CHC NEWS

For Community Health Councils

March 1979 No 40

Follow the medicines code

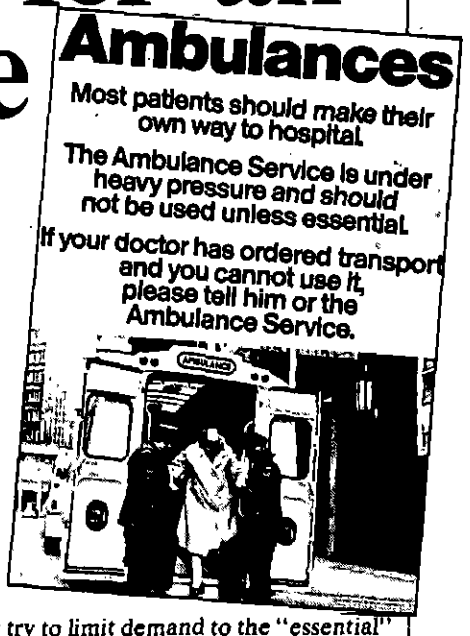
Nine simple rules make up the Medicines Code, the cornerstone of the Health Education Council's campaign to encourage the safe use and storage of medicine in the home. Slogans such as "Will your headache be the death of your children?" stress the risks to very young children who may think pills are sweets. The campaign has the backing of the Pharmaceutical Society of Great Britain (representing 30,000 pharmacists) and leaflets will be available in chemists' shops and from the HEC, 78 New Oxford Street, London WC1A 1AH.

We'll help ourselves

Medway CHC is launching a major drive to encourage sponsorship of its local health services — by individuals, voluntary organisations and local firms. Despite its support for the *concept* of resource allocation, the CHC has concluded that for the time being at least RAWP has failed in the SE Thames region — hence the emphasis on financial self-help. Over 3,000 letters are being sent to potential sponsors, and with the aid of the local media a different aspect of Medway's NHS — eg maternity services — will be publicised each month. The whole exercise is to be called "Medway Health Development Year".

The CHC's disillusionment with RAWP follows correspondence with David Ennals and regional chairman Sir John Donne, on the subject of Lambeth, Southwark and Lewisham AHA's deliberate overspending. CHC chairman Bob Sayer told Mr Ennals: "It would be easy for Medway and the Kent AHA to follow . . . (this) policy, but then anarchy would rule and this is something we are not as yet prepared to advocate". Mr Ennals rejected Medway's request for an inquiry into the overspend, and Sir John commented that RHAs have only "very limited authority" in such situations.

The need for an ambulance



The dilemma about medical, social and economic needs for ambulances is not clarified at all by the guidance in the long-awaited DHSS circular on ambulance services (HC(78)44). The circular accompanies a poster reminding doctors and patients that the service is under "heavy pressure" — mainly because of the enormous expansion of need for transport of patients attending day-care facilities in hospitals.

The circular brings together and supersedes information contained in nine previous health circulars. As a draft, it was circulated to CHCs by ACHCEW, and most of the CHCs' comments approved the spirit of the draft. The final form does not differ substantially from that draft. However, CHCs did point out that no criteria are given as to how medical and non-medical needs for transport might be distinguished, and there were complaints that the Secretary of State's duty, devolved to health authorities, to "meet all reasonable requirements", was vague.

The guidance is concerned mainly with non-emergency ambulances. Authorities are urged to involve senior ambulance officers at an early stage in the planning of day-care facilities, and to review catchment areas as soon as new units are opened. They are also encouraged to create posts for ambulance liaison officers. Experience shows that these appointments can lead to reduced waiting times for patients and more efficient use of staff and vehicles.

The special problems of rural areas are acknowledged and the circular suggests that the "medical need" policy should be more flexibly interpreted here. Even so, AHAs must try to limit demand to the "essential" and this is the tone of the entire circular. "Ambulance transport should not be provided for patients whose medical condition does not prevent them from travelling by any other means . . ." Another example of this emphasis is the suggestion that regular information about current costs of running the service should be brought to the attention of doctors and others responsible for ordering ambulances. Yet the Department has hardly any evidence that the service is abused, nor has any research been published on the misuse of the system.

The circular is limited to discussing ambulance services, rather than patient transport in general, although it does remind authorities of the County Councils' powers under the new Transport Act and urges them to maintain close liaison with local government.

Slower progress on RAWP

Spending on the NHS will rise 2% in real terms in the coming financial year, with an extra £84m at November 1978 prices going to health authorities*.

Mr Ennals has also announced revenue allocations to regional health authorities for 1979-80. The "worst-off" regions will get up to 3% further progress towards their targets, as set by the RAWP formula, compared with 4% progress in 1978-79. The "best-off" regions will get at least 1% real growth, as against 0.6% a year ago.

Mr Ennals intends the "wealthier" regions to spend their increases on their more deprived areas, and will insist on "the clearest justification for any departure from this".

* *The Government's expenditure plans, Cmnd 7439, HMSO £4.25.*

● **See Comment, page three**

INSIDE . . .

Your letters

Cutbacks and strikes

Kate Truscott, member of Fightback, 30 Camden Road, London NW1

We were dismayed about the resolution passed by South Tyneside CHC which "deplores the suffering to patients resulting from repetitive strikes in the NHS" and calls for "alternative negotiating procedures for NHS staff such as those in the police and defence forces".

The CHC seems to place the *sole* blame for the deterioration of patient care on to staff who strike for apparently no reason. My experience, as an ex-ancillary worker and as a health care campaigner, tells me otherwise.

What many CHCs do not seem to realise is that the deterioration of the NHS is more to do with cutbacks, and it is these which have had such a devastating effect on the working conditions of NHS staff and on the kind of health care they can give. Yet staff have continued working for low pay and poorer hours and conditions than most. Space does not permit me to chronicle here the havoc wreaked, not by strikers, but by cutbacks and closures which have a *direct* effect on patient care and are a direct cause of suffering by extending waiting lists. The evidence available from AHA minutes and plans is overwhelming.

So why *do* health service staff go on strike, as it only aggravates the problem? The answer is that more and more staff are no longer prepared to tolerate the all-round deterioration of the NHS. Taking industrial action is the only way to make this public.

Fightback supports local campaigns whose aims are for better health care, freely available to all. But we know that the blame lies squarely on the Government's public expenditure cuts.

As the "patient's voice", CHCs should be the *first* to realise that health workers only take action under severe duress, and that increasing strikes reflect the underlying crisis in the NHS. But banning strikes will not make this crisis, caused by cuts and low pay, go away.

What is needed now is public monitoring of the terrible effects of cuts, and for all CHCs *to take an active stand* alongside local health staff and fellow workers in the local community and campaign for *an end to all cuts* and for a better health service for all.

An incongruous practice

Cyril Gumbley, Secretary, East Dorset CHC

On 30 September 1978 the *Pharmaceutical Journal* reported the opening of a new "family store" by a well-known firm of multiple pharmacies in Dundee. Amongst the amenities this store offers is "a tobacco kiosk at its entrance". Letters in subsequent issues of the *Journal* revealed that this was not an isolated case. Whilst supporting the retention of as many pharmacies as possible, the incongruous practice of pharmacists selling tobacco must surely be deplored.

The Pharmaceutical Society's *Statement upon matters of professional conduct* (paragraph 20) states: "A pharmacist should not supply to any member of the public any substance, medicinal product or medicinal appliance which the pharmacist knows or has reason to believe is intended to be used in a manner which would be detrimental to health". How else is tobacco used?

My council has asked me to draw this matter to the attention of other CHCs, in the hope that they may take appropriate action to resist this practice in their own districts.

Trouble-free elections?

H. Bradley, Secretary, Macclesfield CHC

At the recent election of voluntary organisation members to CHCs, a number of voluntary organisations in this district voiced their consternation at the very vague procedure laid down in circular HRC(74)4. This states that "once the list of voluntary organisations has been determined, it will be for the RHA to invite these organisations to agree amongst themselves how the places to be filled by them should be allocated".

Have other CHCs received similar complaints from voluntary organisations in their districts? We would be delighted to hear from them, and also from CHCs whose elections have been held in a trouble-free and satisfactory way.

Funding day-care abortion

Caroline Langridge, Secretary, Wandsworth and East Merton CHC

The article on day-care abortion units in *CHC NEWS 38* was very timely, but it is a pity the authors did not extend their research to look at methods of funding such units. In many districts CHCs have been successful in making a case for day-care abortion, but have been stymied by a lack of NHS finance.

In March 1976 this CHC submitted detailed plans for a day-care unit to our district. The proposals were accepted early in 1978, but like so many good ideas seemed doomed to stay in the pending file, due to lack of funds for new developments in an area already suffering heavily from RAWP.

We then suggested that the unit be funded from joint finance, as a "primary care project" (see section 11 of Appendix 1 to circular HC(77)17), and to our delight this was agreed by the borough council, the AHA and the DHSS. Naturally we hope other CHCs will follow this precedent.

Humanising official letters

Shirley McCarthy, Secretary, NW Herts CHC

One of NW Herts CHC's concerns is that Family Practitioner Committee letters to patients should be written in readily understandable and human terms. We have looked at the standard letter which Hertfordshire FPC sends to patients being removed from a doctor's list, and we feel that its wording is brusque and off-putting, particularly in a situation where the patient may feel rejected.

It would help us to secure improvements to have examples of the letters used in other areas. We would therefore welcome any examples CHC secretaries can forward.

Ear piercing

Coun. Bill Craddock, Member, Sunderland CHC

Hull CHC is concerned about the health problems of ear piercing (*CHC NEWS 37*). We in Tyne and Wear County Council have also recognised this problem, along with tattoo problems, and new powers to complement the provisions of the Tyne and Wear Act 1976 are shortly to be presented to Parliament as a Bill.

The relevant clause will "require persons engaged in tattooing and ear piercing to register with the district authority, and enable a district to make byelaws securing standards of cleanliness".

Hazards of private practice

Christine Hogg, Secretary, Kensington, Chelsea and Westminster (South) CHC

Getting NHS dental treatment is harder and harder, especially in Central London, where the hazards of private practice have to be overcome. We can often help to find an NHS dentist, and our Family Practitioner Committee is very helpful in this. But most of the complaints relate to private treatment, and here we cannot help. These two are typical of many we receive.

Miss F went to a dentist hoping for NHS treatment. She was told that no dentist would treat her on the NHS, so she agreed to be treated privately. She didn't need much done, just an examination, scaling and fillings. The dentist said he couldn't give an estimate, and that it might be possible after all to do some of the work on the NHS. Later Miss F was very upset to receive a bill for £70, which she couldn't possibly pay. As it was a private transaction we couldn't help. The Local Dental Committee said the bill was reasonable, and the dentist finally let her pay in instalments.

Mr T had also been told that NHS treatment was impossible. On his first visit as a private patient he was taught brushing techniques and charged £10. He was told that next time he would have the necessary fillings. On his second visit the surgery was closed. When he went for his next appointment he was told the dentist was running late, and he couldn't possibly be seen. When he turned up for the fourth appointment the surgery was again closed! We were able to give him the name of a dentist who still does NHS work.

Adverse reactions to "Pexid"

E J Ashley, Secretary, South East Staffordshire CHC

A patient in this district is suffering severe adverse reactions as a result of taking "Pexid" (perhexilene maleate) for the treatment of heart disease. Apparently the reactions (which include peripheral neuropathy, abnormalities of liver function, hypoglycaemia and weight loss) were

Continued on page 10

Comment

The DHSS has always maintained that movement towards RAWP targets should be slow and steady. The Department uses a points scale to illustrate progress in closing the gap between the poorest and the richest regions. According to this, the gap before the 1977/78 allocations was 29 points. A drop of five points was achieved by the allocations for 1977/78 and 1978/79. The gap will be reduced by a further two points, to 22, by the 1979/80 allocations (see p 1). But to achieve regional equity by the mid-1980s, as David Ennals has promised, will require a drop of at least three points with each annual allocation. So clearly some acceleration in the RAWP programme will be needed if Mr Ennals' expectations are to be realised.

No large amounts of extra money will be available for the NHS in the next few years. The present increase is 2 per cent, and no more can be expected in the years up to 1982/83. (And who knows what inflation above the rate allowed for will do to a 2 per cent "real" growth?) Yet the way the money has been allocated this time suggests that the rate of redistribution can only be maintained by increasing the total to be shared out.

Another way of looking at progress on RAWP, besides the points scale, is to see how close each regional health authority is moving towards its RAWP target revenue. The poorer regions are getting nearer their targets. For example, the North Western Region will be less than 9 per cent under its target revenue as a result of the present allocations, compared with 14 per cent in 1976/77. But the Thames RHAs will be getting between 1 per cent and 1.34 per cent extra in 1979/80, with the result that these regions will actually move further away from their RAWP targets. Oxford, which was slightly below its target in 1978/79, will move into a plus position as a result of its 1.75 per cent revenue increase in 1979/80. Within the "well-off" regions the extra money is to be directed towards the deprived areas and the "cinderella" services.

So it looks as though the revolt by the Lambeth, Southwark and Lewisham AHA, and the clamour of the poor areas in the "rich" regions, have paid off. That may not be a bad thing, if the effect is to achieve a general levelling up of provision and some much-needed sub-regional redistribution. But it must be remembered that the poorest regions are now receiving smaller percentage increases than in 1978/79. And it could be argued that by giving the richer regions "an additional margin for growth", the historical imbalances in revenue allocation, which RAWP was intended to remove, will be perpetuated.

If the cushioning for the richer regions is repeated in succeeding years, overall progress with RAWP might thereby be slowed down. Another point that needs watching is whether the extra money going to the "better off" regions actually gets to their deprived areas. Mr Ennals has said that he will require the "clearest justification" for any departure from this programme. But it would be good to know whether he has any plans for monitoring sub-regional allocations, or any sanctions up his sleeve if regions don't seem to be toeing the line.

Health News

No all-clear for Primodos

Hormonal pregnancy tests such as *Primodos* have *not* been cleared of the suspicion that they cause birth defects — despite a review of the evidence by the Committee on the Safety of Medicines, which concluded that *a causal relationship* between the use of HPT and congenital abnormality had not been established. This conclusion was relayed by Roland Moyle to the House of Commons, and subsequently got splashed around in the medical press.

However the DHSS — on behalf of the CSM — has assured *CHC NEWS* that the CSM's warning issued in November 1977 still stands. This told doctors and chemists that an *association* between HPT and birth defects had been confirmed, and advised that HPT should not be used since "alternative methods are available which are free from this risk".

Inner city GPs

Improvements in primary care services in inner cities could be achieved if there were greater incentives for GPs to practise in these areas. Rewards for GPs with higher qualifications, cheaper capital loans for buying or improving surgeries, and permission to continue private practice from health centres are among the recommendations of the Conservative Medical Society's discussion paper *Primary Health Care in the Inner Cities**. The Society also makes proposals aimed at attracting health visitors and district nurses to inner cities and urges GPs to cooperate more with workers such as these.

*Free, from the Publicity Department, Conservative Central Office, 32 Smith Square, London SW1.

The risks of mixing booze and pregnancy

"It doesn't seem to be a good idea to combine drinking and pregnancy". This was the cautionary message which emerged from a meeting of the American Association for the Advancement of Science recently. Studies in Washington, San Diego and Seattle have confirmed a link between drinking and foetal damage which extends into the realm of "social drinking". Women who are alcoholics may produce severely malformed babies, but even in non-alcoholics constant tippling or the occasional "heavy session" can inflict slight behavioural defects — such as sluggishness and lower IQ. Ironically, this effect had to be *re*-discovered in Seattle in 1972 before it began to receive proper attention — French researchers had originally discovered it in 1963, but their report was never translated into English (*New Scientist*, 11 January).

Hospital at home in Peterborough

A three-year pilot scheme has been launched in Peterborough to provide "hospital at home" (HAH) facilities. A charity is providing most of the money, but Cambridgeshire AHA has agreed to include the scheme in future plans if it turns out well. HAH will take about 12 patients at a time. Where the patient's GP is willing *and* where the home is judged suitable *and* where the patient and family opt for HAH rather than hospital, any type of case will be considered, including acutely ill people. The GP will be assisted by a nurse and "patient's aides". Aides will combine the work of a home help and a nursing auxiliary and will be trained and supervised. Consultants and therapists will be called in when needed.

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The steamroller

by Jean Coupe, Secretary, Tunbridge Wells CHC

In August 1977 the proposed closure of the Tunbridge Wells Maternity Home was discussed in private by the Kent Area Health Authority. For us the agenda of this meeting was the first indication that such a closure was being considered. The CHC received copies of the consultation document days before it was made public.

In November, having undertaken a survey, we submitted a response to the AHA. We accepted the transfer of the in-patient beds, but objected to closure of the ante-natal clinic. We also made alternative proposals for the use of the building as a community clinic, which is desperately needed in Tunbridge Wells.

Early last year the CHC discovered, almost by accident, that the in-patient beds had been transferred to a local hospital maternity unit in November. The ante-natal clinic had ceased to operate from December, although no reply had been received from the AHA to the CHC's alternative proposals.

The AHA sent us copies of all the responses to its consultation document which it had received, and in February 1978 it announced that it had decided to dispose of the home forthwith. The AHA did not meet us to consider the responses to consultation until May, despite continuous pressure from the CHC.

At the meeting the AHA announced that it had reversed its decision of February, and presented totally new proposals. These were to retain the home for temporary use by geriatric patients, during the redevelopment of the Kent and Sussex Hospital.

Six weeks later we received draft minutes from the AHA, for agreement. These stated that our chairman, Mrs Meade, had agreed on behalf of the CHC that our main objections to the proposed closure had been answered, that we would not now be producing an alternative scheme, and that we would support the proposed new use of the building. Mrs Meade had stated emphatically that the CHC representatives present had no power to take decisions, and that any new proposals would have to be considered by the full council.

A subsequent AHA meeting was told by the area administrator that the CHC had now withdrawn its objections and accepted the AHA's alternative proposals. The AHA also wrote in similiar vein to various organisations throughout the district. The CHC has objected strongly.

The CHC considered the new AHA proposals in June. We were very much aware that any delay in work to adapt the home could have serious repercussions on the start of the hospital redevelopment. The CHC decided, therefore, that it would accept temporary "decanting" of geriatric patients to the maternity home until the completion of this redevelopment. We reserved the right to consult further with the AHA at an appropriate time.

We firmly believe that the AHA has attempted to steamroller this closure through. In-patient beds were closed within a matter of days of the end of the consultation period, and out-patient facilities were closed within weeks — all before the responses were considered by the AHA. Only when it became apparent that the home was required urgently for an alternative use did the AHA go through the motions of completing consultations with the CHC. Even then scant regard was paid to the position of the CHC, and our views were totally misrepresented.

We feel strongly that there is a need to tighten up the whole closure consultation procedure, with the role of the CHC being strengthened. We have written to the Secretary of State, and the matter is under investigation.

We also submitted our survey of how mothers would travel to the new unit — which showed very poor bus services — to the local authority. Kent County Council has now diverted buses via the hospital. We appear to have more impact with non-NHS authorities, which are perhaps more conversant with democratic processes.

Participation Bolton-style

by June Corner, Secretary, Bolton CHC

Photo: Bolton Evening News

To sound out public opinion by random sample is easier — and cheaper — than is sometimes feared. This was one conclusion of our recent public participation exercise.

Our comments were sought on a long-term hospital plan, which AHA officers presented to our August meeting. We had until November to respond. How to consult the public was in part determined by the turn-out at that first meeting, which was packed. We drew several uncomfortable conclusions.

- **The plan was too complicated for a yes/no vote to be taken, either on the information before the council or which could easily be put to the public.**
- **The plan was immediately and wrongly seen by the public to be about the ambulance service, and to represent a way of moving walk-in casualty services to where it was easiest to build. CHC members were also confused about the issues.**
- **The CHC appeared to be the only body through which the public could be informed as well as consulted.**
- **Whether we liked it or not, the CHC was committed to hold further public meetings, despite the danger that these would attract only those with an axe to grind. Our ordinary monthly meetings were public and the next two would have to be held in bigger premises because of the numbers the debate was attracting. So we booked a hall seating 300, spent £100 on advertising, and arranged a variety of speakers.**

We realised we would also have to use less conventional methods, to interest those who never think about hospitals unless they are ill. We booked the town's comfortably-furnished Medical Institute, and ordered buffet teas for 100, on two evenings of the same week of October.

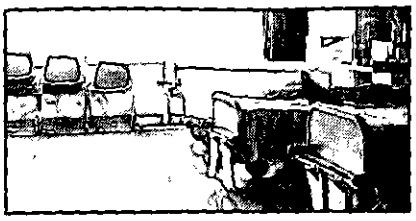
We worked out random routes in every ward of the borough (population 250,000). Then, armed with printed invitations (cost £10), 25 CHC members and friends knocked at every tenth door on these routes. They left personally-written invitation cards only where there was a commitment to come out.

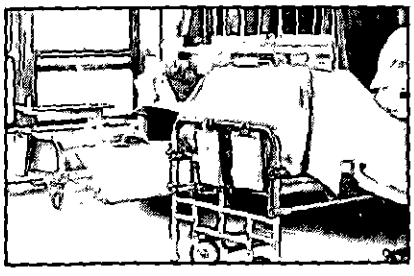
On the Monday 105 people came, and 15 fewer arrived on a very wet Wednesday. They mingled with doctors, officers and CHC members, and read a brief fact-sheet while they drank their tea and munched sausage rolls. They then split into groups, where their discussions of the plan were faithfully recorded by "out-of-town" observers.

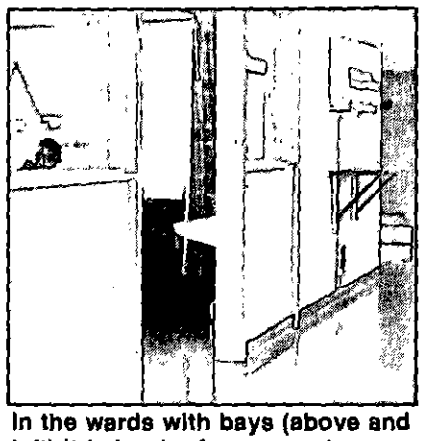
At the end of the evening the "experts" — including the regional medical officer — tried to relate the problems discussed to the plan. On Monday we had too many experts who talked too long — including our own CHC members — but by the Wednesday we had learned some lessons.

In November the plan went through the AHA and the borough council with little qualification, and many congratulations to the CHC. Even those who voted against agreed that the Bolton public could not say it had not been consulted.

The exercise attracted over 400 column inches of writing and two pictures in the local press, several paragraphs in the national press, and radio and TV interviews.







In the wards with bays (above and left) it is harder for nurses to observe patients.

DESIGN MATTERS

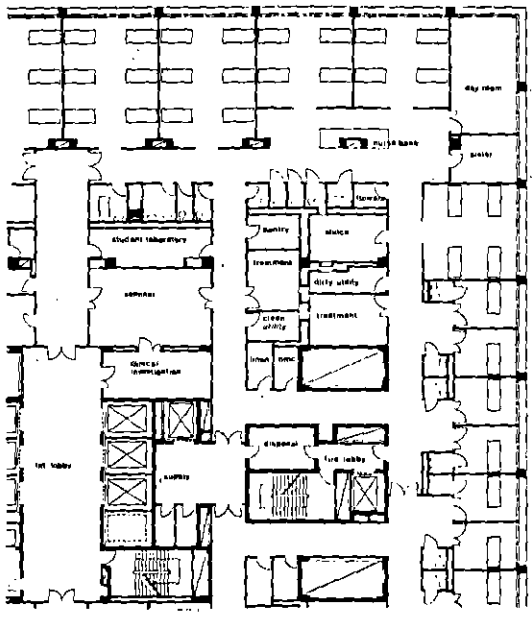
An acute hospital ward is a long, light, high-ceilinged room, with tall windows and rows of beds along each side. There are thousands of wards like this, built on designs set out by Florence Nightingale.

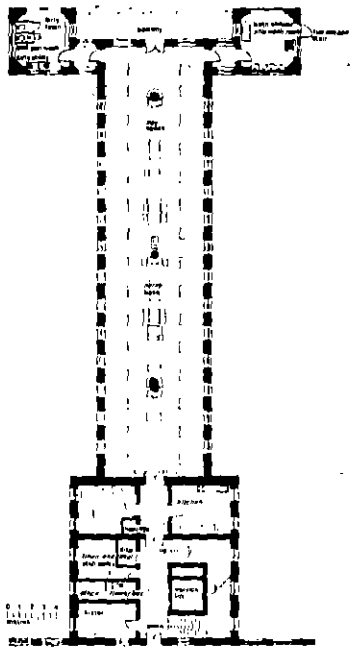
But ward designs have changed, even though the old Nightingale lay-out remains the popular image of what a ward looks like. Clearly ward design affects and is influenced by the type of medicine being carried out, which will determine the kind of nursing required. But the patients' needs also vary, depending on their age, sex, length of stay, and degree of mobility.

In 1955 a report* rejected the Nightingale wards, because patients said they hated them — blaming lack of privacy and dignity as well as disturbance from noise. St Thomas' Hospital, London, contains traditional Nightingale wards as well as wards with four-bed bays, day-rooms and a centrally located nurses' base, built in 1966. The newest wards, opened in 1976, are almost square, with bays around two sides and the rest of the 'square' filled with ancillary rooms (sluice, linen, offices, day-room). They rely on air-conditioning and artificial lighting (see centre diagram).

A unique opportunity arose, with these three different wards all in use within the same hospital, to survey the views of patients, doctors, nurses and others on the distinct types of ward design.

The survey** casts grave doubts on the validity of the criticisms previously levelled at the old-fashioned wards. Patients in these wards were very satisfied and the complaints about the noise were not much greater than in the wards with bays. People liked having plenty going on, and being able to watch and to catch a nurse's eye rather than ring a bell. Nurses had no trouble in observing all their patients, often quite unobtrusively. Although these wards had very few amenities, "it was surprising how well the wards functioned without them".





Photos of St Thomas' Hospital by Medical Architecture Research Unit.

In wards designed with bays, nursing required more effort and energy and the workload was greatly increased. Nurses complained about loss of job satisfaction and staff shortages were felt more acutely. For patients, the noise was still a nuisance and fewer found the ward cheerful and friendly. Fewer lavished praise on the nurses. Many more of the bed-bound complained of boredom — 69 per cent compared with 38 per cent on the old wards.

Clearly these findings cannot be indiscriminately generalised, but they do point to the need for a re-think on ward design and show how important it is for the smooth running of the ward and the quality of care for patients. The sad thing is that once millions of pounds have been spent on new wards, this money cannot be unspent and the design changed.

Patients in the traditional wards liked being able to watch whatever was going on.

Photo: Liz Heron

References

*Studies in the functions and design of hospitals: the report of an investigation by the Nuffield Provincial Hospitals Trust and the University of Bristol (OUP) 1955.

**Ward Evaluation: St Thomas' Hospital, by the Medical Architecture Research Unit, The Polytechnic of North London, N7 8DB (£2.50, inc. post).

CRISIS INTERVENTION IN PSYCHIATRY

*by Dr L. Ratna**

Since 1970 Napsbury Hospital (Barnet, Hertfordshire) has been running a unique programme of community care which enables patients needing psychiatric help to be seen in their own homes within two hours of referral, at any time of the day or night, any day of the week, by a team consisting of a psychiatrist and a community nurse or social worker. The aim of this programme is to provide round the clock treatment for psychiatric patients in their homes.

None of the treatments carried out in psychiatry (with the exception of sleep therapy and leucotomy) requires a hospital, so psychiatry is one of the specialties where treatment can be actively carried out in the home. The concept of the hospital in the home is not new, but Napsbury is alone in having been able to achieve such a programme with existing numbers of staff and the resources available to all mental hospitals.

The pattern of working is that referrals, as far as possible, are made through the patient's GP, who contacts the psychiatrist's secretary, who, after taking basic data and checking past notes, arranges an immediate appointment in the patient's home with the crisis team. The patient is seen wherever possible with his family, so that the family is supported and involved from the very beginning, and resources within the family are actively used in treatment. An important development stemming from this pattern of work is the finding that patients in crisis seen in their own homes are far more susceptible to therapeutic intervention and respond much more quickly to psychotherapy carried out from the very first interview.

Photo: EMI Films Ltd

A scene from the Ken Loach film Family Life (1971)

A recent study (1) shows that as a result of operating the crisis service Napsbury Hospital has been able to reduce its admission rate by 45%. There has been no increase in the suicide rate. In fact, since the crisis service began, there have been fewer overdoses —Napsbury area is the only area in London where overdoses are not on the increase.

The emphasis on community care has been closely associated with intensive work on patients resident within the hospital. As a result of being able to support the patient and his family effectively in the community more patients are being discharged to the follow-up service. Napsbury Hospital has been closing down beds since the inception of the crisis service at the rate of 100 beds a year.

The main effects of the crisis service are:
(1) a reduction in the total admission rate;
(2) a reduction in the admission rate of patients contacting a psychiatric service for the first time;
(3) a reduction in the overdose rate;
(4) a reduction in the chronic resident population within the mental hospital.

The crisis service can be operated within existing staffing norms and the achievements of Napsbury Hospital were brought about despite severe shortages in such basic resources as day hospitals, hostels, Part 3 and half-way homes.

As more and more patients are integrated in the community, Napsbury Hospital has been able to close two-thirds of its admission wards. Napsbury now operates at the level of 0.2 beds/1000 population, well below the DHSS minimum of 0.5. This reduction in bed occupancy represents a saving of a quarter of a million pounds each year.

(1) *The practice of psychiatric crisis intervention* by L Ratna, published by League of Friends, Napsbury Hospital, 1978.

**Dr Ratna is a consultant psychiatrist at Napsbury Hospital.*

Healthline

Babysitting

Is babysitting an allowable expense when on CHC business?

There should be no difficulty. Yorkshire RHA, in correspondence with some CHCs on this matter, said that CHCs come under the same regulations as health authority members. They may be compensated for financial loss within the terms of *NHS (Authorities Travelling Allowances etc) Determination 1973*, as amended.

FPCs and the Ombudsman

My CHC has helped a patient to complain to the Family Practitioner Committee, but she is not satisfied with the outcome. What next, the health Ombudsman?

No. The Ombudsman or Health Service Commissioner has no powers to investigate complaints about family practitioner services. For details of his scope, look at DHSS circular HSC(IS)10 and the leaflet from the Commissioner's office — Church House, Great Smith Street, London SW1P 3BW. If this patient wants to appeal, she must ask the Secretary of State to hold a DHSS tribunal (see Pauline Phillips' account of a tribunal in *CHC NEWS 33, p 9*).

Outpatient travelling

Travelling for outpatient appointments can be very expensive — is there any financial help?

Patients who get supplementary benefit or family income supplement can claim travelling expenses involved in outpatient attendances. Payment will usually be based on the cheapest form of available public transport even when a private car is used. DHSS leaflet H11 gives details of how to claim.

Homoeopathy

Are there any NHS hospitals providing homoeopathic services?

The Royal London Homoeopathic Hospital, Bristol Homoeopathic Hospital and Tunbridge Wells Homoeopathic Hospital provide treatment within the NHS. Homoeopathic services are also available at Mossley Hill Hospital and the Liverpool Clinic, both in Liverpool.

Counting heads

What is the difference between a resident population and a catchment population?

The resident population or the projected resident population is the number of people living or expected to be living in a given area. The catchment population figure would take account of people who might cross administrative boundaries for a particular service — such as a hospital or a school. It is important to know on which type the planners are basing their estimates.

Joint this and that

Is joint funding the same as joint financing?

The terms are often used interchangeably, to mean projects involving health authorities and local authorities using "joint finance" money, allocated by the DHSS to AHAs for this special use. DHSS circular HC(77)17 describes the scope of this cooperation. Strictly speaking joint funding means any scheme *not* using "joint finance" money, in which the AHAs and local government are each bearing a share of the costs. The important difference is that once local authorities have agreed to take part in a joint finance scheme, they do not have the right to withdraw, as the Borough of Wandsworth found recently with an abortion unit.

The School Health Service

Although the school health service (SHS) is now an NHS responsibility, it remains something of an anomaly. In many respects it duplicates the primary and hospital child health services — though one could argue that it thereby provides a valuable safety net. But the SHS also offers the opportunity for children with learning difficulties to have their health needs assessed in an educational setting, and for their progress to be kept under review by people with educational as well as medical skills. So what, in 1979, are the functions of the school health service supposed to be?

Legislation affecting the health of schoolchildren was introduced as far back as 1906/07, on the basis that ill-health should not be allowed to interfere with the learning process (1). The poor physical condition of army recruits led to successive Acts being passed which extended the scope of the school medical service, as it was at first known. The Education Act of 1944 gave local education authorities (LEAs) the duty to provide medical and dental inspection and treatment for children in all types of maintained schools.

From the start the emphasis was on prevention and detection, but so successful was the detection that a considerable treatment element had to be developed. The first school clinic opened in 1908 and before 1948 the school clinic was for many children the only paediatric clinic in their area. The clinics treated all kinds of minor ailments, skin, eye and ear diseases, and even sometimes provided operative treatment for tonsils and adenoids.

Perhaps the most important function of the SHS has always been, and certainly is today, the detection, assessment, placement and surveillance of children with handicaps. It is now generally accepted that wherever possible children "with special educational needs" (the term favoured by the Warnock Committee (2)) should be educated in ordinary schools. Almost all blind, partially sighted and deaf children are taught in special schools, but more children in other educational categories of handicap attend ordinary than special schools. There are also special classes in ordinary schools — for example, for partially hearing children.

Clinic sessions are held for children with problems such as asthma and bedwetting. It is common for members of many disciplines to take part in the assessment and treatment of the school child — including speech therapists, social workers, physiotherapists, chiropodists, audiometricians, orthoptists, psychotherapists, and educational psychologists.

The first child guidance clinic opened in 1932. By 1970 over 400 such clinics had been provided by LEAs, attended by 70,000 maladjusted children. Under the 1944 Education Act "educationally subnormal" children were divided into those who could be educated in the school system and those held to be the responsibility of the local health or hospital authorities. The education and training of all mentally handicapped children passed from the health to the education authorities in 1970, and about 400 special schools were set up from existing provision to cater for them.

The school nurse was and is a central figure in the SHS. Originally she did much of her work in the children's homes, particularly in the socially deprived areas. Today she does most of the vision and hearing tests on schoolchildren, administers periodic questionnaires to parents on the health of their children, assesses the need for selective medical examinations, carries out immunisation programmes, and does routine hygiene inspections. School nurses are usually qualified health visitors. The Court report (3) recommended that school nurses should receive specialised training.

The school doctor may be a local GP or one of the band of clinical medical officers (many of them women working part-time) who work mainly in child health clinics, the school health service and the environmental health service. The clinical medical officers see themselves as specialists lacking a career structure.

Under NHS reorganisation responsibility for the SHS was transferred from LEAs to the DHSS, specifically to AHAs. Services are coordinated by the area specialist in community medicine (child health), with the support of the area dental officer and the area nursing officer. The detailed aspects of the SHS, such as school medical examinations and clinics, are managed at district level by the DMT. Coordination between health and education authorities is theoretically ensured through the joint consultative committees (see HRC (74)5).

Pious hopes about the importance of health education as an arm of the school health service seem to outnumber actual achievements. School nurses have undoubtedly helped to promote healthy practices among the children and parents they see. But, as surveys by CHCs have shown, health education is still usually introduced only incidentally into the school curriculum. Kettering CHC calls it an "orphan" subject, presented as seems most appropriate at the time by religious education, physical education, or biology teachers. Out of 168 schools in the area, the CHC found only 31 which actually used the services of the school health education department. Harrow CHC found that health education was a timetabled subject in only a handful of the schools it surveyed. The main reasons given were shortage of curriculum time, lack of teacher training in health education, and a feeling among staff that the subject was best covered as it arose.

Confusion about the role of the SHS can be well illustrated by the long-running controversy on routine versus selective medical examination of schoolchildren. A circular in 1908 recommended that "needless medical examination of healthy children should, for obvious reasons, be avoided". Regulations in 1946 stipulated that all children should have three medical examinations during their school lives, but later LEAs were allowed to substitute selective examination of children felt to be specially at risk.

The DHSS draft document on preventive health services for children at present being considered proposes a comprehensive medical assessment for each child at school entry, plus regular screening of vision, hearing and growth, and annual health care interviews (to be carried out by the school nurse). Regular meetings between doctors, nurses, teachers and psychologists would, it is thought, obviate the need for further routine examinations.

Kettering CHC, worried by the wide variations in standards and practice in the SHS, believes that there should be a statutory minimum of three medical examinations during a child's school career, and a specified age (perhaps 8 years) for vision and hearing tests. Other shortcomings found by Kettering in its survey include: failure to notify parents of medical examinations or to encourage them to attend; inadequate facilities in schools for carrying out examinations; apathy about the school health service on the part of teachers; poor contact with GPs and faulty record-keeping; and lack of training for school nurses, who seem to carry out more infestation inspections than health examinations.

Given the present confusion and ignorance about the function of the school health service, the patchy provision, and the lack of national standards and monitoring procedures, it is perhaps time to think again about the whole concept of a separate school health service.

Photo: Maria Bartha

(1) *The school health service 1908-1974*, HMSO £1.
(2) *Special educational needs*, Cmnd 7212, HMSO 1978 £5.65.
(3) *Fit for the future*, Cmnd 6684, HMSO 1976 £6.50

No place for children

By Jean Davis, vice-chairman, North Camden CHC.

From time to time there is a revelation of the quality of care for the most vulnerable members of our society which shocks us into action. One such was Maureen Oswin's recent study *Children living in long-stay hospitals* (1). She looked at the lives of 223 mentally handicapped children, many of them spastic, living permanently in special care wards in eight mental handicap hospitals, and her findings were horrifying.

The children in this study were 223 out of 4600 currently in long-stay hospitals — another 1500 mentally handicapped children live in large children's hospitals or in small units attached to geriatric hospitals. Out of the many aspects of their care observed by Maureen Oswin, perhaps the most pitiful was the almost total absence of mothering. She spent long periods in the wards seeing what actually happened in the children's day and found that on average a child could expect to get about an hour's physical attention in 10 hours. This was made up of 12 minutes for breakfast (if the child was a "good" feeder), eleven minutes to dress, ten for lunch, six minutes to change, nine for supper and twelve for bathing. Some children might get extra attention, some cuddling and playing, for about five minutes in the ten hour period. For the rest of the time. the children tended to just sit or lie.

In June of last year North Camden CHC had a meeting at which Maureen Oswin spoke and the council subsequently passed the following resolution:

1 The Government should make it mandatory on each local authority to provide appropriately for the mentally handicapped children from their areas (in total 5,000) who are now in mental handicap hospitals; this should be achieved by 1980 at the latest and such provision should be made within the range of the customary domestic-style facilities for children who are not able to live with their own families.

2 The programmes, which will include foster care and places in ordinary children's homes, as well as in special children's homes, will be met out of a specific grant. In the tiny minority of cases (eg highly disturbed or blind/deaf children) who have specialised needs, we would like to see the development of highly specialised boarding schools on a regional basis.

3 By January 1982 at the very latest, the local authority programme of alternative care having been completed, no child would be living in a mental handicap hospital. The children's wards should then close and no more children would be admitted.

4 As an interim measure local authorities should be required, as from 1 April 1980, to pay the cost of hospital care of mentally handicapped children coming from their own areas. This would be a positive incentive for local authorities to create their own facilities.

5 Distinct from this programme, we assume a continuing development of preventive and supportive services from local authorities for families caring for handicapped children.

This is in line with the campaign being waged by five organisations under the title *Exodus*. But in spite of the official commitment (in the White Paper *Better services for the mentally handicapped* (2)) to the principle that hospital is not the right place for people to live their whole lives, not everyone in the field of health care agrees with the contention that *all* children at present in long-stay hospitals should be brought back into the community. The only argument in our opinion which might carry any weight is that there is a small group of mentally handicapped children and adults with severe physical handicaps who need to live in hospital, because only in hospital can appropriate care be given to them. This is in fact suggested in the White Paper.

This is not a valid reason for keeping children in hospital. We do not accept that the specialised treatment that they may need can only be provided in long-stay hospitals, rather than through local services. In any case — and this is perhaps the most cogent reason — it is not as if the children at present in long-stay hospitals are actually getting the treatment they need. Maureen Oswin's study provides convincing evidence of this. Because all the children she was looking at were physically handicapped, many of them severely spastic, she enquired particularly into arrangements for giving them physiotherapy. Only 75 out of 223 children were having physiotherapy at all. What about other forms of specialised treatment which these children might be supposed to need to live in hospital? Maureen Oswin found that none of the children was having speech therapy, and none was having occupational therapy.

So if the children in this study were not in hospital because they were receiving specialised treatment, what were they there for? The tragic answer in so many cases is that they are there because their families, in the absence of local support and treatment services in the community, could not cope with their care.

This is the key issue. The needs of mentally handicapped children at present in long-stay hospitals have to be met within the context of a comprehensive programme of local services, including residential units for those children who cannot be cared for at home. There must be a firm commitment to the objective of caring for all mentally handicapped and multiply handicapped people in the community. Experience shows that where services are properly provided on a local basis, including short-term "respite" and emergency care, many severely handicapped children who might otherwise be in hospital can be cared for at home (3).

The North Camden CHC has now set up a working group in conjunction with local parents, voluntary organisations and professional workers, to consider existing services for mentally handicapped children and adults within the borough of Camden. Some services in Camden are good already, but the social services department in particular has plans to develop services such as fostering, after-school and holiday care for children in special schools and "respite" care.

There is however a serious lack of residential accommodation for mentally handicapped children and adults in Camden, even though we are fortunate in having nearby such facilities as Allison House, the centre run jointly by Westminster Society for Mentally Handicapped Children with Westminster social services, which will take children living in Camden. We also have Field House, in the neighbouring borough of Islington, which opened this year. This is a model of a small unit providing both long-stay and "respite" care for mentally handicapped children.

Many CHCs are concerned with the development of support services for the families of mentally handicapped children living at home, with the aim of enabling these children to stay with their own families. We have been associated from the outset with the project of a family support unit for all handicapped children in the district.

At the same time the prevention of handicap is an issue of central importance for CHCs. In 1971 1800 children died before the age of one. For every child who dies, two survive handicapped — often severely — giving a total of 3600 damaged children each year. Half of the total number fall into two categories — born too soon and born too small — and these are likely to be spastic, epileptic, autistic, blind, deaf or mentally handicapped. We are urging our area health authority to increase publicity about antenatal care to ensure that pregnant women attend antenatal clinics by 16 weeks. We also want full screening facilities (including amniocentesis) available to all pregnant women at risk. We would also like rubella (german measles) immunisation compulsory for all school girls and women of child bearing age. Because of the epidemic of rubella in 1978 it is likely that as many as 1000 children will be born deaf/blind in the coming year.

Photos: National Society for Mentally Handicapped Children

Meanwhile, in hospital now . . .

Helping mentally handicapped people in hospital is the latest report from the National Development Group for the Mentally Handicapped (NDG) which advises the Secretary of State on national policies*. The report recognises that for many mentally handicapped people, a hospital is an inappropriate place to be, but states that "it is the needs of people now in hospital that are our main concern in this report".

The chapter on children's needs sets out three principles which underline all the Group's recommendations. First, the need for a "substantial improvement in living conditions and staffing ratios on children's wards". Secondly, "rapid implementation" of the policy that local authorities and health authorities should agree on a target date after which no child will be admitted to a mental handicap hospital for long-term care, unless there are very special circumstances. Finally, the needs of each child *now* in hospital should be reviewed immediately and this review "must be conducted in full partnership with local authority staff and with the child's family".

The Group makes over 20 specific recommendations. On the question of stopping inappropriate admissions, it notes that some local authorities have made no provision whatever to accommodate mentally handicapped children as such. It calls for a local level review by all concerned, including joint care planning teams, joint consultative committees, CHCs and local voluntary organisations. This is so urgent, says the NDG, that it should begin now. The Government is urged to consider legislation and a specific financial allocation to ensure adequate community services.

Meanwhile, the manipulation of "paper" staff ratios is attacked by the Group which says that nursing managers tolerate too easily the appallingly low staff levels. As an "absolute minimum", the report calls for one staff to two profoundly or severely handicapped children and one staff to three for the less severely handicapped. Recommendations on good practice call for the children's accommodation to be separate from the rest of the hospital, "considerable independence" for the staff, family groups of not more than six children, and personal clothing, toys and possessions for each child.

**Helping mentally handicapped people in hospital*, published by the DHSS, was issued in November 1978, with DHSS circular HN(78)150.

References

1 Maureen Oswin: Children living in long-stay hospitals (Spastics International Medical Publications 1978).

2 Better services for the mentally handicapped — Cmnd 4683 (HMSO 1971).

3 F S W Brimblecombe: Honeylands — a project for handicapped children (Action magazine, Autumn 1976, National Fund for Research into Crippling Diseases).

Your letters

Continued from page 2

known before the drug was given a product licence by the Committee on Safety of Medicines (CSM) in 1975. However, it is said that the drug provides relief in angina when other products fail, and that patients usually recover from reactions if the drug is withdrawn promptly when symptoms occur. The manufacturer's data sheet draws attention to the possibility of neurological and hepatic adverse reactions, and in July 1977 the CSM issued an Adverse Reaction (yellow warning) notice on Pexid.

It would be helpful to know if any other CHCs have been contacted by patients suffering from adverse reactions to this drug, and what action if any has been taken.

Don't forget the phone book

Melanie Winterbotham, Assistant Secretary, Haringey CHC

We are writing to remind CHCs of the value of at least one entry in each of their local telephone directories. Subscribers can always get one entry free in the alphabetical directory, and one in Yellow Pages. Extra entries or entries in bold type cost only a few pounds a year. Many of our callers have found our number in the phone book, and we also get calls asking for the numbers of other CHCs. This important means of information for the public is well worth pursuing with the GPO, if you have not already done so.

Health education

Irene Watson, Secretary, Hull CHC

I would like to reply to your Comment about health education (*CHC NEWS* 38, page 3). I accept that there are many people who do not contribute to their own well-being by sensible practices, but might I suggest that health educators could equally well direct some propaganda towards physicians themselves.

For example —

Doctors rarely seem to explain to their patients the incompatibility of certain drugs where more than one is prescribed. This also applies to the inadvisability of consuming alcohol during a course of certain drugs. Bronchitic patients do not have explained to them the distress they can suffer by inhaling cold night air when their condition becomes aggravated. While some patients do decline admission to hospital through fear, there are others who have the courage to seek early treatment only to be told that their condition is not serious enough. There are conditions that appear and subside periodically, and if an appointment with a consultant coincides with a subsidence of that condition it is the patient's hard luck (haemorrhoids is one example). The complete disregard with which many hospital staff view non smoking signs is appalling. Medical and nursing staff should insist on these notices being enforced, particularly with visitors.

We were framed!

S. Fitches, Secretary, NW Durham CHC

I was interested to read the letter about the display of NHS spectacle frames by opticians (*CHC NEWS 38*). Our Local Optical Committee has presented each of the four CHCs in the Durham area with a display case containing the range of frames available under the NHS. When enquiries are received from members of the public, we now have the frames on display. Perhaps other Local Optical Committees could do the same?

Bringing psychiatry out of the dark

Dr Harry Jacobs, Chairman, Society of Clinical Psychiatrists, Severalls Hospital, Colchester, Essex

Mental and emotional illness still arouse dark fears among the general public, and dramatisations of mental illness in TV programmes generally do little to dispel such fears.

Public prejudice appears to be less in those parts of the country where psychiatric patients are treated, like people with other types of illness, in the general hospital. The advantages for the patients are that relatives and friends are close at hand. And the scale of such places is much more human — patients are not exposed to a sea of anonymous faces and intimidating corridors and buildings.

Medical and nursing staff in other sections of general hospitals find it helpful to have free contact with the psychiatry department, as this breaks down misunderstanding of mental illness. Medical and gynaecological patients not uncommonly become psychiatrically disturbed when in their own wards. Likewise, psychiatric patients may develop acute illnesses requiring urgent specialised attention. Where all major specialties are within one hospital, all are available round the clock, and information about patients, and ideas and information in general, are much more likely to be passed between departments, to the benefit of all staff and patients.

If all general hospitals had a psychiatric section, this would create better understanding of psychiatric illness and lead to more effective use of resources.

The missing health educators

Miss J. M. Waghorn, Secretary, Association of Area Health Education Officers, c/o Surrey AHA, Health Education Department, Friary Court, 31-37 High Street, Guildford, Surrey

Members of the AAHEO have for some time been concerned that not all AHAs have yet appointed an Area Health Education Officer. I am writing to invite support for these appointments from CHCs in areas where such posts do not yet exist, so that the increasing demand for health education can be met.

Is the RCN a trade union?

R. W. Shankland, Secretary, Sunderland Health Service Branch, National Union of Public Employees, 37 Burdon Crescent, Seaton, Seaham, County Durham

Michael McGeorge (*CHC NEWS 36*) complains that you omitted to mention the Royal College of Nursing in your article on trade unions in the NHS (*CHC NEWS 34*). To set the record straight the RCN is *not* a trade union, despite the fact that it is considering TUC affiliation.

It is also nonsense to claim that NUPE and COHSE represent only nursing auxiliary grades. NUPE represents nurses up to and including nursing officer grade — indeed a nursing officer sits on our National Advisory (Nursing) Committee.

RCN members may be employed in the armed forces, on overseas appointment, in private nursing or in agency nursing. What we in NUPE want is proportional representation *for those nurses working in the NHS* — ie implementation of the McCarthy report on the Whitley Councils.

Reigate's dirty dogs

Joan Martin, 3 High Trees Road, Reigate, Surrey

We have a petition to Parliament under way in Reigate to curb dog fouling in public places, and we are also hoping to cover other towns and cities. Following your article *Dogs and diseases (CHC NEWS 36 page 3)*, could we ask any readers concerned about this problem to contact us?

The right to die

Cllr Nicholas Reed, Member, Guy's CHC

It was good to see that North Camden CHC recently organised a public meeting on the subject of euthanasia and the right to die. Curiously, though, both the chosen speakers were opposed to any legislation on the subject. This is quite contrary to the majority view expressed in both recent national opinion polls, which showed a clear majority in favour of a legal right to die.

Of course the official establishment view should be represented at any such meeting — but so should the popular view. One hopes that in future CHCs will consult the Voluntary Euthanasia Society at 13 Prince of Wales Terrace, London W8, if they have any difficulty in presenting both sides of the argument.

Intolerable chairman

Cllr Mrs C Newell, Member, Guy's CHC

I was interested to read the Healthline item "When can we get rid of our chairman?" in October *CHC NEWS* (p 10). It would seem to me that the advice given indicates two things. First, that the CHC concerned must have an inefficient secretary if a member is not in possession of the Regulations which clearly set out the conditions of membership and election of chairmen. Second, any CHC which is in the unfortunate position complained of, surely would not tolerate for a second the kind of behaviour which would reflect on the council as a whole. If any of my colleagues found it necessary to send you such a query, I would advise them very strongly to look at their own responsibilities in the matter.

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.

FIGHTING WITH FIGURES

Tom Richardson, Secretary of Oxfordshire CHC, describes how a study of AHA accounts can show up shifts in spending.

This article attempts to show that each CHC has within its grasp an effective means of monitoring the progress of every health facility in its area. The method makes use of the AHA's own accounts and involves some simple arithmetic. Its purpose is to identify changes in spending patterns.

The figures all relate to Oxfordshire, a single-district teaching area, with a population of over half a million, of whom about a fifth live in Oxford City. We already have two fairly large teaching hospitals in the city, and a third will be opened this year.

The basis of the method is to compare the amount on a service in, say, 1974/75 with that spent on the same service in, say, 1977/78. Each amount is expressed as a percentage of the total revenue spendings in the particular year, thereby illustrating the relative movements of money into or out of a service.

The first page of our AHA's Annual Accounts gives a picture of spending, under very broad headings, for the previous financial year. *Table 1* (right) compares the amounts spent on all hospital and community health services by extracting figures under the headings given. Percentages have been taken to one decimal place.

The figures used in this article have all been taken from the AHA Annual Accounts and Cost Accounts, and only the NHS headings and definitions are used. As a result, the cost of "Administration" as shown (right) is far lower than the real figure, since items such as medical records have been excluded, and the full cost of such things as nursing administration are not easily discoverable, so they have not been taken into account.

From *Table 1* it appears that there has been a gradual and continuing shift of money away from community health services into hospitals, which consumed 65.7% of revenue in 1977 as against 64.9% in 1974. Comparisons in cash terms are of course misleading unless adjustments are made to take account of inflation. But to give some idea of the cash sums involved, this percentage change represents a movement of an additional £456,000 (in 1977 terms) into hospitals in 1977 compared with 1974 (and similarly a movement out of community services of £149,000).

Within the large budgets for hospital and community services there have been shifts in expenditure on items such as nursing and administration. *Tables 2* and *3* compare the amounts spent on these items as percentages of the total budget for hospital and community services (sums have been rounded to the nearest £1,000). The variations in spending shown in column 5 are the cash equivalents of the percentage difference in spending between 1974/75 and 1977/78. These have been calculated as percentages of the total spending on hospital and community services respectively.

Thus the amount spent on nursing dropped considerably in 1977/78. At a time when Oxfordshire's share of NHS revenue is declining, it may be that the management of the nursing budget is the largest single factor under the control of local management. The AHA can "save" money by cutting back on nursing; this "saving" was worth about £½ million in 1977/78.

The reverse trend is shown when the costs under the headings of "Administration" are analysed. I recognise that administration is a favourite target, but this should not stop us asking questions about it. Perhaps after the first difficult years of reorganisation the figures will settle down.

From the two books of Annual Accounts and the Cost Accounts, together with the monthly review of sector spending, it appears that all parts of the NHS in Oxfordshire are capable of keeping more or less within their budgets, except for the teaching hospitals.

In unadjusted cash terms, hospital expenditure in Oxford rose by 65.4% between 1974/75 and 1977/78, while the rise in the cost of all services was 63.4% (although in real terms NHS spending in Oxford actually fell). It seems likely that the teaching hospitals absorbed the bulk of this increase, rather than the community, general or psychiatric hospitals. The spending on community health services presents the opposite trend, with a rise of only 56.9%. Considerable variations occur within this heading — for example, the cost of the chiropody service rose by 38% in the period and community nursing by 50%. (It is perhaps of interest to note that pharmaceutical costs under the FPC rose by 75% in the same time.) These figures give cause for concern. It could be argued that covert cuts have been made in community health services in Oxfordshire.

Differential rates of increase in the cost of living might be said to cast some doubt over this broadly based method. But little difference in the general trends is shown when the Retail Price Index is taken into account. If 1974 is taken as 100, then the Index for 1977 is 167.7. Table 4 gives some examples of quoting 1977 in 1974 prices. Column 3 of this Table should be compared with column 5 in Tables 2 and 3. (I am grateful to David Taylor, Office of Health Economics, for help with these figures.)

This way of analysing NHS expenditure may be a useful tool for CHCs. It is particularly effective in monitoring the provision of services under broad heads, or when examining what is happening to family planning, or chiropody or drugs bills — or whatever concerns an individual CHC. Reductions in spending may be necessary, but let us at least make sure that the decisions are conscious ones, based on a knowledge of the facts, and not brought about by hidden internal pressures.

Table 1

	1974/75 Amount	1974/75 % of total	1977/78 Amount	1977/78 % of total
Hospitals	£22,171,138	64.9%	£36,671,079	65.7%
Community health	£2,294,909	6.7%	£3,600,109	6.5%
Total area expenditure (including FPC)	£34,155,513	100%	£55,792,610	100%

SPENDING ON NURSING

Table 2

	1974/75 Amount	1974/75 % of sector total	1977/78 Amount	1977/78 % of sector total	Variation between 1974/75 and 1977/78 Amount*
Hospital	£6,851,000	30.9%	£10,915,000	29.7%	−£416,000
Community	£1,256,000	54.7%	£1,889,000	52.5%	− £81,000

SPENDING ON ADMINISTRATION

Table 3

	1974/75 Amount	1974/75 % of sector total	1977/78 Amount	1977/78 % of sector total	Variation between 1974/75 and 1977/78 Amount*
Hospital	£1,460,000	6.6%	£2,744,000	7.5%	+£331,000
Community	£312,000	13.6%	557,000	15.5%	+£67,000

*In 1977/78 terms

ADJUSTED FIGURES

Table 4

	1974/75	1977/78 (in 1974/75 terms)	Variation between 1974/75 and 1977/78
Hospital nursing	£6,851,000	£6,509,000	−£342,000
Community nursing	£1,256,000	£1,126,000	−£130,000
Hospital administration	£1,460,000	£1,636,000	+£176,000
Community administration	£312,000	£332,000	+ £20,000

What happens in a health centre?

by Nick Harris, Secretary of Manchester Central CHC

In all the debate about health centres it is important to remember that many members of the public have only a very vague idea of the range of services extended by a health centre and little or no actual experience of one. Healthlink Manchester Central CHC, in accordance with its general policy of community involvement, is committed to organising public meetings prior to, or shortly after, the opening of all the new health centres that are currently being built

Photos: Liz Heron

in the central district.

In October 1977 a public meeting was held in Longsight, where the health centre has now been open for over a year. This was followed by a meeting on patients' committees, and in September last year the CHC organised a public meeting to talk about the Levenshulme heath centre, which will be opened this autumn. Before the meeting council members and staff, helped by volunteers, leafletted 8000 houses in Levenshulme ward and parts of Rusholme ward (a health centre is also being built in Rusholme, and we shall be organising a separate meeting on this). This leafletting was coupled with door-step canvassing in a number of areas. Local organisations, schools, clinics, Inner Cities meetings and so on were also informed about the meeting. In the event, over 90 local people came, together with a representative of the Family Practitioner Committee and CHC members.

The meeting was told about the services that would be provided at the health centre. There will be: GPs, a district nurse, a social worker and health visitors; community chiropody and dental care for priority groups (mainly those over 65); ante-natal, baby and child health, and family planning clinics; welfare foods; school medical services; physiotherapy and dietician sessions; and a cleansing unit.

A large number of points were raised by members of the public at the meeting, many of which the CHC was able to answer on the spot. People asked, for example, whether they could use the health centre for clinic sessions even if their own GP didn't practise there, and about home and emergency treatment, optician and pharmacist services, X-ray facilities, access for the disabled, and play provision for children. The meeting expressed almost unanimous opposition to an appointments system for GPs at the health centre, and the CHC asked the FPC to convey this feeling to the doctors. However, since the majority of people at the meeting were elderly, the CHC has also suggested that GPs carry out a survey to get views from a wider cross-section of the public.

As a result of points raised at the meeting, the CHC has decided to press for further action on: the extension of community chiropody, dietician and psychiatry services, the development of well women clinics, and publication by the DMT of information for patients in Asian languages.

A full report of the Levenshulme meeting has been sent to all those who attended, and 2000 copies of a short summary are being distributed in Levenshulme and Longsight wards. Also, a follow-up meeting is being held at the Longsight health centre to which both the Longsight residents who went to the original public meeting there, as well as those who came to the Levenshulme meeting, have been invited. We hope that this will give a chance for the Longsight residents to voice their views on the health centre after one year of operation, and for those from Levenshulme to gain an idea from patients as to how a health centre actually works. And both groups will be able to talk with the people involved in running the health centres.

The CHC is very concerned about the low level of public awareness on developments in health care provision in the district. We

feel strongly that local residents should be consulted before a health centre is decided on, and then kept informed of progress. We will continue with our policy of holding public meetings on new health centres. Next time we intend to alter our approach slightly, perhaps holding the meeting in a school building and canvassing a wider range of organisations in the area in order to get a better balance of age-groups. We are also thinking that the DMT (or perhaps the CHC) should produce an information leaflet on community health services.

Parliament

Congenital rubella epidemic

The number of infants born with congenital rubella in the winter of 1978/79 could possibly rise to 1500-2000, compared with an estimated normal annual figure of 400. Rubella vaccination was first introduced for girls between 11 and 13 in 1970, and became available for all susceptible women of childbearing age in 1976. There is evidence that the number of women of childbearing age susceptible to rubella has already fallen. But a "considerable campaign", designed to eliminate congenital rubella, is being launched. The effort will not necessarily all be directed at the vaccination of adult women, and the desirability of a national advertising campaign has not been accepted (Lewis Carter-Jones MP, Eccles, 7 November).

Eye damage to babies

The number of newly born babies suffering from retrolental fibroplasia — damage caused by lack of control over oxygen levels in intensive care units — is not known. The degree of visual defect is variable and the defect does not become identifiable at any particular stage. In the year ending 31 March 1976 about 14 children under 5 in England are thought to have been registered as blind or partially sighted as a result of this condition, but the figure may be an underestimate (Max Madden MP, Sowerby, 11 December).

Age of hospitals

A 1972 hospital maintenance survey indicated that perhaps almost a quarter of hospital floor space had been provided since 1948. The figure for psychiatric hospitals was one-sixth, and for acute and general units with more than 200 beds, one-third (Bryan Gould MP, Southampton Test, 14 December).

Private homes for the elderly

The statutory provisions for the registration and inspection of private and voluntary homes for the elderly are being reviewed. Consultations on proposals to amend them are expected this year (Stephen Ross MP, Isle of Wight, 5 December).

Joint financing

The original guidelines for joint financing have been extended to encompass the funding of agreed projects in primary health care, as well as social services projects as

CHCs can make the headlines!

by Leo Long, Member, Haringey CHC

The following views are based on a year's experience as convenor of our Publicity Working Party. I do not think we have done particularly well in Haringey, indeed I lack the broader perspective to compare us with other CHCs. What I do know is that increasing public awareness of CHCs is slow, uphill work. A small sample survey in April 1976 showed that only one in every ten local people had even heard of Haringey CHC.

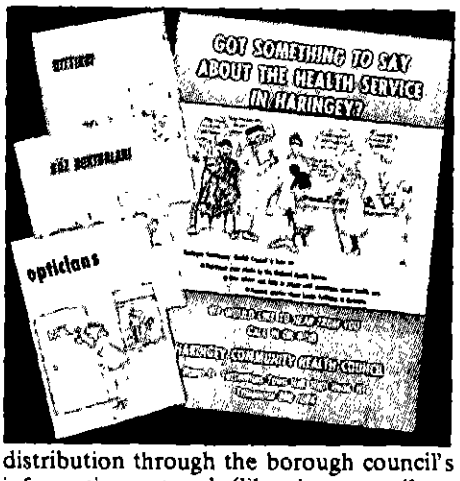
The process starts internally, with keeping thirty or so members abreast of the many activities of a CHC. Members find it hard enough to keep up with their own special interests, yet must vote on a variety of issues on which they cannot possibly have read all the relevant papers. *Priority One* was therefore a newsletter, aimed primarily at members.

Theoretically this should have just involved editing contributions from each working party. In practice it doesn't work like that, because hard-pressed convenors are not good at keeping to deadlines. We only really got off the ground when the newsletter became a routine chore for the office staff (also hard-pressed!).

Although the newsletter is primarily for members, we always had in mind a wider informed audience, which could read as it were over our shoulders — NHS and social services staff, the press, and those of the general public interested enough to ask for information.

The newsletter now comes out every two months, and roughly 400 copies are distributed. Each edition highlights particularly important current topics and also gives reminders of important dates coming up. We have a stock of paper pre-printed with our letter-head, and we photocopy a master typed on an electric "golfball" machine.

Also with the public in mind we have prepared two posters: one general-purpose, promoting the role of the CHC, and the second a "framework" which can be overprinted with notices of "issue" meetings, special campaign items etc. These posters are intended primarily for



distribution through the borough council's information network (libraries, council notice-boards, etc).

Our second objective we saw as informing the public of what was available from the NHS, and how to get it. With the help of Job Creation staff from the Council for Voluntary Service, leaflets were produced dealing with general practitioner, dental and optical services in the Tottenham area. There was some murmuring from professional circles about over-simplification, but we felt that this was a fault on the right side. In any case we were meeting a need which should have been met by the NHS itself. The next step will be to extend coverage to other areas of the borough, and provide translated versions for ethnic groups.

By adding new information leaflets we aim eventually to have, together with posters and general leaflets, an easily assembled display kit for which we should find as many permanent sites as possible (libraries, community centres, housing estates etc). We still have some way to go, as was evident at the last Haringey Show, when we had to supplement our display with much health education material. We have produced some effective leaflets and posters, quickly and cheaply, but we could do more to get shopkeepers and others to display such material locally.

The original Publicity Working Party was a prime mover in pressing for our "issue" meetings to be held at different places around the borough, away from the civic centre. We have now dispensed with a Publicity Working Party as such, and replaced it by meetings of all working party convenors, under the chairmanship of one person skilled in lay-out and with knowledge of print resources, usually timed to begin half an hour before the business meetings of the CHC.

An area where in my view we have been lacking is that of proper budgeting. The one-time working party was faced with a budget fixed by hit-and-miss methods, and had to cut its cloth accordingly. What we need to do before the next budget is submitted is to assess our commitments and make a bid accordingly. We shan't get all we ask for, but at least we shall have a basis for deciding where we must cut back.

Final thoughts: a newsletter is essential, and the main burden of this and other publications will inevitably fall on the office (worth bearing in mind if you have to appoint a new secretary or assistant). You may be lucky in finding a member with skills in lay-out or writing. Never, but never, allow a committee to draft a leaflet — milk their ideas and then let one person retire into creative seclusion.

originally intended (Laurie Pavitt MP, Brent South, 7 December).

Regional obstetric and neonatal units

The DHSS strongly recommends that mothers at risk of having a baby who will require intensive care should be delivered at a hospital providing such care. Every combined special child intensive care unit for the new born in England is associated with a specialist maternity department, where beds are available for mothers before and after delivery. Where a baby is transferred to a combined unit the mother should if she wishes receive her postnatal care in the same hospital to which the baby has been transferred (Nicholas Winterton MP, Macclesfield, 14 December).

CHCs and FPCs

FPCs are not to be made subject to a time limit by which they should comply with the Secretary of State's request that they should invite observers from CHCs to the non-confidential part of their meetings. The hope is that progress can be made on a voluntary basis, though the Department's view is that in the end it must be ensured that CHC observers are allowed in (Laurie Pavitt MP, Brent South, 7 November).

NDT strengthened

The National Development Team for the Mentally Handicapped is to be strengthened in several ways. The team will in future visit at the Secretary of State's request as well as by invitation. It will follow up all its visits, as a matter of routine, with the authorities concerned. The Team's operations in relation to social services will be strengthened. Arrangements will be made for reports to be issued more quickly, and the possibility will be discussed of giving a wider circulation than at present to the Team's reports on its visits (Eric Moonman MP, Basildon, 20 November).

Fluoridation

The DHSS can give no assurances that AHAs will not introduce fluoride into the authority areas which have voted to reject fluoridation. The decision to fluoridate water supply of those local AHAs as part of their statutory responsibilities for preventive health in their areas. Such decisions are taken after consultation with local authorities and others and consideration of the evidence on the safety and efficacy of fluoridation. A study of the evidence offered in the recent case in Pittsburgh, Pennsylvania, alleging a link between water fluoridation and cancer, has not caused the DHSS to change their view that such allegations are groundless (Rev Robert Bradford MP, Belfast South, 13 December; Andrew Bowden MP, Brighton, Kemptown, 14 December).

Scanner

NALGO and NUPE

Are both trade unions whose members work in health and personal social services. NALGO (local government officers) has analysed public spending in Wales, as an example of a depressed region, and NUPE (public employees) has examined health care spending in London. Both demonstrate the effects of the cuts in public spending. *Public expenditure*, free, from NALGO, 1 Mabledon Place, London WC1H 9AJ (01-388 2366). *Under the axe*, 30p from NUPE, Civic House, Aberdeen Terrace, London SE3 0QY.

How to get what you pay for

Child Poverty Action Group have published an up to date 80-page edition of their *Guide to contributory benefits and child benefit: rights guide no. 3.* 70p from CPAG, 1 Macklin Street, London WC2B 5NH.

1979: Year of the child

Projects being promoted by the United Kingdom Association of the Year of the Child include a children's legal centre and activities by and for children. The Association will encourage people to look at local facilities, such as shops, clinics, libraries, public lavatories, to see if they are designed and run with children's needs in mind. The hospital practice of separating new-born babies from their mothers is highlighted as an item due for change. IYC, 85 Whitehall, London SW1.

Notes on good practice

Is the title of a series of leaflets for NHS managers. Topics include admissions policy, mobile chiropody clinics, out-patient appointment systems, bed "pooling", home laundry services. The series aims to describe, briefly and simply, examples of good procedures and to encourage managers to learn from them. Details of other topics from Editor, *Notes on Good Practice*, Central Management Services (NHS), DHSS, Reyrolle's Building, Prince Consort Road, Hebburn, Tyne and Wear NE31 1XB.

Vaccine damage payments: HN(79)7

People wanting to claim lump sum compensation for vaccine damage to their children or themselves, can get an information leaflet and claim form from Vaccine Damage Payments Unit, DHSS, North Fylde Central Offices, Norcross, Blackpool FY5 3TA.

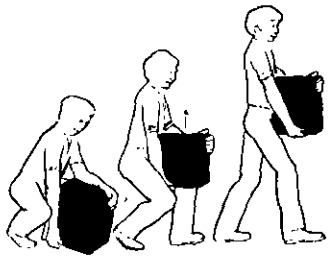
Newly blind people

The Royal National Institute for the Blind has compiled details of services available to people who are losing their sight, to help them go on leading active lives. *Services for newly blind people*, free, from RNIB, 224 Great Portland Street, London W1N 6AA (01-388 1266).

RAWP research

Research being done on resource allocation in the NHS has been indexed by the National Association of Health Authorities. *RAWP index of research* (£1 plus postage) from NAHA, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT.

Back pain



***Talkback** is the newsletter of the Back Pain Association*. Each year 13 million working days are lost in Britain as a result of back pain. And a report to Mr Ennals by a DHSS Working Group on Back Pain calls for more research into "unorthodox treatments" for such pain. The report is due to be published this month.*
**Back Pain Association, Grundy House, Somerset Road, Teddington, Middlesex TW11 8TD (01-977 1171).*

Ileostomy

The Ileostomy Association is a charity which aims to help people who are about to have or have just had an ileostomy operation, to resume a full life as soon as possible. It has many local branches and a quarterly journal. Details from 23 Winchester Road, Basingstoke, Hants, RG21 1UE (Basingstoke 21288).

New editions of two rights handbooks

Child Poverty Action Group has published the eighth edition of its *National Welfare Benefits Handbook*, 90p inc post from 1 Macklin Street, London WC2. Age Concern has updated *Your rights for pensioners*, 45p inc post from PHM Mailing Ltd, PO Box 81, High Wycombe, Bucks HP11 2PX.

Transports of delight

CHCs concerned about transport problems should find the Department of Transport's *Guide to community transport* (HMSO £1.95) a useful work of reference. In 60 pages it explains in detail how to run a community bus service, organise a social car scheme, make better use of existing services (eg GPO and school buses), and how to carry out a transport survey.

Transport Act 1978: HC(78)44

Draws attention to Department of Transport circular 9/78 (Welsh Office 105/78) which aims to enable flexible solutions to rural transport problems. It sets out new regulations for community buses, car-sharing and "social car schemes", *The transport act 1978: bus licensing*, HMSO, 60p.

Looking after teeth

Information presented to the public by dental health educators is unnecessarily complicated, frequently contradictory and sometimes wrong. A policy document issued by the Health Education Council reviews the causes of dental disease and the most effective methods of prevention. *The scientific basis of dental health education*, free from HEC, 78 New Oxford Street, London WC1A 1AH.

Avoiding pregnancy — twice

A booklet about contraception for young people with literacy problems has been published by Brook Advisory Centres. *A look at safe sex*, single copies free, from Brook Advisory Centres Education Unit, 10 Albert Street, Birmingham B4

Book reviews

Our bodies ourselves

Boston women's health collective – British edition by Angela Phillips and Jill Rakusen, Penguin £3.50

No-one expects that each of us should have a comprehensive knowledge of illness but the general level of ignorance about our bodies in *health* is devastating and this book will go a long way to helping more than half our population find out about being "well-women". Written by women who are also feminists and part of the "movement" for women's liberation, the book aims to help women have more control over our own lives by learning about our own bodies and thus ourselves. It covers not only the usual "gynae" topics such as menstruation, contraception, pregnancy, childbirth, but also discusses issues such as sexuality, relationships and our feelings. One hopes that men will write a book as useful and accessible as this about their bodies, themselves.

Medical hubris

by David Horrobin, Churchill Livingstone, £3

Few people who have read Ivan Illich's book *Limits to medicine* (an earlier version of which was called *Medical nemesis*) have been unimpressed. Illich's vision is of a society organised as a gigantic clinic, with all of us as "limp and mystified voyeurs", clamouring for medical solutions to all our problems, however ineffective or inappropriate.

Even so the book is unsatisfactory — its nuggets of truth are awash in a sea of rhetoric, overstatement and awkward sentence construction. David

7UD (021-643 1554). And contraception is the subject of the latest Family Doctor booklet, published by the BMA. *Contraception: choice – not chance* by Barbara Law (45p inc post) from BMA House, Tavistock Square, London WC1H 9JP.

CHCs score seven per cent

Only 7% of people can tell you what organisation is supposed to represent their views in the NHS — though when shown a list of consumer organisations 49% realise that they have heard of CHCs. These findings come from a national opinion poll carried out for *Clapham Omnibus*, a new quarterly magazine published by the National Consumer Council. The best-informed people tend to be male, middle-class and middle-aged, and "there seems to remain a conviction that the supplier represents the consumer interest". *Clapham Omnibus* aims to provide a "platform for free expression of views" within the consumer movement, and is for free circulation to members of consumer organisations. It can be contacted at 18 Queen Anne's Gate, London SW1. Tel: 01-930 5752.

Rights and drugs

A guide to psychotropic (ie mood-altering) drugs and a handbook explaining patients' rights in psychiatric hospitals and units have been published by MIND. *Mental health and medication*, compiled by a psychiatric social worker, costs 60p including postage, and *Patients rights handbook* costs 70p. Both available from MIND at 22 Harley Street, London W1..

An excellent 16mm colour film on the work of the Employment Medical Advisory Service has been produced for the Health and Safety Executive. In 30 minutes it shows how EMAS doctors and nurses investigate and help improve people's working conditions – in surroundings as varied as a steel plant, a distillery and a sheep farm. In the above still from the film, an EMAS nurse (right) discusses health problems on the shop floor of an electronics factory. ***Health at work*** *can be hired for £6 plus VAT for a single day, and subsequent days cost 50p plus VAT. Contact The Central Film Library, Government Building, Bromyard Avenue, London W3, quoting catalogue no. UK3397.*

Mentally handicapped children

There is a new address for the National Society for Mentally Handicapped Children — 117-123 Golden Lane, London EC1Y 0RT (01-253 9433).

"I'd forgotten how marvellous strawberries tasted"

The Health Education Council has issued a free anti-smoking booklet, to back up the TV commercials it broadcast earlier this year. It explains how your health, love-life, children, appearance, sense of taste and standard of living could all benefit. Copies from HEC, 78 New Oxford St., London WC1.

RAWP advisory group: HN(78)153

Announces a new working group of NHS and DHSS officers, to consider the proposals of the Resource Allocation Working Party and suggest improvements. The group will be advised by clinicians, economists and people "with special knowledge of particular issues under consideration".

Sterile supplies: HC(78)43

Announces Mr Ennals' decision on the report of the Steering Committee on Standardisation of Supplies from Central Sterile Supply Departments (the Cunliffe committee). Reservations on two of Cunliffe's 25 recommendations will be reviewed by the DHSS, or by the proposed Supply Council if one is created. Meanwhile, health authorities wishing to set up or expand a CSSD should consult the DHSS.

Losing your benefit

If you go into hospital what happens to your social security benefit or pension? (DHSS leaflet N19). This explains why, how and when a wide range of benefits and pensions may be reduced when the recipient, or a dependant, goes into hospital.

Directory of CHCs: changes

An updated version of the Directory of CHCs came out in October, and each CHC was sent a copy. Further single copies are available free from the *CHC NEWS* office — please send a large stamped addressed envelope (9½p). Changes will continue to be published monthly in *CHC NEWS*. Please notify us of any alterations in address, telephone number, chairman or secretary.

Page 2: York CHC Chairman: Mr H Creaser
Page 3: Airedale CHC Chairman: Mr G R Vere
Page 13: Kettering CHC Chairman: Mrs A Perkins
Page 15: East Birmingham CHC Chairman: Rev R Bashford
Page 17: Central Southern Liverpool CHC 57-59 Whitechapel, Liverpool L1 6DX. Tel: 051 236 1176

Horrobin's "reply to Ivan Illich", *Medical hubris*, may be a useful tool for thinking about the strengths and weaknesses of Illich's view of the world.

Hubris is the Greek word for the pride which comes before a fall — the fall being *nemesis*. Dr Horrobin argues that he and his colleagues need more *hubris* not less — they need "a knowing involvement in decisions which will affect the stucture of society".

His criticisms of factual errors in Illich's book, and of his misleading use of technical language, seem valid. His point that most of the evidence Illich quotes was first published in the "establishment" journals of the medical profession shows how wrong it is to think of doctors as if they were all the same.

But Horrobin can only deal with many of Illich's criticisms by agreeing with them, which clearly shows the importance of Illich's contribution.

Books received

Epilepsy '78 compiled by the British Epilepsy Association (£2.50 plus 50p post from BEA, Crowthorne House, New Wokingham, Berks RG11 3AY).

Economics and health planning edited by Kenneth Lee (Croom Helm £9.95).

Medicine, health and justice: *the problem of priorities* by Alistair V Campbell (Churchill Livingstone £2.95).

An ageing population edited by Vida Carver and Penny Liddiard (Hodder in association with The Open University Press £3.25 paperback).

Medical care of the elderly by Hall, McLennan and Lye (HM + M publishers £4.50).

The social audit pollution handbook by Maurice Frankel (Macmillan — paperback £3.95).

Innovations in patient care edited by David Towell and Clive Harries (Croom Helm £8.95).

Manual of primary care by Peter Pritchard (OUP £3.95).

Trends in general practice 1977 — a collection of essays by members of the Royal College of General Practitioners (British Medical Journal £4.50).

Answers to suicide by the Samaritans (Constable £2.95).

News from CHCs

☐ **Northumberland CHC** has persuaded its RHA not to transfer the regional spinal injuries unit from Hexham to Newcastle. Instead the existing unit will be upgraded and almost doubled in size. The CHC has been concerned about the future of the unit since 1974, and sees the avoidance of a "move for the sake of it" as a major success. Because of the impending move Northumberland AHA had been reluctant to agree to improvements, but a CHC report presented at a meeting of the authority won AHA support. Support from the **Northern Region Association of CHCs** was also crucial.

☐ A letter from a worried mother led **Frenchay CHC** to uncover plans to run down and close Wendover Maternity Hospital, which provides obstetric services for the Frenchay district but is managed by neighbouring Southmead. Investigations revealed that GPs had been discouraged from referring mothers to Wendover, and staff had been advised to seek other jobs. A document prepared by the Southmead DMT, reviewing its maternity services, was unearthed and found to contain the proposal: "That to end anxiety and uncertainty in the staff the firm date of 31 March 1979 be approved as from when Wendover Maternity Hospital shall cease to be used for maternity purposes". Copies had been sent to Frenchay DMT and **Southmead CHC**, but not to Frenchay CHC. In September the hospital closed for deliveries because of staff shortages, but thanks to pressure from Frenchay CHC, parents, GPs, health visitors and midwives it was re-staffed and reopened in November. Frenchay would like to see Wendover transferred to its own DMT, which agrees it should stay open. So far there has been no formal consultation from the AHA about possible closure.

☐ **SW Leicestershire** and **NW Leicestershire CHCs** have told the Severn Trent Water Authority that they are opposed to fluoridation, following a resounding No from the public in local consultation exercises. The SW CHC had ballot papers printed in local papers, and received 28 votes for and over 1500 against. In the NW CHC's postal ballot the score was three votes for and over 500 against, and the CHC also held three public meetings which all rejected the idea. SW secretary Brian Marshall commented: "This is a triumph for CHCs. It's now up to the AHA to recognise that they are only the managers of a service in which the public are the share-holders". **East Leicestershire CHC** supports fluoridation, and has found that a majority of parish councils in its district agree with this.

☐ **Medway CHC** is applying to the Manpower Services Commission for staff to investigate the employment needs of local disabled people. The MSC has told the CHC that it cannot consider projects which would employ less than three people, so the CHC is now applying for three project staff instead of one.

☐ **Dewsbury CHC** has produced a leaflet on how hit-and-run road victims can claim compensation for personal injury (see *CHC NEWS 34 page 2*), and has distributed this through hospitals, clinics, libraries and shops in the district.

☐ **Tunbridge Wells CHC** has surveyed the funding of CHCs in the four Thames regions. Responses from 45 of the 61 Thames CHCs show an average budget of £6613 (excluding salaries) and a range from £2305 to £14,100. Regional averages were £3725 (SE), £8064 (SW), £7125 (NE) and £7695 (NW). On average the budgets of the 19 CHCs in non-NHS premises were 29% higher than the rest.

☐ A resolution calling for the gradual elimination of lead from petrol, backed by eight CHCs, has been passed by the **ACHCEW** Standing Committee. The association will be taking the matter up with the DHSS.

☐ *Members and supporters of Islington CHC demonstrate outside a meeting of the Camden and Islington AHA, about the "appalling physical state" of the maternity department at the Whittington Hospital. The AHA has since found £53,000 for minor improvements, furniture and fittings.*

Photo: Hampstead and Highgate Express

☐ David Ennals has agreed with Wirral AHA that its two districts should be merged. No date has been set for the merger, and so far no decision has been taken about the future of the two CHCs. **Wirral Northern** and **Wirral Southern CHCs** are agreed that they should remain separate at least until 1982/3, when a spate of local closure proposals will have been dealt with and the new DGH at will be "run in". The Southern CHC feels that even after this separate CHCs may still be desirable.

☐ The West Midlands RHA is setting up a committee on information services, library services and survey research for its CHCs. This will provide support in these fields, and will vet CHC applications for research funds. The committee will consist of an RHA member in the chair, six CHC representatives, two "research experts" and two non-voting RHA officers. In 1978/79 the RHA allocated £380,000 for CHC spending, but retained £25,000 of this as a "contingency reserve" to cover non-recurring costs. £8000 of this was earmarked for CHC research projects. David Johnson, secretary of the **West Midlands Regional Association of CHCs**, commented: "We shall have to suck it and see"

☐ Unrestricted visiting of children in hospital is now the rule in the **Hastings** health district, thanks to pressure from the CHC. The council has also persuaded its FPC to send a poster showing the full range of NHS spectacle frames to all local opticians, for display.

☐ The North Western RHA has been criticised by **Stockport CHC** for attempting to "pre-empt and undermine" the NHS planning cycle. The problem arose when Stockport AHA revealed that "region have asked to be informed of any capital proposals in advance of the submission of these proposals through finalised service plans". Replying to the CHC's formal objection, the RHA explained that its aim was to assist officers preparing its capital programme, and gave an assurance that "lists of schemes submitted will not be approved by the RHA out of context of the overall developments outlined in the strategic and operational plans". The CHC nevertheless concludes that "there is still progress to be made in harnessing service and capital planning within the RHA".

☐ Secretaries of the four CHCs in the Hereford and Worcester health area need no longer resort to "crawling across the floor" to advise their chairmen during AHA meetings. The AHA has agreed to a suggestion from **Kidderminster CHC** that secretaries should be allowed to speak at the invitation of the AHA chairman.

☐ A survey organised by **Sutton and West Merton CHC** has shown "deep concern" amongst local GPs about provision for geriatric and elderly mentally ill patients. Out of 92 GPs, 74 said more places were needed in units for the elderly mentally ill, and 68 thought more sheltered accommodation should be provided in the community. The CHC has also published a leaflet on *How to choose your doctor*.