is within an area where the number of residents born outside the UK is higher than in any other part of the South East Thames Region; where the population density is 92.3 persons per hectare compared to 3.7 in Kent and 3.5 in East Sussex; where unskilled manual workers comprise 10.2% of the population compared to 5.7% in Kent and 4.1% in East Sussex. There are more households with no water supplies, no fixed bath or shower, and no inside WC than in any other part of the region. So it is no surprise that the perinatal mortality rate for the district was 19.8 per 1000 in 1976 compared to an average figure for England and Wales of 17.7, or that the rate of malformed babies was 31.5 per 1000 compared to 24.4 for the South East Thames Region. The immunisation rate is low and has been falling over the last three years. Attendance at mothercraft classes by first-time mothers is barely 50% at present; only 40% of 2-year-olds are seen in the clinics and in 1977 29% of children referred for special screening failed to attend. We need more health visitors to ensure that services reach those most in need.

In the context of early discharge from hospital and the district's commitment to helping the elderly to remain independent in their own homes, further community resources for the elderly must be developed. That means more preventive clinics for the over-60s, and further growth in chiropody, domiciliary physiotherapy, and night nursing services. The district has no hospital facilities for the adult mentally handicapped and no staffing expertise, so it will be a race to establish services before the closure of Darenth Park Hospital.

The district is being encouraged to move towards greater effectiveness of the community services by access to joint financing, and to monies through the Inner Cities Partnership for Lambeth. But at the same time it faces massive cut-backs in revenue over the next 10-15 years. There is to be no appointment of a hearing therapist because the salary cannot be guaranteed in the future, and the community play scheme based at the children's hospital is under threat for the same reason. These are just two examples of opportunities that will be lost.

Because of regional differences in the way the health service has developed, people at equal risk of illness in different parts of the country have unequal access to health care. The aim of the Resource Allocation Working Party was to develop a formula which would allow these disparities to be progressively reduced. In its report — *Sharing resources for health in England* (HMSO, 1976, £1.70) — the working party set revenue targets for each region. The four Thames regions and the Oxford region were above their targets and have therefore had to restrict their growth. On this page the effects of the reallocation policy on two districts in the South East Thames Region are reviewed.



The problems of a deprived district (which has lately had a rapid increase in population) in a region which is losing under RAWP are outlined by Graham Hills, secretary of Medway CHC.

"Medway's health services at the start of the next century will still be in a state of deprivation". That was the conclusion reached at a debate we recently held to mark the anniversary of the NHS. It reflects the view of lay and professional people in Medway that RAWP will not be able to achieve the measure of redistribution required to bring our local health services up to an acceptable level.

Our district's claim for more resources is undeniable: it is the most heavily populated health district in the so-called "prosperous" South East Thames Region and yet receives one of the smallest financial allocations to districts in the region. Its population has increased 30% in each of the last decades, and currently we are £9.4m short of our 1987/88 RAWP target allocation. The catalogue of deficiencies is too extensive to mention here and is not adequately described in terms of shortage of beds, long waiting lists, Dickensian buildings and so on, although all these are present. Suffice it to say that Medway is that strange phenomenon with which RAWP finds it impossible to deal adequately — a "deprived" health district in a "losing" region.

In times of no growth Medway can only benefit as a result of the levelling down process which is causing our colleagues in the Area Health Authority (Teaching) and in Greenwich so many problems in terms of hospital closures and cut-backs. The same seems also to apply in times of growth, judging by the blatant failure of the SE Thames RHA to apply the RAWP formula to its share of the £50m Budget handout, which was not earmarked.

Since RAWP was introduced Medway has had some modest increase in revenue, principally as a result of the measures taken by the Kent AHA, which is pursuing

continued on page 10

Parliament

The lead debate (1)

The Environment Department's report *Lead pollution in Birmingham* was attacked by local MP Jeff Rooker when the Commons debated lead pollution on August 2. A working party has been set up to investigate the high levels of blood lead found in the city's pre-school children, but Mr Rooker claimed this had been "fixed in order to pacify those who are concerned". The new enquiry will examine children attending day centres, who are unlikely to be among those exposed to high levels of environmental lead. "This sort of enquiry, coupled with the inaction of the past, leads people . . . to believe that someone, somewhere, is in someone's pocket," Mr Rooker remarked.

The lead debate (2)

The DHSS says it has "no substantive evidence of injury to health as a result of exposure to lead in the general environment". It has sponsored five studies relevant to this in recent years, and the Environment Department has just announced three new pieces of research, including studies of possible effects of lead on children's behaviour (Ivan Lawrence MP, Burton, 3 August).

CHC observers on FPCs

About half the Family Practitioner Committees in England now accept CHC observers, and David Ennals is "closely watching progress being made by way of local arrangements" before deciding on further action (Ian Wrigglesworth MP, Teesside Thornaby, 3 August).

Eraldin side-effects

GPs have sent the Committee on the Safety of Medicines 2,010 reports of suspected "adverse reactions" to the drug Eraldin, including 35 deaths. The DHSS has so far received no information from CHCs on this (Sydney Tierney MP, Birmingham Yardley, 27 June).

Employing the disabled

The Government is making available £500,000 in 1979/80, to adapt public buildings in 56 British towns. The aim is to provide at least one Government office in each town where disabled people can be employed (Lewis Carter-Jones MP, Eccles, 3 August).

Official policy on hospices

There are about 40 hospices for the dying in Britain, mainly receiving NHS support. About 20 more are in the pipeline. The DHSS supports hospice development in principle, but it is for health authorities to decide what provision is needed locally (David Penhaligon MP, Truro, 3 August).

The cost of mouth disease

In the year ended May 1975, 743,000 days' work were lost because of "diseases of the oral cavity" (Ivan Lawrence MP, Burton, 19 June).

Vasectomies

In 1976 regional figures for vasectomy (male sterilisation) ranged from over 2,000 (in Trent, SW Thames, West Midlands and North West) to "Nil" in E Anglia (Jeff Rooker MP, Birmingham Perry Barr, 20 June).

Money from pay beds

Revenue from English and Welsh pay beds was £24.8m in 1976/77. The estimate for 1977/78 is £27.3m (John Biggs-Davison MP, Epping Forest, 3 July).

Deaths from anorexia nervosa

In 1977, 21 people are known to have died from anorexia nervosa in England and Wales. It affects 1% of girls aged 16–18, and may be commonest in social classes I and II (Lewis Carter-Jones MP, Eccles, 20 June).

Prescribing costs

About £512m-worth of drugs are expected to be prescribed by English GPs during 1978/79. In the hospital and community services in 1976/77, drugs cost £87m (Mike Thomas MP, Newcastle-upon-Tyne East, 28 June).

Healthline

Mixed hospital wards

What is the DHSS policy on mixed wards?

It is up to AHAs to decide their own policies, says the DHSS. When wards contain men and women patients, people should be told of this before they are admitted and offered alternative accommodation, if possible. In wards which are adapted for mixed use, an acceptable degree of privacy should be safeguarded.

Professional misconduct

What is the procedure for complaining about doctors' professional misconduct?

Allegations of serious professional misconduct are dealt with by the Disciplinary Committee of the General Medical Council. The Committee's primary duty is to protect the public. All doctors must be registered with the GMC before they may practise medicine in this country.

Complaints come under the following headings: neglect of responsibilities towards patients; abuse of professional privileges or skill (such as illegal abortion or undue influence); personal behaviour which endangers the profession's good name (such as drink or drugs); and advertising for customers. The GMC has powers to suspend registration or even erase a doctor's name from the register. Many GMC cases have already been heard by the Medical Service Committee of an FPC.

Professional Conduct and Discipline, published by the GMC, gives guidance on its scope and procedure. General Medical Council, 44 Hallam Street, London W1N 6AE.

Health Advisory Service

Are CHCs entitled to see HAS reports on local services?

No. According to the latest HAS Annual Report (1976), CHCs may only receive a summary of the recommendations, as you have done. Several have protested that this is unsatisfactory.

RAWP

continued from page 9

an active policy of redistribution. This policy has been described as one of "robbing the poor to pay the destitute", since all six of Kent's districts are below their RAWP targets. From our viewpoint it seems that the RHA is less than committed to RAWP and the region's current policy of only expecting to achieve between 25% and 40% of RAWP targets in the next 10 years will mean that in real terms we will actually lose ground to the allegedly over-provided districts within our region.

Roland Moyle's attitude to the problem of deprived health districts in losing regions seems to be a tacit acceptance that RAWP will take some time to work through and that in the meantime, in view of the massive capital investments made by the DHSS at St. Thomas's, Guy's, and Greenwich, local GPs had better start changing their referral patterns and sending patients there instead. At present these hospitals meet only 2½% of the acute district workload of Kent and East Sussex, which are the two peripheral areas of the region.

In effect he is saying to these areas: "I cannot give you any money to improve your position, but these and other hospitals are regional resources (many of which are also of course national and international institutions) and should be used more extensively than hitherto by the deprived districts at the expense of Londoners and other regions' users." Whether local GPs decide to take advantage of this policy remains to be seen.

Naturally enough many local people question the wisdom of cutting back on the AHA(T) and the centres of excellence. But even more than this, they bitterly resent a policy which means that districts throughout the country which are similarly deprived are treated differently through a freak of geography. We fondly thought that the objective of RAWP was to reduce these historical and geographical inequalities.

Scanner

The latest on lead

Ways of persuading local authorities to survey the harmful effects of lead from exhaust fumes are described in the Campaign Against Lead in Petrol's latest newsletter. Recent legal and medical developments are also described, and a 'workshop' is being held in London on 25 November. Details from CALIP, 168 Dora Road, London SW19. Also available is *The health effects of lead on children: A review of the literature published since 1976*, price £1. Meanwhile the Health and Safety Executive has issued a consultative document on the *Control of lead at work*, HMSO 50p.

Be a sport!

"Exercise can make an important contribution to health and well-being. It is now clear that the less active members of the general public would benefit from increasing their levels of physical activity." Research carried out for the Sports Council produced this conclusion, and has led the council to launch its *Sport for all – Come alive!* campaign. *Come alive!* posters and stickers, leaflets on jogging, cycling, swimming and walking, and a booklet on the Sports Council itself, are all available from 70 Brompton Road, London SW3.

Time off for safety training

From 1 October this year NHS trade unions have been entitled to appoint safety representatives, and to request health authorities to set up safety committees. A new code of practice entitling safety reps to time off with pay for approved training is now available free from the Health and Safety Executive. It should be read alongside the booklet *Safety representatives and safety committees*, HMSO 35p. Both from HSE, Baynards House, 1 Chepstow Place, London W2.

Phenacetin to be banned?

The DHSS wants to ban the pain-killer phenacetin, and is consulting about this. Phenacetin has been in use since 1887, and may cause kidney damage. There are believed to be about 50 phenacetin-containing products on the market — notably Codeine — and about 500,000 prescriptions for these products are written annually.

● **See Health News, page 3.**

Children in hospital: HC(78)28

Advises how to maintain or restore family links when children have been in hospital more than a few weeks. Loss of contact with parents can cause emotional problems, or "failure to thrive" in very young children, and it also makes it difficult to consult parents about a child's treatment, education and future. Section 14 asks health and local authorities to carry out six-monthly joint reviews of children who have been in hospital over three months, bearing in mind the possibility of day-care treatment. Also issued in Wales as WHC(78)29.

Child health report: HN(78)108

Accompanies the 53-page report of the joint Child Poverty Action Group/DHSS conference on *Reaching the consumer in the ante-natal and child health services*, held last April. CHCs have been sent a copy — further copies from DHSS Store, Scholefield Mill, Brunswick Street, Nelson, Lancs BB9 0HU.

Travel assistance: HC(78)23

Schemes providing free travel to work or reimbursement of public transport fares may be continued where staff were recruited on the understanding that such schemes would be available, but may no longer be offered to other members of staff. Assisted travel schemes listed in HC(77)32 — hospital transport, partial reimbursement of public transport fares, or car mileage allowances — may be offered instead, where difficulties in staffing justify this.

Coming and going

An illustrated 34-page booklet, designed to help NHS staff communicate with patients in eight foreign languages, has been produced by the Health Education Council. *The medical phrase book* is 70p inc post from HEC, 78 New Oxford Street, London WC1. For people going abroad, DHSS leaflet SA30 summarises visitors' rights to medical treatment in 23 countries.

Reports round-up

CHC NEWS has been inundated with reports lately. Here is a list: *The Government and the voluntary sector: a consultative document* (free from the Voluntary Services Unit, Royston Road, Cambridge); *The pattern and range of services for problem drinkers* (free from SH Division, Room B318, Alexander Fleming House, London SE1); *Age Concern at work* (large 15p SAE to 60 Pitcairn Road, Mitcham, Surrey); *Health Education Council Annual Report (AR) 77/8* (78 New Oxford Street, London WC1); *National Assoc of CABx AR 77/8* (110 Drury Lane, London WC2); *Central Health Services Council AR 77/8* (HMSO 70p); *National Consumer Council AR 77/8* (18 Queen Anne's Gate, London SW1); *Manpower Services Commission AR, 77/8* (166 High Holborn, London WC1); *Report on war pensioners for 1977* (HMSO £1.50); *Incontinence: a burden for families with handicapped children* (£1.50 from Disabled Living Foundation, 346 Kensington High Street, London W14).

CHC observers at FPC meetings: WHC(FP)78(2)

This Welsh version of HC(FP)(77)2 takes a stronger line than its English counterpart. Instead of FPCs being "asked to consider" inviting CHC observers, they are "urged" to invite. The circular argues that observer status promotes better mutual understanding between CHCs, FPCs and the public. It refers to the six-month trial of CHC observers in Powys, which "seems to have worked well".

Pocket money in mental hospitals: HN(78)111

From 12 November, the standard amount of "pocket money" which may be paid to patients in hospitals for the mentally ill and mentally handicapped will go up from £3.50 per week to £3.90.

Registration of patients: HN(FP)(78)46

Accompanies *An outline of registration procedures*, a revised guide to registering patients, for use by FPCs. The DHSS hopes the new guide will lead to a reduction in "the inflation of doctors' lists".

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 (9½p) 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.

Below are alterations to the new directory.

Page 1: West Cumbria CHC Chairman: E Urquhart
Page 2: Gateshead CHC Chairman: Cllr C Ryans
Page 3: Huddersfield CHC Chairman: Cllr A W Green
Page 5: Sheffield Southern CHC Chairman: Mrs Josie Brown
Page 6: East Hertfordshire CHC Chairman: Mrs I M Baker
Page 7: Hounslow CHC, Hospital Road, Hounslow, Middlesex (Tel: 01-572 8455).
Page 8: North Camden CHC Chairman: David Delaney
Page 8: East Roding CHC Chairman: Cllr Rev P Duncan
Page 13: Bristol CHC Chairman: Cllr W Watts-Miller
Page 14: Gloucester CHC Secretary: Mrs Judith Gill
Page 14: Torbay CHC Chairman: W H Carr
Page 16: Sandwell CHC Chairman: Mrs M F Cooper
Page 17: Blackburn CHC Secretary: Ralph Berry
Page 17: Liverpool Eastern CHC Chairman: T Colton
Page 17: Wirral Northern CHC Chairman: Rev Godfrey Kenyon
Page 17: Wirral Southern CHC Chairman: E A Hebron

News from CHCs

☐ **Peterborough CHC's** Family Planning Project Group has chalked up two successes. When plans were put to the AHA to close sessions at family planning clinics and to limit access to vasectomy and sterilisation services, the group alerted local women's organisations. They arranged meetings, radio and television coverage, and a petition with 3,000 signatures, which was presented to the AHA at its September meeting. This meeting decided that the clinics should be maintained and priority be given to sterilisation facilities. The AHA has also accepted the Family Planning Project Group's counter-proposal to prevent the closure of a monthly family planning session.

☐ Since June of this year **Roehampton CHC,** which has 18 members, has been asking South West Thames RHA to allow the council to increase its membership, mainly in order to widen its representation from voluntary bodies and to ease the workload. So far the RHA has produced "a rich variety of excuses for inaction", according to CHC chairman Morris Malin. It has now agreed to review the size of all CHCs in the region — but this may take several months.

☐ The closure of Cowley Road Hospital is to be opposed by **Oxford CHC,** following the public's response to the proposal. The AHA says that the geriatric hospital must be closed in order to fund the opening of the new John Radcliffe Hospital. The CHC printed a leaflet setting out the arguments for and against the plan, and collected over 5,000 signatures for a petition against the closure. Opposition is based on the fact that the new plan would break up the present community at Cowley Road (which has very strong voluntary support) without offering any improvement in quality for Oxford's geriatric services or any means of coping with increased future demand.

☐ Out of the 48 local health councils in Scotland, 35 are now affiliated to the **Association of Scottish Local Health Councils,** and 33 were represented at the AGM held in Edinburgh on 28 September. Probably the most important issue resolved was that the Association should have its own premises and the services of a full-time, permanent secretary and an assistant. Despite magnificent efforts, the president reported, lack of staff time had meant that the real work of the Association had hardly been touched. Matters of common concern to LHCs were the difficulty of getting information from health boards and of being involved in decision-making and planning at the formative stages. Other topics discussed included waiting lists, shortage of paramedical staff, training for GPs' receptionists, grading of LHC staff and LHC premises. David Currie was re-elected president and the Rev Frank T. Smith vice-president.

☐ **South Hammersmith CHC,** which has been trying to resolve difficulties with Ealing, Hammersmith and Hounslow FPC about CHC participation in service committee hearings, has discovered that written reports of such hearings are not verbatim but are edited, or "screened", accounts. The FPC administrator says that the editing is simply to remove repetitions. But the CHC is worried that the practice may hinder complainants in pursuing their case on appeal.

☐ Mr Ennals has given the go-ahead to the merging of the two Gloucester AHA districts, despite opposition from doctors, unions, and **Gloucester CHC** and **Cheltenham CHC.** The Secretary of State has however decided that CHCs should be consulted on the detailed management arrangements when restructuring of districts is proposed. A decision is still pending on the proposed merger of the two Somerset districts, which **East Somerset CHC** is opposing. The South Western RHA will be reviewing the position of all CHCs in the region. The feeling among the CHCs is that there should if anything be more, not fewer, councils.

There are now only two CHCs in Sheffield — **Sheffield Northern CHC,** with 30 members, and **Sheffield Southern CHC,** with 32 members. **Sheffield Central CHC** ceased to exist when the three CHCs merged into two. The RHA decided that the staffing establishment should be cut, from six to four, but the two remaining CHCs, backed by local MPs, have appealed to Mr Ennals to have the decision reversed. The **Trent Regional Association of CHCs** has protested at not being consulted about the reorganisation of CHC establishments in Sheffield. And **North Derbyshire CHC** has suggested that the development of CHCs should be incorporated in the NHS planning system.

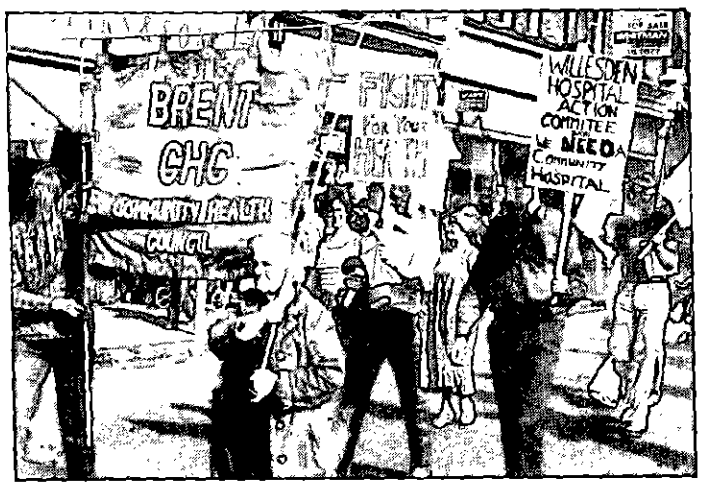


Photo: Andrew Wiard (Report)

☐ *Willesden Hospital was closed as a general hospital two years ago and since then* ***Brent CHC,*** *as a member of the Willesden Hospital Action Committee, has been pressing for a community hospital to be established at Willesden. The campaign has been gathering speed, with a demonstration in September (see picture), at which speakers included Laurie Pavitt, MP for Brent South, and a representative from the CHC. Following a conference on community hospitals at the end of October the CHC will put its final proposals to the AHA this month.*

☐ **South Camden CHC** has published a Guide Book to the Health Services as part of its annual report for 1977/78. It provides simple explanations of how the NHS is organised, and what the CHC is and does, and a list of NHS establishments in South Camden.

The five CHCs in the Cheshire area are hoping to collaborate in producing a health services information booklet.

☐ **South East Cumbria CHC** is seeking representation on the Windscale Local Liaison Committee and the right to be consulted on the disposal of radioactive waste. It is asking British Nuclear Fuels Ltd whether whole-body monitoring facilities are available to the general public. And the council, believing that the level of lead in petrol in this country can and must be reduced, has recorded its dissatisfaction with a letter from the Department of the Environment which speaks of reducing the lead in petrol "where practicable".

☐ A progress report on **Manchester CHCs'** efforts on behalf of the Association for Children Damaged by Hormone Pregnancy Tests shows that so far 18 CHCs in England, Scotland and Wales have agreed to act as a postbox in distributing and collecting information, 5 have decided to give press publicity to the campaign, and 23 have resolved not to participate. The Manchester CHCs want to stress that the aim of the exercise is to provide a basis for establishing whether the handicaps can be attributed to an adverse drug reaction.

☐ A document on underfunding has been sent by **West Roding CHC** to Mr Ennals, the DHSS, MPs and the RHA. It draws attention to the district's special problems, placed as it is between Essex and the inner city areas. It has a high proportion of elderly people and children, a large immigrant community and a poor housing stock. Yet it receives none of the benefits from the Inner City Partnership Programme. The CHC calls for an extra £500,000 a year to halt the decline in the district's health services.