CHC NEWS

For Community Health Councils

April 1979 No 41

THE STATE OF PRIMARY CARE

This is the subject of the sixth research paper published by the Royal Commission on the NHS*. It is the report of a small sample survey of two groups of the public, the elderly and parents with young children, in two contrasting communities — Stoke Newington in London and the Cockermouth-Maryport area of West Cumbria. The study was financed jointly by the Royal Commission and the National Consumer Council, which has prepared the report and made some general recommendations on family practitioner services which are not necessarily related to the survey findings.

Access to GPs was generally found to be satisfactory. Old people had greater physical problems in getting to their doctors, but greater ease of relationship with them. There were problems with access to out-of-hours (as opposed to emergency) care, particularly for parents. GPs were sometimes reluctant to call and were angry if they felt they had been brought out unnecessarily or would be paying a deputising doctor for a non-essential call. One of the NCC's recommendations is for a comprehensive NHS deputising service.

Most patients expected to have to wait to see their GP, and the report emphasises the deferential attitudes of patients and what it calls the "social ethic" about correct use of the NHS. Both the areas surveyed were technically overdoctored though obviously doctors were under pressure. The NCC suggests that factors such as housing and industrial and environmental conditions, and high proportions of elderly, disabled or very young patients, should be taken into account in deciding on the distribution and remuneration of GPs.

The main barrier to access to dental and optical, and to a lesser extent chiropody, services was confusion caused by the mixture of NHS and private practice and charges or free NHS provision. People were either deterred from seeking the attention needed, or paid unnecessarily. Children on the whole got good dental care through the community dental service, but by no means all children had their eyes tested at school. The NCC would like to see a shift in the onus of establishing whether or not dental treatment is on the NHS from patient to dentist — and in the long-term completely free NHS dental and optical services, perhaps with dentists paid like GPs and salaried opticians.

The biggest problem with the NHS chiropody service (available only to pensioners, schoolchildren, the handicapped and pregnant mothers) was long waiting times and low frequency of return visits — the result of acute shortages of staff. Access to pharmacists was satisfactory, though many people did not know about the rota system for out-of-hours opening. Many people, particularly parents, sought advice from the pharmacist, and the NCC suggests that the Government should provide financial recognition of this advisory role.

*Access to primary care, Royal Commission research paper no 6, HMSO £1.50.

PATIENTS' CHARTER

A patients' charter is to be drawn up by the National Consumer Council. The framework for the charter will be the relationship between doctors and patients. As well as giving patients information about their rights in their "contract" with the health service, it will be a campaigning document, like the tenants' charter. It will aim to define areas of the health service where more consumer involvement is appropriate. The people drafting the charter will examine existing attempts to promote patients' rights and will consult CHCs and other consumer interest groups.

Welsh CHCs go filming

Photo: Harley Jones

A film about CHCs in Wales will receive its world première screening in Cardiff this month. The 25-minute colour film, You and your health, *has been made by the Association of Welsh CHCs. A £6000 grant came from the Welsh Office and another £2000 from voluntary hospital funds.*

The film shows activities of CHCs in Wales, but much of it applies to all CHCs – helping with complaints, campaigning for more resources, intervening to prevent hospital closures.

Part of the film was made on location, and some of it is animated cartoon film (see above). Versions of the film have been made in English and in Welsh. Further details from the Association of Welsh CHCs, c/o Ceredigion CHC, 5 Chalybeate Street, Aberystwyth, Dyfed (Tel: Aberystwyth 4760).

Size increase for CHC News

The Editorial Board agreed in January that *CHC NEWS* should be expanded to 16 pages, and this will be the regular size from now on.

The subscription to *CHC NEWS* has been £2.50 since the first (8-page) printed issue was published in April 1976, though the cost of producing the magazine has obviously risen since then. In view of the increased size, we hope subscribers will accept an increase in the annual subscription rate to £3.50 (£3 per subscription for orders of five or more copies) from May. Subscriptions expiring after the May issue will run at the old rate until renewal.

INSIDE . . .

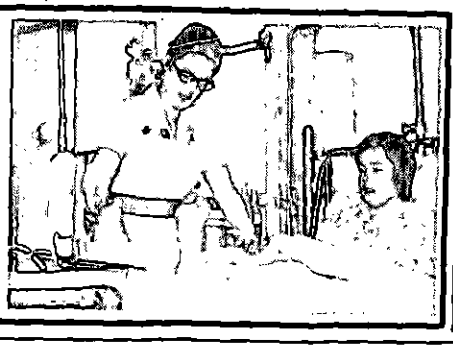

Photo: Photo Reportage

Your letters

Putting surplus NHS land to better use

Juliet Mattinson, Secretary, East Berkshire CHC

For local reasons this CHC has been thinking about the handling of realisable capital assets — NHS land and buildings.

With CHC agreement one of Maidenhead's two hospitals was closed, with a transfer of certain functions to the other site. After a battle, it was accepted that the sale proceeds would be re-invested in the town. We suggested that the disposal procedure could be started before actual closure, but we were told this was not possible (HC(77)6). Today the site is an eyesore as the vandals have been at work. The town is quite rightly scandalised, and nearly two years later not one penny of this capital asset has been realised, let alone put to work.

We blame the system, not those who are trying to work it. We maintain that the NHS is profligate with land (East Berks has less than ten beds per owned hospital acre) and that there is a vast surplus which represents a squandered resource. We are not prepared to go on with this idiotic waste of resources, and hope other CHCs will agree.

Our solution would be a less cumbersome disposal procedure coupled with the institution of an *NHS Sale Proceeds Bank*. This would take deposits for withdrawal at an appropriate time, perhaps within a specified period, and have the ability to offer secured loans, which would earn interest and so enable deposits to hold their value. Possibly part of the DHSS capital allocation might be used for "pump-priming".

With the ability to borrow capital, East Berkshire could make some important improvements to the coordination of services for patients (eg community services on a community hospital site) *and actually save revenue*. The loan could be repaid from consequent land sales and the revenue savings.

We plan to put our suggestion formally to the DHSS in about two months' time, and we are particularly interested to know the views of other CHCs — both for and against the idea.

Further guidance on consultation procedures

Jean Coupe, Secretary, Tunbridge Wells CHC

As a postscript to my article in March *CHC NEWS* (p 4) on the closure of the Tunbridge Wells Maternity Home, I am glad to report that we eventually received a response to our protest from the DHSS. This admits that "the CHC was not kept fully informed of the decisions taken".

The DHSS also admits that the point we make about informal consultation with CHCs prior to the issue of a formal document has caused difficulties elsewhere, and agrees that authorities tend to confine their dialogue with CHCs to the formal procedure only. The letter states: "this is something we are currently looking at to see whether any further guidance would be helpful". If CHCs agree that further guidance *is* necessary, this may be a good time to let the DHSS know precisely what form we would like it to take.

Abortion protest

Mrs Mary Sambrook, Member, West Birmingham CHC

As a recently appointed CHC member I would like the opportunity to record my complete disagreement with the article on day-care abortion units in our NHS hospitals (*CHC NEWS 38, pages 6 and 7*). Indeed, I am against all abortion, whether legal or illegal, for abortion destroys the life of a growing human being.

I am astonished that the authors of the article claim in the first paragraph that they are talking about therapeutic abortions. Over 90% of pregnancies terminated under the 1967 Abortion Act are performed on healthy mothers. The vast majority of the foetuses are healthy too. What a waste of human life! I would like all CHC members in the country to know that one voice disagrees with the policy of the DHSS — which blatantly ignores the law and forges ahead to provide abortion on demand.

Abortion and mental health

Mrs M L Oldbury, Member, Central Birmingham CHC

Women should be made aware of the danger to mental health implicit in the aftermath of abortion. A study carried out by Dr Ian Kent of the Department of Psychiatry, University of British Columbia, and reported in the *British Columbia Medical Journal* (April 1978) and in *Psychiatric News* (3 March 1978), showed that women undergoing psychotherapy expressed feelings about their abortions that were "invariably of intense pain, involving bereavement and a sense of identification with the foetus". These feelings appeared in patients who had rationally considered that abortion was inevitable.

The author says that these findings confirm the views of Freud and Deutsch that "at a much deeper, initially unconscious level, abortion is regarded by many women as an act of infanticide".

Abortion counselling

David Flint, Abortion Law Reform Association, 88 Islington High Street, London N1 8EG

I accept Debby Sanders' assurances (*CHC NEWS 37*) that *Women for Life* does not seek public support for counselling activities or "homes for unmarried mothers". Unfortunately other anti-abortion groups *do* seek such support — "unfortunately" because counselling is best done by those who wish people to make their own decisions, and the opponents of choice are not amongst that number. Happily good counselling is available under the NHS, and from the Pregnancy Advisory Service.

Families with handicapped children

Josephine Dennis, Secretary, Wirral Northern CHC

In Wirral we are trying to establish a parents' support group for newly handicapped families. It is hoped that parents with experience of coping with handicapped children can assist parents of newly identified handicapped children — with emotional adjustment and acceptance of their child, introducing them to services, and overcoming the language barriers created by jargon. If anyone has any information about a successful similar group, please let me know how it operates.

Ear piercing and ACHCEW

Cyril N Gumbley, Secretary, East Dorset CHC

The letter from Hull CHC in November *CHC NEWS* says that ACHCEW is being asked to consider the hazards of ear piercing in the hope that appropriate legislation might result. Surely this is taking a sledgehammer to crack a nut, and putting "domestic" ear piercing on a par with back-street abortions?

If ACHCEW — faced with agendas full of serious matters — gives this subject priority, member CHCs will start questioning whether their subscriptions are being responsibly spent. Contrary to what Hull CHC believe, "infective hepatitis" is not associated with ear-piercing. In rare instances, serum hepatitis (a notifiable disease) may follow ear piercing, but it is more commonly associated with the sharing of syringes by drug addicts.

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.

CHC NEWS

April 1979 No. 41

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

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

Comment

A slow but steady drip of horrifying information about medicine in prisons continues to emerge in the media.

In a prison on the Isle of Wight, inmates with no "formal illness" were given a major tranquilliser drug to overcome "control problems". In Dartmoor male sex offenders are being treated with drugs to reduce their sexual urges — drugs which also cause them to develop breasts. Later they require mastectomy operations. And according to the Society of Radiographers, the people operating most prison X-ray machines are not qualified to handle radiation safely.

Little wonder that the vexed question of integrating the Prison Medical Service (PMS) with the NHS has been raised yet again — this time by the Royal College of Psychiatrists, in its evidence to the inquiry into the UK prison service.

The RCP doesn't mince its words: "Prisons highlight the doctors' dilemma in bringing into sharp focus situations where there might be conflict between the prisoners' interests and those of society . . . the forces of the total institution powerfully influence staff and inmates". The PMS is isolated, anachronistic, and often provides only a minimal service.

The RCP's solutions are equally clear-cut: "Medical services to prisoners should be provided wholly by the NHS . . . GPs would be contracted to provide a full range of services. . . . They would also be responsible for managing in-patients in existing prison hospitals . . . community physicians would be employed by districts to provide public health requirements of prisons . . . comprehensive psychiatric services to prisons . . . should be the responsibility of the NHS".

Yet integration with the NHS has always been the sticking point for official enquiries into the defects of the PMS. One alternative, which surfaced last year during a conference on the PMS*, is a dual system — one group of prison doctors employed by the NHS to provide a personal health service for prisoners, and another group of Home Office doctors to deal with custodial and administrative matters. The NHS doctors would have no responsibility for control or punishment, and so would be free to pursue the best interests of their patients without divided loyalties. Their work could also be open to the scrutiny of CHCs.

ACHCEW has already discussed prison medicine with MIND and the National Council for Civil Liberties, and the present inquiry gives these three bodies an ideal opportunity to take a joint initiative. Surely that drip of indefensible information deserves some response?

*Report £1 from the King's Fund Centre, 126 Albert Street, London NW1.

Health News

Twisting the arm of the Crown

Crown notices are beginning to bite in the health service. They were invented last July by the Health and Safety Executive, as a way of getting around the legal immunity against prosecution enjoyed by Government (Crown) employers, including AHAs and RHAs.

The new notices have no legal force, but are intended as a form of heavy moral persuasion. They warn the recipient that "failure to comply is a serious matter and will result in a formal approach from the HSE to an appropriate person with higher authority in your organisation, or, if necessary, from the chairman of the Health and Safety Commission to the responsible minister". This is backed by the implied threat of local publicity if cooperation is not forthcoming.

Like notices issued under the Health and Safety at Work Act 1974, Crown notices come in two forms. *Prohibition notices* require an immediate halt to activities which threaten personal injury, and *improvement notices* set a date by which specified improvements must be made in situations where the threat to health or safety is less immediate.

Perhaps the first Crown notices affecting NHS premises were issued late last year, both to Berkshire AHA. They were prohibition notices, and both concerned unsafe slicing machinery in the kitchen of Fairmile Hospital, in Wallingford. Since then, improvement notices have been issued to Redbridge and Waltham Forest AHA and Essex AHA. The first concerns the work of laboratories handling dangerous micro-organisms at Whipps Cross Hospital, Leytonstone, and the second involves "contamination by an unsealed radioactive substance" in the radiotherapy department at Essex County Hospital, Colchester.

These cases are coming to light partly because of the HSE's nationwide programme of visits to hospital premises. NHS premises which appear to need inspection should be reported to the appropriate HSE area office — details from the HSE on 01-262 3277.

Clearing the air continues

A remarkable 65% of smokers, and a less remarkable 80% of non-smokers, agree that smoking in public places should be even more restricted than it is now. The results of this latest DHSS opinion poll have encouraged David Ennals to write again to

Photo: Health Education Council

a wide range of organisations, asking them to review their existing practices.

Following his earlier initiative, in December 1977, British Rail increased the proportion of non-smoking seats on its trains from 50 to 65%, London Transport asked smokers on buses to sit at the rear of the upper deck, and more and more theatres and shops began to sprout "no smoking" signs.

Included in Mr Ennals' new mailing shot are the local authority associations, the Post Office, the main banks, the Building Societies Association, and the gas and electricity boards. He is suggesting that a policy of "flexible discouragement", such as has already been agreed between the Civil Service and staff unions, should apply in offices where the public may go.

In the NHS, Mr Ennals has said that he expects hospital managers "to do everything possible to confine smoking to specified areas . . . smoking should *normally* be forbidden, and only permitted in special places". Detailed advice was issued in circular HC(77)3, *Non-smoking in health premises.*

Child abuse registers

Debate about child abuse registers relates both to their desirability in principle and to their effectiveness in practice. The registers are intended to help prevent child abuse and to improve the management of known cases by providing a means of pooling information from the different agencies in contact with the children and their families and of facilitating cooperation between them. Misgivings about the effectiveness of registers stem partly from the wide variation in the criteria used for including names and the lack of uniformity in the data held. A draft circular from the DHSS, *Child abuse: the register system*, proposes procedures for general use.

Previous guidance concerned *non-accidental injury* to children; the present circular, relating to *child abuse*, goes wider. Five criteria for registration are suggested: as well as physical injury (suspected or known to have been inflicted by those in charge of the child) and neglect, these cover babies whose perinatal and family histories suggest a high degree of risk of abuse, children in households with a parent or other person known to have abused a child, and children in none of the other categories who are felt to be in equal

Continued on next page

Health News

Continued from page 3

danger of physical, mental or emotional abuse. One of the debatable proposals is that the register should contain details of cases where child abuse is suspected but not substantiated — with some system, such as coloured flashes, to distinguish between them.

There are proposals on the method of registration, the type of data to be held, and monitoring and deregistration procedures. Each case is to be reassessed at least once every four months in order to check on the data held, on changes in the child's situation, on progress in treatment, and on the continuing need for a name to be kept on the register. Parents are normally to be informed when their child's name is put on the register.

The draft circular has not been sent to CHCs, but ACHCEW is among the national bodies being consulted, and regional groups have been asked to collect CHCs' views on the proposals.

Mental handicap nursing

It will be the end of the year before the government takes any decision on the recommendations of the *Report of the Committee of Enquiry into Mental Handicap Nursing and Care* (Cmnd 7468, HMSO, Vol I £3, Vol II £4). David Ennals has announced that there will be widespread consultation on the proposals. A summary of the report is available and any comments should go to DHSS, Room C412, Alexander Fleming House, London SE1 6BY.

Mrs Peggy Jay, chairman of the committee, said that the most important recommendation was for a unified training for both NHS and local authority staff. The committee proposed that the Central Council for Education and Training in Social Work should take charge of training. The number of staff caring for mentally handicapped people in hospitals and local authority homes should be doubled.

There were minority reports from three dissenting members of the committee. One, David Williams of COHSE, recommended that training should remain the responsibility of the health service. But the entire committee supported the principle underlying the report — the fullest possible integration of mentally handicapped people into the community.

Diagnosis of death

For many centuries cessation of the heart-beat was accepted as the moment of death. Now that open-heart surgery and successful resuscitation after cardiac arrest are common, this definition of death is no longer applicable. In 1976 the Conference of Medical Royal Colleges and their Faculties in the UK agreed that "brain death", when it had occurred, could be diagnosed with certainty. This report was widely accepted, but it did not touch on the question of whether death itself should be presumed to occur when brain death takes place, and it made no reference to organ transplantation.

The Conference has now published a supplement to that report (*Lancet* and *British Medical Journal*, 3 February 1979). This explains that usually brain death follows successive organic failures, and is the point of no return, but that occasionally brain death occurs as a result of severe damage to the brain itself. In this situation respiration, heart-beat and other essential functions can be artificially maintained. The conclusion of the Conference is that "the identification of brain death means that the patient is dead, whether or not the function of some organs, such as a heart-beat, is still maintained by artificial means". Doctors have sometimes been accused of being too eager to switch off machinery when there is a possibility of kidney transplantation. This statement should help to clarify the position both for the profession and the public.

Britain still a bottle-fed nation

Of the large sample of mothers in the survey carried out in 1975 by the Office of Population Censuses and Surveys, over half of those who started out breastfeeding their babies had stopped by six weeks, and only a quarter were still breastfeeding *at all* at four months. 86% of the breastfed babies were given artificial feeds during the first week, though only 17% of babies who were breastfed at six weeks were having solids, compared with 47% of bottle-fed babies.

These are some of the survey conclusions which are presented, together with comments and recommendations, in a booklet from the DHSS Committee on Medical Aspects of Food Policy: Panel on Child Nutrition (*Breast feeding*, HMSO 80p). Mothers need a lot of encouragement in deciding to breastfeed and then in doing it successfully. But the booklet makes it alarmingly clear that health professionals do not always give mothers accurate information about feeding their babies, and often fail to support, and may even undermine, their efforts to breastfeed. For example, babies born in hospital in the evening are unlikely to be put to the breast until the next standard feeding time, which could be nine hours away. Most mothers who stopped breastfeeding by six weeks because of lack of milk asked advice from a health visitor, midwife or doctor — yet 90% were advised to give the baby bottles of milk, and only 6% were told to put the baby to the breast more often. The question of how they were to feed their babies had been discussed during antenatal session with under a third of mothers — and the subject was least likely to have been raised at a GP surgery or clinic.

Hearts in their mouths

It seems harder and harder to know *what* to think about fats and coronary heart disease (CHD). Perhaps the involvement of the butter lobby (in the blue corner) and the margarine industry (in the red) — and of course their sponsored experts — goes some way to explaining this. There seems to be no limit to the amount of confusion money can buy.

The latest foray in this battle has been made by Sir John McMichael, a medical professor and a former president of the World Congress of Cardiology. Writing in the *British Medical Journal* (20 January, pages 173–5) he castigates "commercial, professional and even government-sponsored propaganda" in favour of cholesterol-reducing diets, and calls for the withdrawal of official medical endorsement for such diets.

His view is that CHD is not a nutritional disorder, and that studies of large populations which claim to show the benefits of polyunsaturated-fat (ie low animal fat) diets are "misleading and grossly biased". Too much vegetable oil may cause gall-stones and degeneration of heart muscle, he warns, and compounds produced during the "hardening" of vegetable oils into margarine might be injurious in ways we do not yet understand.

Interestingly, Sir John fails to refer to a paper titled *The pattern of food and mortality in Belgium*, published in the *Lancet* in 1977 (21 May, pages 1069–72). This reported that over ten years people in north Belgium have reduced their butter intake by four-fifths and doubled their margarine consumption — reducing CHD and increasing their life expectancy.

Meanwhile the experts at the DHSS seem to be sitting slightly to one side of the fence, with the remark in *Eating for health* that "the balance of opinion is clearly that it would be wise to reduce the amount of fat, especially saturated fat, in the diet".

Easy reading

An "arbitrary" review of a selection of CHC annual reports in *Hospital and health services review*, February 1979, remarks among other things on the good-looking or off-putting appearance of the reports. Printed reports are preferred to duplicated ones, and a special brickbat is reserved for plastic grips for binding — "they make the document inflexible and if the sheets come out one has to decide between trying to put them back or using the wastepaper basket".

Sorry, when we said relocation...

Photo: Scarborough Evening News

...we actually meant closure

Ken Henderson, Chairman, Scarborough CHC

The four-year saga of East Ayton Lodge poses these questions:

- Are procedures more important than people?
- Is money more important than moral obligations? and
- Are objections more effective than objectives?

East Ayton Lodge is a mansion house-type property set in its own grounds, some four miles from Scarborough. It was donated to the NHS by Lady Nunburnholme, in memory of her son who was killed in action in the Second World War. Before reorganisation it was used as a holiday home or temporary residence for psychogeriatric patients, bringing pleasure and hope to many and fulfilling the express wishes of the donor.

After reorganisation the property continued to be used for the same type of patient, and its family atmosphere was such that to some it became their home. It lacked many "modern" attributes and presented certain administrative and staffing problems, which the CHC believed could be solved when money was available.

Informal discussions started in 1975, when it was suggested that the 21 residents should be relocated to a hospital in Scarborough, where psychiatric and geriatric specialties and facilities were available, and that the lodge should be used as offices. The CHC accepted that it would be in the best interests of the patients if the beds were relocated, but felt unanimously that the lodge should continue to be used for health care purposes. The DMT agreed to undertake a feasibility study with this in mind.

In April 1976 capital funds were made available to provide the new Scarborough unit, and formal closure procedures were set in motion immediately. The closure consultation document referred to the relocation of the beds and the closure of the unit, but made it perfectly clear that discussions were taking place about possible alternative uses of the building for health and social services purposes. The CHC accepted the proposals, but reiterated that it was "of the unanimous opinion that the lodge should be retained by the authority, and be used for the benefit of the patients of the Scarborough Health District".

In the belief that the "closure" of the building *as opposed to the relocation of the beds* was still open to objection, discussions with the DMT and AHA about its future use continued between May 1976 and December 1977. Due to financial restrictions funds could not be made immediately available to upgrade the lodge for other health care needs. The office accommodation occupied by the finance department was urgently required to enable a much-needed day hospital to be provided, so with some reluctance the CHC endorsed a DMT recommendation that the lodge should be used for office accommodation. It was thought that the AHA would continue to own the lodge, and that when money became available it could be brought back into use for health care purposes.

The AHA did not agree with this recommendation, and submitted the closure consultation document and our views to the RHA with a request that the property be *disposed of* and the *proceeds* used for the benefit of the NHS in the Scarborough district.

The CHC — believing that this was the next formal step in the closure procedure — immediately prepared a detailed objection and submitted this to the Secretary of State, the RHA and the AHA. The views of the CHC had been repeated consistently throughout, and were well known and acknowledged by the AHA.

Seven months later the CHC learned that the property was being offered for sale to an organisation outside the NHS. We immediately objected to the DHSS that the CHC had not been notified of the outcome of its appeal, and eventually a letter was received which said:

"... *in our view, proposals for* the disposal of a property which has been vacated after consultation in accordance with the procedures laid down are a matter for management decision by the RHA/AHA based on the procedures for land transactions. ... We consider that proposals for closure and future use of a facility are two separate but related issues, and that options for future use should be considered and consulted upon within the context of the formulation of plans".

After we had made further representations, Mr Ennals apologised for the discourtesy in not letting the CHC know immediately of his response to the RHA, and stated that *he did not in fact make a decision on the future of the lodge.* The *disposal* of the property which had been vacated *was a matter for management,* and the RHA could proceed to dispose of the property if it so wished. While options for future use should be consulted upon in the context of the formulation of plans, they need not be subject to *formal* consultation locally.

We put it to Mr Ennals that an important point of principle was involved — was a CHC which in the best interests of patients accepted a relocation of beds to be deprived of its statutory right of appeal against closure? And if this was so, should it not be made perfectly clear during the consultation procedure? So far this has not been answered.

Although we have recently been informed that a "reasoned" case against a closure should be acceptable to an AHA, and that the regulations should not be interpreted absolutely literally, until that happy day dawns perhaps all CHCs should consider taking the following steps:

1 Lodge a formal objection against every closure, even if it should be disguised as a "relocation of beds", and so keep your options open while consultations about future use are taking place. Yes, it is wasteful, but what alternative is there?

2 Concentrate upon the "closure or withdrawal of facilities" and not on the disposal, which we now learn is a management responsibility outside the jurisdiction of the Secretary of State, so long as the "procedures" are followed.

3 If property is to be donated by deed of gift, ensure that some restrictive covenant as to its use or disposal is imposed — don't rely on moral obligations.

● See also East Berkshire CHC's proposals for an NHS Sale Proceeds Bank, on page 2.

A day in the life of...

... a physiotherapist

by Janet Williams, a physiotherapist in a large general hospital

There are five of us working in the physiotherapy outpatients' department on a Monday morning, each with about fifteen people to treat. We keep our own separate lists and make the appointments ourselves. Once a patient has seen the doctor ("specialist") at the hospital — which can take months after their GP's referral letter — we send them an immediate appointment for treatment two or three times a week, usually for three weeks. We order them ambulance transport if they need it.

I ask my first two people to come in, and show them to a cubicle each. The large lady with arthritic knees is not getting any better. I've explained to her that the deep heat treatment she is having will make her knees feel a bit better, but that unless she improves her thigh muscles by doing the exercises I've taught her and loses some weight, her poor knees will go on getting crushed. I find it hard to boss her into caring about her knees, she thinks the deep heat machine will work a magic cure on her arthritis.

My other 9 am person is a victim of a motorbike accident. His leg has been broken in several places but he is out of plaster now. He's young and very fed up with being at home. I plonk two bags of ice on his scarred and wasted leg. Ice is precious stuff on a Monday morning because it's a fire risk to leave the machine on at the weekend.

The wax is slowly melting in its tank beside the ice. A lady with a recent fracture of the wrist dips her hand in and out of the liquid part. "That's the last dip", she says, shaking off the drips, so I wrap it up in paper and a plastic bag and leave her to stare for twenty minutes at the pigeons in their filthy nests on the window ledge. I rescue the boy from his ice and, unrelenting, I hang a 6lb sandbag on his ankle and give him instructions about exercises.

Someone comes out of a cubicle and I rush to the waiting room to collect one of my people before anyone else gets to it. The old lady is slow to get up, she has a very painful back and can hardly walk. I help her out of about eight layers of clothing and a complicated surgical corset and go in search of a little stool so she can be manoeuvred up on to the high bed. She also has a bad chest and cannot lie down, so I collect more pillows from other cubicles and finally settle her with the large deep heat electrode over her painful back.

She pleads for a raised toilet seat in her home and a hand rail for the stairs. She is 83. Unreasonably, I'm annoyed. It means I have to search by phone for a social worker and the boy will have finished his exercises and now needs ultrasound on his leg. This is given with a hand-held machine that emits radio waves which reduce swelling. There is no answer from the social workers so I tell the old lady that I'm doing all I can. Now she wants to know how many more treatments she has to come, so I get her card and count up. She does not have a further appointment with the doctor — he obviously does not expect the treatment to improve her condition and wants us to discharge her. It's difficult to tell someone that the doctor does not want to see them again. Sometimes we do make further appointments, even when the doctor has asked us not to. But it feels very daring to do this, and there are always repercussions. It becomes more vital now to get the old lady her raised lavatory seat, so at least she'll feel something has been done.

Photo: Clifford Photography

As I lift the large lady's arthritic knees from the stool, and marvel at her courage in carrying on walking with such swollen grating knees, she says, "There's lots worse off than me." We should have a sign over the door saying that: it's everyone's consoling thought on finishing treatment. I mutter, "and better off, too", so she can hear it if she wants to, and settle her back in the waiting room with *Woman's Own* to wait for the ambulance.

A little girl is waiting with her arm in a sling, nearly in tears. She is new and terrified. I put my arm round her and sit her in the middle of the department so that she can see we're not actually massacring people. In the cubicle I see that the jagged end of her fractured bone is nearly through the skin. I am horrified, so I phone for her notes and X-rays to find out if it was like that when she saw the doctor in casualty. Our invaluable physiotherapy helper walks miles from the old block to the new block to collect them. It seems that the doctor considers the fracture to be in a satisfactory position. I cannot agree. Many doctors are relatively unaware of what we do in physiotherapy and can be very defensive in their ignorance. Sometimes we feel that the treatment they specify is inappropriate, but approaching the doctors on this level is often difficult, their manner and expression precluding discussion.

A long buzzer now sounds, and everyone groans. It means we have to turn off all the machines until it rings again twice. Our machinery interferes with the electrocardiograph machine being used on a ward upstairs. (We're camping out in a ward at the moment, while our own department is being de-cockroached and made water-tight.) I remember about the social worker and ask the switchboard operator to bleep her. Ten minutes later the ambulance people have come to collect patients who have not yet finished their treatment. The ambulances can't wait, having other people to collect, which means that our people may well wait a further two and a half hours to be taken home. We turn the machines on again without waiting for the buzzer, risking the wrath of the ECG lady. The phone rings for the twentieth time and I try to sort out why the ambulance didn't collect someone last Friday and if they will collect them this morning. The social worker arrives, takes down a few details and says she'll tell another social worker, whose concern it is, and let me know next week. I relay this small consolation to my back lady and help her into her eight layers of clothing, which do not smell of lavender water.

I return from the waiting room with two more women, one a private patient who has had a bunion removed. I get a tray of water and place two electrodes in it connected to a machine that will stimulate the muscles of her feet electrically.

The other woman takes longer. She has an ulcer on her leg which has to be cleaned, treated with ultra-violet light, repacked and dressed and the leg exercised. We chat about her arthritis, which she has as well, and about her living alone and being immobile.

A young woman with an extremely painful back comes into the department to let me know she is here. I show her straight into a cubicle and while she gets undressed, teach the little girl some arm exercises. They hurt her, but a stiff shoulder will only compound her problems. The young back woman is nearly ready, and I catch her in the process of bending down incorrectly to pick up her handbag. Again I explain that bending like that is the worst possible action for her back, but she just smiles and says that with three small children it's impossible to bend any other way.

Soon there is to be a weekend course for physios, to teach them effective gentle manipulation for painful backs and necks. These manipulations were not part of the syllabus when I trained and I would love to go on the course. It will cost about £15 and to date the hospital is not allowing financial help. I give the lady ultrasound treatment and put her onto the deep heat (short-wave diathermy). Two more people wait, a young woman with bronchiectasis whose afflicted lung I try to clear of sputum prior to her having it removed, and a man who wears a large foam rubber collar round his neck. He is a worn resigned man whose neck has not improved with treatment. He will be one who on keeping his follow-up appointment with the doctor will be told, "Well, you'll just have to live with it." If we saw people more quickly after the onset of their first symptoms we could do more. Mostly by the time we treat people the symptoms are so consolidated that we cannot reverse them. Bad posture, unhappiness, repetitive tasks and stress cause untold structural damage to the body. We just do not have time to go into people's lives and convince them of the value of relaxing physically and moving safely.

Physiotherapists work on every ward in the hospital. We are on call every night, all through the night in rotation, and we work every weekend, also in rotation. We do orthopaedic work, chest drainage in the Intensive Therapy Unit, and work with special care babies in incubators. Everyone who has an operation has pre- and post-operative breathing exercises shown them, and people who have had strokes or limbs amputated have help with general mobilisation, passive movements and walking re-education. We hold antenatal and postnatal classes and swimming classes once a week at the local swimming pool for people who benefit from exercises under water. An on-call physio gets £1.50 a night and starts on a salary of under £3,000 a year after training for three years.

This is the first article in what we envisage as an occasional series on the daily lives of people who work in the health service. We would be glad to have suggestions on possible subjects and writers.

Book reviews

Doctors on trial

by Dr John Bradshaw, Wildwood House, £5.95.

There are few books that can wholeheartedly be recommended to CHCs as valuable additions to their library. Dr Bradshaw's book is an exception.

Although the setting he uses, of a "court of enquiry", was perhaps overdone in the 1960s, nevertheless it is a useful way of presenting material and maintaining interest, using the drama of cross-examination and judge's remarks. As the evidence accumulates there is little doubt in the reader's mind as to what the verdict will be. But this is by no means a simple case of doctor bashing. Eighteen sessions of the imaginary enquiry are reported, ranging over topics as varied as stress, prevention, high technology medicine, family doctors and so on.

Dr Bradshaw is well known for his encyclopaedic knowledge of source material. Those CHCs who have had him speak to them will need little encouragement to obtain a permanent record of the facts that he presents. The book is lively and a "good read". If it does nothing else, his concern for unimpeachable source material will be an object lesson to CHC members and officers and — dare one say it — to those who write about CHCs and their activities.

Jack Hallas
University of Leeds

Holes in the welfare net

by Maureen Oswin (Bedford Square Press of the National Council for Social Service, £3.50 inc. post).

One skill essential to CHC members is being able to listen. Official visits with ritual "And how are you today?" questions tend to gloss over the real problem. Maureen Oswin skilfully encourages people to describe their worst fears and frustrations. Her book also examines poor aspects of health care which CHCs need to work on.

There is the intelligent ex-company secretary who is treated as incompetent to work, to choose his friends, meals or entertainment, simply because since a road accident, he has lived in a home for the disabled. "Visitors forget the most important thing — that we were once people with lives of our own, the same as them."

The book looks at babies, children, adolescents and adults with physical and/or mental handicaps, living at home or in hospitals. This is a sad book, but it is well worth reading because it describes things every CHC ought to be looking at and shows us how to look at them.

Priscilla Alderson
Tunbridge Wells CHC

The search for better resource allocation methods in the health service

by David Allen, Working paper no 2, Health Service Management Unit, Department of Social Administration, University of Manchester, £1 inc post.

If you are new to CHCs, this may serve as a brief and elementary introduction to some of the techniques used to aid decision about allocation of health service resources. The paper provides a potted history of attempts to improve the distribution of manpower and physical resources, beginning with 1948, when the NHS inherited hospitals which were often not in the places where they were most needed, and of which many were extremely old.

There were experiments with cost benefit analysis, cost effectiveness studies, avoidable cost studies, social indicators and planning programming budget systems — all these techniques are outlined by David Allen. The emphasis is on techniques, yet technical competence alone will not ensure redistribution of health service resources without a strong political commitment. Thirty years after 1948, that commitment seems at last to exist.

David Fruin
NW Herts CHC

An ageing population

edited by Vida Carver and Penny Liddiard, Hodder and Stoughton in association with the Open University Press, £3.25.

In compiling a collection of 47 expertly written papers on the subject of growing old, surviving actively and dying with dignity, Carver and Liddiard have produced a most readable and informative volume. They set out with the intention of producing something for the professionals, they also aimed at the general reader and they have succeeded in both. The fact that this is a "set book" for an Open University course may seem daunting, but one need not fear.

Ageing is a subject too easily put aside for consideration at a later date. Every one with concern for health and well-being should dip into this book, not least those who talk about the theories of ageing, without the profound experience of participating in this irreversible process.

J Sluter
Roehampton CHC

Books received

Alternative medicine by Robert Eagle (Futura 90p).

On the state of the public health — annual report of the Chief Medical Officer of the DHSS for the year 1977 (HMSO £2.50).

Take care of yourself — a practical do-it-yourself guide to medical care by Vickery, Fries, Muir Gray and Smail (Allen and Unwin £6.50).

Not quite like home — small hostels for alcoholics and others by Otto and Orford (Wiley and Sons £7.95).

The management of terminal disease edited by Cicely Saunders (Arnold £8.50).

The wheelchair child by Phillippa Russell (Souvenir Press £4.00).

Helping your handicapped baby by Cunningham and Sloper (Souvenir Press £4.50).

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

Management of minor illness — ten seminar papers (King's Fund £4.00).

Management of chronic illness edited by McCarthy and Millard (King's Fund £3.00).

When I went home — a study of patients discharged from hospital by Gay and Pitkeathley (King's Fund £3.00).

If you would like to review books for CHC NEWS, *please write to us. We would particularly like to hear from people who are interested in reviewing books about primary care, physical handicap, ethnic minorities, health planning and priorities, but all would-be reviewers will be welcomed.*

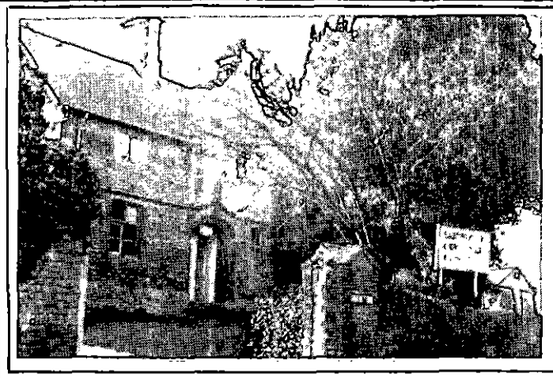


TABLE: Units which could exist within a community hospital

- Group practice health centre
- Offices for community nursing (district nurses, midwives and health visitors)
- Out-patient clinics for nearby DGH Day-care abortion unit
- Ante-natal and post-natal clinics
- GP obstetric unit
- Day-care unit for the elderly
- Rehabilitation unit (physiotherapy and occupational therapy)
- Day-care psychiatric unit
- Chiropody clinic
- Dental unit
- Social services offices
- Health education unit
- Community health council offices
- Offices for health service pressure groups
- Geriatric long-stay ward
- Disturbed elderly unit

Photos: A J M Cavenagh

Community hospitals

*by Dr Angus Nicoll**

A community hospital (CH) is a small hospital where medical responsibility for patient care is taken by local general practitioners. CHs are therefore a part of primary care. They contain between 20 and 150 beds and serve populations from 10,000 to 100,000.

There is no such thing as a standard CH. Many forms already exist, and more are in a state of wishful planning. Over 300 "cottage hospitals" in small towns and rural areas are being re-designated as CHs, and these vary greatly. As yet there are very few urban CHs.

Patients admitted to a CH all have close links with the area immediately around the hospital. They may live locally themselves, they may work locally, or they may be admitted because their relatives live locally. Most are *acute medical cases* — patients not requiring specialist medical care — and many of these are *social admissions*, people whose circumstances mean that they cannot be cared for at home.

Other patients admitted include *patients transferred after operations* in the local District General Hospital (DGH), *transfer patients* from hospitals elsewhere, *terminal care patients* and *holiday admissions* (to give relatives a rest).

Some CHs may also admit *geriatric and handicapped patients* and *surgical patients* (operated on in the hospital). Patients not admitted to CHs include: *children, severely disturbed patients* and *patients requiring the facilities of a specialist hospital department.*

CHs usually have facilities for simple X-rays, and via the DGH there is access to laboratories. But the emphasis is on nursing care and rehabilitation. Nursing costs are by far the largest element in the budget. Often a "field-station" casualty is maintained, but all serious accidents and medical emergencies go to the nearest DGH. In rural areas almost all the staff will be local, and a higher proportion will be trained rather than being students. Many will work on a part-time basis, and without the CH they would not be working in the NHS at all.

There is a ready demand for the beds of existing CHs. Length of stay is generally less than a month, indicating that CHs are not at present being used as long-stay geriatric units. But this short length of stay may only reflect the fact that such hospitals tend to be in areas of higher social class, or where the family links to support people "in the community" still exist.

Aside from their GP beds, there are a number of other potential functions for the CH (see Table).

**Angus Nicoll works in community paediatrics in the Tower Hamlets Health District*

Where did the community hospital come from?

Three main trends have led to the current interest in CHs.

One — the cottage hospitals. The first of these was started by Dr Albert Napper in 1858, literally as a cottage with a few beds in it. They have grown to their present strength wherever there were enterprising communities and GPs with the nearest large hospital too far away for easy travel.

These hospitals are "generally regarded with great affection by their local communities. They seem less formal and forbidding than larger hospitals. They are also more convenient for patients, visitors and staff. They are generally staffed by people who live locally and get to know well their patients and their families. Wherever possible people prefer to be looked after in hospitals close to where they live" (from the DHSS guidance memorandum *Community hospitals*).

Many of these hospitals have been under threat of closure recently. But the DHSS has had to contend not just with the logic of their existence in rural areas but also with the considerable "clout" which some country communities wield: "Delegations have been sent to call on MPs and on Ministers and large petitions have been assembled. Particularly in country areas, the policy of concentrating hospital provision on large DGHs has been resisted" (again from *Community hospitals*).

Two — DHSS centralisation policy. The DHSS policy of the 1960s was to centralise facilities in the DGH — what has sometimes been known as the "edifice complex". This implied that most cottage hospitals would be sacrificed to the DGH. One region, Oxford, realised that Departmental logic was asking it to shrink its 103 hospitals down to eight DGHs, and lose 75% of its beds into the bargain. This would have left much of the region's scattered population many miles from the nearest hospital.

In response the region made plans for CHs, mainly involving the re-designation of existing cottage hospitals, and in 1969 set up two experimental hospitals, one in new premises at Wallingford. One hope behind the project was that care of patients would be cheaper in the CH, away from all the extraneous technology of the DGH. This project was closely followed by the DHSS. In 1974, having ignored the cottage hospitals for years, the DHSS issued a key document — the guidance memorandum *Community hospitals* (1). This not only acknowledged the existence of the cottage hospitals and changed their names to CHs, but also laid down that they were an integral part of the NHS. One or two should exist in *every* health district.

Three — rationalisation and closure policies. The growing power of the DGHs to gather in financial resources, inflation in hospital costs, the virtual standstill in the NHS budget and the introduction of the RAWP procedures for resource re-allocation made it inevitable by the late 1970s that small hospitals should be "rationalised". Usually this has meant closure.

These recent developments, however, have moved the debate into the cities. Generally small city hospitals have been those most under threat, especially in London. Faithfully following the "inverse care law" — the more you need health care the less available it is to you — the cities are where the GP service is weakest, the reliance on hospital casualty departments is greatest, and the community is least able to care for its sick at home or to defend its local hospital.

Opposition to closures in the cities has not been as successful as in the country, partly because of the presence of the rapacious teaching hospitals, whose ability to defend their slice of the cake against all comers is well documented (2). Some hospital defence groups wishing to make positive suggestions and to strengthen primary care locally, have seized on the CH concept as a constructive alternative to closure (3).

But in 1976 the first results from the Wallingford experiment were published (4), showing that care in an adequately staffed CH was probably *not* cheaper than in a DGH. Hence "rationalisation" of the small hospitals into CHs was perhaps not after all to be DHSS policy. On the other hand, the DHSS has admitted that its 1974 memo does apply to urban areas (5).

Photo: Pulse

How might community hospitals be organised?

With the units listed in the Table, a CH would be the main focus for community and primary care in its locality. It would be concerned with prevention and care rather than cure. For the patient not in need of high-technology medicine it would have many advantages. Local people would see it as their "own" hospital. The hospital doctor would also be their GP, and would know them, their family and their environment. Most importantly, the doctor would take medical responsibility for the patient both inside and outside the hospital, so the common practice of "dumping" patients who are "difficult" out of the hospital into the community, or vice versa, would not be an option. GPs would have the satisfaction of admitting their own patients to hospital and caring for them there. This is an extra responsibility, for which GPs would have to be paid (6).

Management of the hospital could be by an executive elected from a committee of hospital workers and users. This would hopefully cut across barriers between professions (doctors versus nurses versus ancillaries), between departments (NHS versus social services) and between people (professionals versus patients). The CH *could* be a place where many of these impediments to health and health care begin to be broken down.

Problems, dangers and conflicts

General practitioners. The "hospital" side of the CH, even though it might involve only a minority of the patients using the hospital daily, will probably be the function on which the whole hospital is judged. This side will only be as good as the GPs that run it, yet the inner city areas which most need CHs have on the whole the weakest GPs. More are in single-handed practices, and more are elderly, yet when they retire or die they are not being replaced by younger GPs (7). The DHSS made a grand statement recently about encouraging new GPs into these areas, but there has been no action.

CHs as dumping grounds. There is a danger that CHs will end up doing everything the DGH doesn't want to do, but without the resources the DGH would get to do it. Every DGH seems to have a dumping ground where it can send patients who are "difficult" or "medically uninteresting" — the old, the mad and the bad. Hospital doctors' emphasis on "curing" means that a significant proportion of those who need hospital care are really not of interest to DGHs, eg mentally ill people, the old and the handicapped. They lose out in the provision of DGH resources — beds and skilled nursing — and their problems get little attention during the training of medical students.

For example, there is often (8) medical resistance to the incorporation of geriatric beds into a DGH — running directly contrary to DHSS, health authority and General Medical Council policy. Health

Continued on next page

Healthline

Researching RAWP

I want to do some research on *resource allocation in the NHS*. What can I read as a start?
Try these: *First interim report of the Resource Allocation Working Party,* DHSS August 1975.
Sharing resources for health in England (the "RAWP report"), HMSO £1.70.
Allocating health resources: a commentary on the RAWP, Royal Commission on the NHS research paper no. 3, HMSO 85p.
Reflections on RAWP, occasional paper no. 13 from the Health Services Management Centre, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT. 50p.
RAWP deals, from the Radical Statistics Health Group, c/o BSSRS, 9 Poland Street, London W1V 3DG. 25p.
RAWP: index of research, from the National Association of Health Authorities, Park House, 40 Edgbaston Park Road, Birmingham B15 2RT. £1 + post.
And see page 7 of this issue.

Advice about gas (1)

An enquirer is concerned about *her gas supply being cut off. Is* there any guidance on this?
If there is hardship the local DHSS office or council social services department should be able to help. Her supply should not be cut off if she is willing to pay off the debt over a "reasonable period". Another alternative is to have a slot meter installed, though gas may cost more this way. A code of practice *Electricity and gas bills for your home* is available free from the PR Dept, Electricity Council, 30 Millbank, London SW1.

Advice about gas (2)

Can specially designed gas fires, cookers and so on be supplied for disabled people?
Special adaptors to help disabled people use gas appliances are described in a leaflet *How gas makes life easier for disabled people,* free from British Gas, Home Services Department, 326 High Holborn, London WC1. A free visit from a British Gas home service adviser can be arranged through your local gas showroom or service centre.

Guides to the NHS

***Which CHCs have published* general guides to their local health services?**
In no particular order: City and Hackney, St Helens and Knowsley, South Camden, Trafford, Newcastle, Ealing, Northampton and Kettering (jointly), North Tees and Renfrew LHC.

The blind and partially sighted

Is there a simple guide to services and benefits for the blind and partially sighted?
There was a very useful article on this in the *British Medical Journal* of 20 January 1979, on pages 180/1. It had sections on reading difficulties, benefits, education and genetic counselling, and contained several useful addresses. We'll send you a copy.

Antenatal classes

Who should people contact to find out about attending antenatal classes?
NHS antenatal classes are held free in local antenatal clinics. The National Childbirth Trust also runs antenatal classes, often in the evenings, in most large towns. Charges range from nothing for those unable to pay to about £17 for a course of up to 10 classes. NCT classes start by the 30th week of pregnancy, or earlier, and fathers are welcome. NCT, 9 Queensborough Terrace, London W2.
Tel: 01-229 9319.

NHS dental charges

What are the charges for NHS dental treatment?
At the end of 1978 the maximum charge for routine treatment (ie not dentures, bridges, crowns, inlays, pinlays and gold fillings) was £5. Dentures and bridges cost up to £20 (synthetic resin) or £30 (metal or porcelain). Crowns, inlays, pinlays, gold fillings cost up to £10 per tooth, with an overall maximum of £30. Any combination of the above must not exceed £30 overall.

COMMUNITY HOSPITALS

continued from page 9

authorities will often cave in when opposed by medical power. For instance, one London teaching hospital, if its district plan is implemented, will be totally without geriatric beds (2).

But the number of geriatric patients is increasing and they must go somewhere. It is disturbing that the DHSS memorandum singled out geriatrics and recommended that up to 50% of a district's geriatric beds could be in CHs. There are laudable reasons why old people should be cared for near their families, but they should not be in CHs because care can be provided for them there at lower cost, nor because the hospital medical profession as a whole is not interested in them.

The experimental hospital at Wallingford was a well-run showpiece with high nursing standards — the danger is that DHSS CHs could be staffed on the lines of the psychiatric or geriatric hospitals. Understaffed nursing of the "Cinderella" specialties in CHs is a real and worrying possibility.

CHs as "mini-DGHs". Health care is proceeding along the road of high technology. In America the equivalents of CHs are stacked with medical technology of unproven usefulness. This same trend could start here if GPs were tempted to emulate their DGH counterparts and began to investigate their patients. There is a curative role for the CH, but it must not come before its caring role.

CHs versus DGHs. Despite logically being a part of primary care, the hospital role of a CH will be funded from hospital funds. For its key function, therefore, the CH will always be in competition with the most powerful gatherer and user of resources in the NHS, the DGH. The DHSS memorandum also stresses that CHs must not receive any special priority, or interfere with the development of DGHs.

The future

Interest in CHs has waxed and waned. The 1974 DHSS memorandum triggered off a flurry of comments, articles and research — but there have been *no* new CHs. The Wallingford research showed that, in a rural setting, well-staffed CHs were not cheaper (mainly because an isolated hospital cannot rely on cheap student nurse and therapist labour the way a DGH can), and this has put a damper on things.

The CH has many enemies — the DGH and hospital doctors, some NHS administrators and all those who chisel at public spending. It has few allies — only CHCs, local GPs, trade unions and "the community". Of all the medical organisations, only the Association of GP Hospitals and the Royal College of General Practitioners lend any support. More dubious bed-fellows are the forces that would like to keep "the old, the mad and the bad" somewhere cheap and out of the way.

So the next five years are unlikely to see a mushrooming of CHs — at least not CHs which have been set up in an acceptable way. Hopefully there will be a few rural and urban experiments, but there may also be a trend towards the setting up of under-financed CHs to act as "dumping grounds". However, it should be recognised that properly-financed, properly-run CHs could be an extension of primary care and an expression of the value of caring as opposed to curing.

Further reading

1. DHSS guidance memorandum *Community Hospitals: Their role and development in the NHS,* issued in August 1974 with circular HSC(IS)75.
2. Changing patterns of resource allocation in a London teaching district, by J D Yudkin. *British Medical Journal,* 28 October 1978, pages 1212–15.
3. *A community hospital for Willesden,* Brent CHC, 1978
4. *Cost effectiveness analysis of the Oxford community hospital programme,* by J Rickard, 1976. Available from the Health Service Evaluation Group, Department of the Regius Professor of Medicine, University of Oxford.
5. Statement to the House of Commons by Roland Moyle, *Hansard,* 8 February 1977, columns 1395–1406.
6. Remuneration of GPs in community and cottage hospitals, by D T Jones. *British Medical Journal,* 7 October 1978, p1040.
7. *Health care in Thornhill,* report from the Thornhill Neighbourhood Project. Free from 23 Treaty Street, London N1.
8. *The medical profession and the planning and implementation of policy,* by A L Alaszewski of the Institute for Health Studies, University of Hull. Paper given during the medical sociology section of the British Sociological Association conference in York, September 1978.

There is still time to act on the Finer Report

*by Jane Streather, Director of the National Council for One Parent Families**

Throughout this century there have been dramatic changes in the patterns of births, marriages, divorces and deaths, with far-reaching implications for society and for individual families. Yet legislators continue to frame laws which favour two-parent families to the detriment of the 750,000 divorced, separated, single or widowed parents in this country, who are responsible for rearing 1¼m of the nation's children.

One in every nine families is a one-parent family, and seven out of eight of all lone parents are women. The Finer Committee, appointed in 1969, recognised one-parent families as a distinctive group with special needs. The Finer Report (1), published in 1974, made 230 recommendations covering all aspects of life in a one-parent family. Most of these recommendations are speedily moving into the realm of what might have been.

Government has acted on 48 of them, introducing some welcome reforms. Lone fathers are now allowed to receive supplementary benefit while staying at home to care for their children; the number of hours a low-paid lone parent has to work in order to claim family income supplement has been reduced; lone parents now have the same tax allowance as married men. But Finer's solutions to the *major difficulties* which one-parent families face — in the fields of income, housing and the law — have been rejected.

Income

Finer showed that in 1974 one-parent families had on average only half the income of two-parent families. Figures for 1977 from the Family Expenditure Survey (2) show that this inequality persists — a family with two parents and two children had a gross normal weekly household income of £108, whereas the comparable figure for a one-parent family was £52.76.

Moreover, the numbers of one-parent families dependent on supplementary benefit is large and growing — 60% of all families with children receiving supplementary benefit are one-parent families. About a quarter of one-parent families receiving supplementary benefit have been living on poverty incomes for over five years. Finer recommended that there should be a special one-parent family allowance sufficient in amount to disentangle the vast majority of lone parents and their children from the supplementary benefit net. Unlike the unemployed, the sick, and the disabled, single parents are not entitled to a non-means tested social security benefit. The only exception is widows.

Government has rejected Finer's proposal, mainly on the grounds of cost. In its place it has offered a £2-a-week addition to child benefit, for the first or only child, which is no substitute for the long-overdue introduction of a one-parent allowance similar to the widowed mothers' benefit. Only a handful of one-parent families receiving such a benefit would also need to claim supplementary benefit, and it would also enable many lone parents to work to improve living standards for their children.

Photo: Maria Bartha

Housing

Housing problems "closely rival money problems as a cause of hardship and stress to one-parent familes . . .", stated Finer. Many one-parent families still live in inadequate housing, and too many are homeless. The Housing (Homeless Persons) Act 1978 has been of great benefit to one-parent families, but the fact that 51% of homeless families with children accepted by local authorities in England in the first half of 1978 were one-parent families indicates the serious housing difficulties this group faces.

Finer's recommendations included changes in the law relating to the matrimonial home, and an end to discrimination in local authority policies. Following Finer, the Department of the Environment issued a circular (3) to local authorities, advising them on housing policy as it relates to one-parent families. The Government has refused to monitor the implementation of this circular, but a recent survey (4) showed that many authorities were ignoring it.

It is apparent that in the areas of tenancy transfers, staff training, residential qualifications and procedures concerning rent and mortgage arrears, the policies of most local authorities differ substantially from those recommended in the circular. Furthermore, some authorities, while professing to act in the spirit of the circular, appear to be discriminating against one-parent families. One authority with an "equal policy" for one- and two-parent families, stated: "Flats tend to be offered in preference to houses because the parent, usually a woman, cannot cope with a garden."

The National Council for One Parent Families has been urging the Government to include a non-discrimination clause in the forthcoming Housing Bill, to stop local authorities giving one-parent families worse housing than two-parent families. If the Government fails to grasp this opportunity to implement Finer's most important proposals, then one-parent families may have to wait for a number of years before having their housing interests safeguarded by legislation.

The law

The breakup of a marriage is often in the best interests of all concerned, yet is still likely to be painful. Legal arrangements only too often exacerbate the hurt, cause confusion, and create new bitterness. One-parent families are at present subject to three systems of law, those administered by the divorce courts, the magistrates' courts and the supplementary benefit authorities, all with different rules and procedures.

Finer proposed a unified system of law and the introduction of "family courts" to settle disputes about issues such as custody and maintenance with the minimum of conflict and bitterness. Although the need for family courts is widely recognised, the Government has rejected the proposals, again mainly because of cost.

One-parent families will not go away — there are 6% more of them each year. Society has accepted easy divorce, but fails to provide for the casualties of family breakup. The Finer Report is a sensible, humane and radical document. If only it had been implemented the discriminations and privations suffered by many lone parents and their children could have been removed, and new hopes and freedoms realised.

References

1 *Report of the Committee on One-Parent Families*, Cmnd. 5629.
2 *Family Expenditure Survey 1977*. Department of Employment, 1978.
3 DoE circular 78/77, *Housing for one-parent families*.
4 Survey carried out by the Finer Joint Action Committee, 1978.

* *National Council for One Parent Families, 255 Kentish Town Road, London NW5 2LX.*

What happened to the Court report?

THE CHILDREN'S COMMITTEE

by Jill Page, a member of the Children's Committee and of Leeds Western CHC

The Court report is alive and well and living in Torrington Place! In December 1976 the report of the Court Committee on child health services* was published. It is an inspired document which contains a perceptive study of present child health services and the practical proposals necessary to bring them into line with today's needs. It is also a significant social document. Its philosophy sheds light upon many of our outdated attitudes, leading us on to a new perception of the rights of children.

The Government's response to the Court report, published in January 1978 (see HC(78)5) was disappointing. Although the philosophy of the report was accepted, the Government's proposals were vague and low-key. However, one of the committee's recommendations was that a joint children's committee should be set up to advise the Department of Health "on the coordination and development of health and personal social services as they relate to children and families with children". And in February 1978 the Government announced that the children's committee was to be established. So the recommendation which was given one of the highest priorities by the Court Committee had been accepted.

The Children's Committee consists of 16 people who are workers in the fields of education, health and social services. The "consumers" on the committee include one person who also served on the Court Committee. None of us was chosen to represent any special professional or other interest, but to speak for children.

First of all we had to decide where to start — there were so many issues we could take up, so many documents to comment on, so many wrongs to right. The chairman, Professor Brimblecombe, set us the first task. Within two meetings we had written to the Secretary of State, outlining plans for a campaign to prevent rubella deformities in newborn infants. We felt that the rubella (german measles) epidemic of last summer underlined the need to take action to eradicate this terrible danger to the unborn child. Mr Ennals responded positively in Parliament, and we hope that this year — the International Year of the Child — will see the start of a campaign.

Next we chose a limited number of topics to look at in more depth, while continuing to respond to current issues and to push forward with other matters that affect children's well-being. A group is looking at the health and social aspects of life for

Photo: Maria Bartha

children in inner urban areas, and at the services which exist for them. Perhaps the concern and the cash which are flowing into inner city programmes can really benefit the children who live there.

Another group is studying the needs of the under-fives in the family, and a third group is looking at "out-of-hours" services for children. The perinatal mortality rate (described by the Court report as a "holocaust") and its implications for antenatal and maternity care are the concern of a fourth group. We are asking people who are not on the Children's Committee, but who have special

'GIVE and LET

by Coun. A H Walker, Chairman of North Warwickshire CHC

In November 1977 the North Warwickshire CHC was asked by Leslie Huckfield MP for its comments on the treatment available in the district for patients suffering from advanced renal (kidney) failure. Information we obtained from the district community physician, the chairman of the Regional Advisory Panel on Renal Disease, and the Regional Administrator, revealed that the incidence of kidney failure at that time was about 45 per million total population, and that in the West Midlands only 35% of the need for treatment was being met.

We also learnt that the UK was 17th in the international league table for treating patients by dialysis (with kidney machines) or transplantation. In 1977, 16 new patients per million population were accepted for treatment in the UK compared with 50 per million in the USA and Japan and 33 in France (*see CHC NEWS Feb 1979 p3*). Statistics showed that in the West Midlands alone about 225 people went into renal failure each year and that the cost of maintaining a patient on dialysis was approximately £6000 a year, with home adaptations costing another £6000. The cost of a transplant was between £3000 and £4000, with post-transplantation costs of £1000 a year.

After discussing this information the CHC decided to obtain kidney donor cards for distribution and to mount a campaign to publicise the need for more people to carry a signed card with them at all times. The campaign took place in September 1978. A number of organisations and individuals agreed to help, including the St John Ambulance, the Red Cross, and the Scouts and Guides, Elizabeth Ward, president of the British Kidney Patient Association, and Dr B H B Robinson of the Kidney Unit at the East Birmingham Hospital. He agreed to lend the CHC a kidney machine for publicity purposes during the campaign, and to speak at a public meeting.

We wrote to David Ennals to ask for his support. In his reply he welcomed the campaign and stated: "During the year ending 30 June 1977, nearly 800 kidney transplants took place in the United Kingdom but the waiting list is still over 1100. There is therefore a desperate need for more people to indicate their willingness to donate their kidneys for use after death. I should like to take this opportunity to urge everybody to obtain a kidney donor card, to sign it, and carry it with them at all times."

The "Give and let live!" campaign was launched on 29 August with a press conference held in the Council House, Nuneaton. Those present included the Mayor of Nuneaton, a representative of the Secretary of State for Social Services, a kidney transplant recipient, and Mrs Ward of the British Kidney Patient Association. The event received a large amount of publicity in local newspapers. Next day the CHC secretary visited the Ideal Home Exhibition at the National Exhibition Centre with the "Give and let live!" display, and was interviewed on Radio Birmingham. 4000 cards were distributed on this occasion. The day after I was interviewed about the campaign on BRMB (Birmingham Radio Midland Broadcasting — the local commercial station) and this broadcast was repeated several times during the month of the campaign.

Exhibitions were held during the month at local stores, the market, the railway station, the Nuneaton football ground during a local "derby" match, and at a large factory in the works canteen. A display was also held at an Open Day at the Nuneaton hospitals. These displays were manned by CHC members and volunteers. We bought supplies of large posters urging people to take kidney cards and we used these not only at the displays but also in the window

knowledge and expertise, to help us in our working groups.

The first studies do not cover the whole field. We have not yet, for example, started to look at the needs of the handicapped child. However, two of our members served on the Warnock Committee which reported last year**, and publication of the Jay Committee report on mental handicap nursing will spur us in that direction soon. Other topics that we will be thinking about include the implementation of the Children's Act, children's nursing, services for adolescents and epileptics, training for child care staff, corporal punishment, and dental services.

So what can the Children's Committee hope to accomplish, what real power does it have? The Court report spoke of a "voice for children" and the Children's Committee has the power to speak directly to the Secretary of State — a power that it has already used on more than one occasion. It can advise and call upon its parent bodies, the Central Health Services Council and the Personal Social Services Council, for support. Its voice must also be heard more widely in all matters that concern children (and few do not): in public debate, in controversial issues, in long-term planning. CHCs have an important part to play in this public debate, and in bringing about the changes in services and the changes of attitude which Court envisaged. A local voice for children is essential if changes are to be relevant to the children in your health district.

**Fit for the future* Cmnd 6684, 1976, HMSO £6.50

***Special educational needs* Cmnd 7212, 1978, HMSO £5.65

Nurse recruitment

by Cyril Gumbley, Secretary, East Dorset CHC

Shortage of nurses is often given as the reason for a temporary or permanent reduction in services, or postponement of new developments. The problem is a complex one that cannot be solved simply by training more nurses, as East Dorset CHC found when it focused attention recently on nurse recruitment in the district. The Dorset School of Nursing produces 100 new state registered nurses each year, 90% of whom obtain posts locally. And each year, in East Dorset alone, vacancies occur for more than 200 sisters and staff nurses.

Trained nurses leave on retirement, to have babies and for other personal reasons (for example, when husbands change jobs), to undertake further training, to take up appointments in other areas, or to fill vacancies in the district (necessitating resignations and reapplications). In 1979 the post-1914-18 "bulge" in the birth-rate will result in 76 retirements in East Dorset — a situation which will be reflected nationally.

All districts advertise locally and nationally to recruit trained staff and all have advantages and disadvantages for nurses seeking posts. East Dorset has the appeal of climate, seaside, countryside, the arts, theatres, and so on, yet detracts nurses with its elderly population, lack of industry (for husbands), housing shortage (in a suitable price range and locality) and high cost of living.

East Dorset CHC noted that pressures of advanced technology, higher bed-occupancy and increased patient turnover, together with earlier marriage, lack of married accommodation, and unsocial working hours all took their toll on trained nurses. Concern was also expressed at increasing difficulties in recruiting and retaining staff for geriatric wards, theatres and other specialised units. The opening of geriatric and psychogeriatric wards locally and of a new unit for young chronic sick had been or was being delayed by the inability to recruit trained staff. (Even Joint Board training courses in geriatric nursing and theatre techniques — designed to attract trained nursing staff — were undersubscribed.)

Nurses achieve job satisfaction through the development of successful caring relationships with their patients — they want to nurse ill patients back to health. Yet, in theatres, coronary care units (CCUs) and intensive care units (ICUs), medical advance requires nurses to be more skilled in operating complex machinery than in handling patients. In other specialised units — cancer care, stroke rehabilitation, geriatric, psychogeriatric and young chronic sick — nurses face wards full of patients in terminal states or with little or no likelihood of improvement.

Some specialised units are essential — theatres, ICUs and CCUs — but to these is being added an increasing number of high dependency units which are failing to attract staff and are imposing considerable physical and psychological strain on nurses in post.

Nurses do not object to caring for elderly, infirm, mentally confused or dying patients. Nurses have, in the past, cared for such patients when integrated into general wards. These patients receive every care and attention from nurses, who benefit from also being in contact with a wide variety of less ill and younger patients — allowing them an outlet for tension, an opportunity for light relief and, very often, in time of need, an extra pair of helping hands or watchful eyes.

In East Dorset, programmed improvement to health care services include a new district general hospital, additional geriatric wards, mental illness unit, unit for mentally handicapped children, and 28-bedded acute ward. The CHC supports such developments but does not consider they will necessarily result in improved patient care unless they are adequately staffed and a high nurse/patient ratio is maintained. Spreading the existing (or reducing) nursing work-force over an increasing number of beds could result in increased pressure, frustration, and deteriorating standards in nursing care.

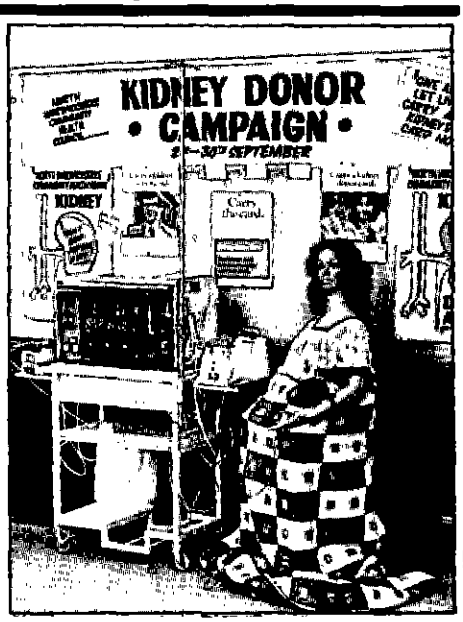
Ostensibly, more beds and more specialised units improve patient care. But unless some of the problems of recruiting and keeping trained nurses are heeded — with planned development towards more day-care wards, five-day wards and domiciliary care — such innovations may have the reverse effect.

LIVE'

of the empty shop (put at our disposal by a Midlands brewery) which was the campaign headquarters. All the commercial establishments in the health district were visited by volunteers who distributed cards, posters and car stickers. Several factories agreed to distribute cards to their employees. With the help of the distribution department of a local newspaper cards and posters were sent to all newsagents in the district.

A public meeting and film show was held in Nuneaton and the speakers were Dr Robinson and the appeals organiser of the British Kidney Patient Association. As a final boost at the end of the campaign kidney donor cards were forwarded to all women's guilds and institutes in the district, to local senior schools attended by mature students and, by the Councils for Voluntary Service, to a large number of voluntary organisations. The nearby Junior Leaders Regiment, Royal Artillery, willingly agreed to distribute 1500 cards to their soldiers and staff.

During the month of the campaign 70,000 kidney donor cards were distributed and the British Kidney Patient Association and the DHSS expressed thanks to the CHC. The effectiveness of the campaign has been indicated by the numbers of individual members of the public and various organisations who have contacted the council to ask for cards. We know that other CHCs have mounted similar campaigns or are considering them. We believe that the success of these campaigns depends on the keen cooperation of the many people involved.



The CHC's mobile display toured the district during the month-long campaign

Photo: North Warwickshire CHC

Mental health volunteers

by Mrs Ann Morris, Member, Harrogate CHC

In Harrogate CHC's annual report for 1977/78 top of a list of recommendations to the AHA is the need for a local psychiatric unit and day hospital. The nearest mental hospital is Clifton Hospital in York, 23 miles away — and there is a waiting list. The CHC, seeing the gaps in local mental health facilities, felt they would like to do something practical to encourage closer coordination between the psychiatrist, family doctor, social worker, community psychiatric nurse and volunteer in the community.

One of the main difficulties is that patients leave Clifton Hospital, where they have been cared for and set on the road to recovery, only, in many instances, to return to their home environment and the problems they had left behind, with little community support available. For a volunteer to visit a psychiatric patient recently discharged from hospital, however, is no easy task. Ideally, the befriending should start before discharge, so that a relationship can be built up in advance and the patient has more confidence when he leaves the security of the hospital. The volunteers who are doing this kind of work must know that there is a professional to call on if necessary, and should also know who to turn to if at any time they want to back out of the work.

I am volunteer organiser of Harrogate's Volunteer Bureau, and I have often felt that volunteers need some preparation before giving such help. As chairman of the CHC's sub-group on mental health, I suggested that a course should be run to encourage understanding of the problems of the mentally ill and to offer volunteers the opportunity to help. We discussed the matter with our local Association for Mental Health and then approached the Workers' Educational Association. As the result of joint effort a course of six weekly lectures was held, entitled *Mental health . . . a chance for volunteers.*

Photo: Chris Schwarz

The course was well supported, with a regular attendance of over 50 people. Among them were volunteers already working with the mentally ill, social workers, people wanting to find out more about mental health, and a few who had themselves experienced a mental health problem. Robin Davidson, a clinical psychologist at Highroyds Hospital, Menston, was the tutor. He made the lectures very interesting — the main criticism was that the course should have been longer! Because of this the WEA is now running a continuation of the course, lasting two terms; 10 of the 21 people attending came from the previous short course.

At the end of the first course 19 people with no previous experience of voluntary work with the mentally ill, and three who had had some experience, offered to give some of their time to working in this field. It was decided that a group should be formed to meet regularly every six weeks. With the guidance of staff in the hospital, Harrogate Social Services Department, and the Volunteer Bureau, this group have all been found work to do. Not only have most of them been to visit Clifton, but some are going over to help with teas on Sunday, providing transport for patients coming out of hospital, and taking families to visit patients in Clifton.

Many of the volunteers have taken on difficult tasks. One is visiting a deaf depressed man, another has befriended a 19 year old boy who has brain damage after a car accident, two have joined a house committee for the local MIND group. Others are visiting the lonely, and one volunteer is going in daily to help a mother who has arthritis in her hands to cope with baby twins.

The CHC feel that to have attracted 21 volunteers to work with psychiatric patients is quite an achievement.

The project's success lies in the fact that the volunteers and patients get to know each other before the patient returns home, and in the encouragement and cooperation given by the professionals, who work closely with the volunteers. The psychologist attends the six-weekly follow-up meetings, where individual problems are discussed and new cases brought forward.

Parliament

Public spending on health care

Figures from the Organisation for Economic Co-operation and Development show public spending on health care in 1974 ranging from 3.0% of gross national product (USA) to 6.5% (Denmark). The UK figure in 1975 was 4.6%. Sweden spent £200 per head of population, as against a 1975 UK figure of £87 (Geoffrey Pattie MP, Chertsey and Walton, 18 Jan; Maurice Macmillan MP, Farnham, 12 Feb).

Waiting lists

In March 1978, 603,200 patients were awaiting admission to English NHS hospitals (the provisional figure for June 1978 was 609,300). 41,200 of the March patients were "urgent", and 65% of these had waited over a month (MPs as above, 18 Jan and 7 Feb).

Charges for family practitioner services

Charges will meet an estimated 20.9% of the bill for general dental services in England in 1979-80. Comparable figures for ophthalmic and pharmaceutical services are 33.2% and 2.9% respectively (Lewis Carter-Jones MP, Eccles, 6 Feb).

Building hospitals in new towns

Although health authorities should normally provide hospitals in new towns, the new town development corporations of Northampton, Milton Keynes and Peterborough have agreed to transfer £½m a year during 1978-82 to AHAs for NHS spending. The North Western RHA is seeking a special allocation from the new towns' programme to help build a community hospital in Skelmersdale (Robert Kilroy-Silk MP, Ormskirk, 7 and 8 Feb).

What seat-belts could save

The British NHS could save £7.2m (at November 1978 prices) if all drivers and front-seat passengers wore seat-belts (Peter Bottomley MP, Greenwich, Woolwich West, 29 Jan).

CHCs and confidentiality

Two cases in which it is claimed that CHCs have breached the confidentiality of FPC service committee hearings have been taken to the DHSS by GPs. The DHSS is also aware of "a very small number" of similar cases (Laurie Pavitt MP, Brent South, 30 Jan).

Private day-care abortions

Private nursing homes may now be licensed to carry out day-care abortions, provided they meet strict Government conditions. This follows a two-year trial, monitored by the DHSS, carried out by the charities PAS and BPAS (Sir George Sinclair MP, Dorking, 29 Jan).

Move right down inside!

Roland Moyle was asked whether 20 places for the general public was sufficient at an AHA meeting. He replied that each AHA "should decide for itself" how many places to provide at each meeting — no figure is laid down by law (Laurie Pavitt MP, Brent South, 1 Feb).

Scanner

The team concept

The Department of Health's Standing Medical and Standing Nursing and Midwifery Advisory Committees have set up a joint working group to "examine problems associated with the establishment and operation of primary health care teams and to recommend solutions". The DHSS has sent CHCs a copy of the letter announcing this decision, and ACHCEW is among those to be consulted.

More on amniocentesis

Increased incidence of foetal loss and of breathing difficulties and orthopaedic postural abnormalities in the newborn are attributed to amniocentesis in the report of a study presented to the Medical Research Council Working Party on Amniocentesis.* (Amniocentesis is a test for foetal abnormalities by analysis of a sample of the fluid surrounding the foetus in the womb). One implication, according to the report, is that in view of the possible hazards, indications for amniocentesis should be more carefully assessed. *Published by the *British Journal of Obstetrics and Gynaecology*, vol 85 1978, supplement no 2.

Statistics galore

The main tables of the *Hospital in-patient enquiry* (HIPE) for 1975 (published in February, HMSO £7.25) contain statistics for a 1-in-10 sample of patients in NHS hospitals in England and Wales (excluding psychiatric patients). They cover items such as discharge rates, waiting times, and duration of stay by diagnosis. Comparisons by region (including Scotland and Northern Ireland) on a wide variety of topics, including population projections, social services, housing and unemployment as well as health, are given in *Regional statistics 14* (1979 edition, HMSO £7.50). The latest edition of *Health service staff statistics*, which is issued annually, gives a detailed summary of all NHS staff in England by RHA and Board of Governors at 30 September 1977 (copies from Mrs J E Nash, Statistics and Research Division, SR7B, DHSS, 14 Russell Square, London WC1B 5EP). And the Office of Population Censuses and Surveys can supply *Monitor* supplements (DH1 79/1) for regional data (by AHA) on infant and perinatal mortality, congenital malformations, and deliveries by caesarian section and induction (free from Information Branch, Dept M, OPCS, St Catherine's House, 10 Kingsway, London WC2B 6JP — state which region).

Social security benefits: the consumer's voice

Social security users — local consultative groups (HMSO 85p), the report of a study commissioned by the DHSS, recommends that one or two users' groups should be set up on a trial basis. The Supplementary Benefits Commission welcomes the idea, but so far refusal by DHSS staff to participate in such groups is preventing action. What claimants think of the social security system is recorded in a recently published survey, *Social security claimants* (free from DHSS (leaflets), PO Box 21, Stanmore HA7 1AY).

Depo-Provera

A campaign has been formed to publicise the use of the injectable contraceptive, Depo-Provera. The drug has not received full CSM approval, and the campaigners want it withdrawn, pending further research into side-effects and a reported association with increased risk of breast and cervical cancer. The first task will be to find out where, to what extent, and on what basis the drug is being offered. *Campaign against Depro-Provera*, c/o 374 Gray's Inn Road, London WC1.

Photo: University of London Audio-Visual Centre

How special?

Is the title of a 40-minute colour film on dental care for the handicapped made by the University of London Audio-Visual Centre. It explores the nature of impairment and the contributory effects of attitudes and environment in creating or intensifying handicap, as well as reviewing the types of dental service available for "the handicapped" and ways of preventing or reducing dental handicap. In the still above a dental health educator is giving help with brushing techniques in an adult training centre. The film was made as training material, but aims to promote self-questioning as much as to instruct. In this it is very successful, and CHCs may well want to hire it (£5 a week + VAT + postage). Contact: The Administrative Secretary, ULAVC, 11 Bedford Square, London WC1B 3RA).

Organisation of supplies: HC(79)2

Confirms DHSS acceptance of the recommendation of the Supply Board Working Group (see *CHC NEWS 34*) that "there should be no independent district supplies organisation", and indicates how the operational control of the Area Supplies Officer should be strengthened, even where circumstances mean that some supplies staff must be placed at district level.

Yellow card system extended

Doctors and dentists have been asked to use the yellow card system to report adverse reactions to contact lenses and contact lens fluids, IUDs, dental pharmaceuticals and filling substances, and certain ligatures, sutures and surgical dressings.

SPOD

Stands for committee on Sexual and Personal Relations of the Disabled, which provides information and advice for disabled people and training for counsellors and other workers. Leaflets on *Your handicapped child and sex* and *Your disabled partner and sex* are the latest in a series of eight (free to disabled clients from SPOD, Brook House, 2-16 Torrington Place, London WC1E 7HN).

Joint finance in Wales: WHC(79)1

Asks health and local authorities to submit new capital and revenue projects for joint financing. The extent to which the Welsh Office will contribute towards a health authority's contribution will vary, but will not normally exceed 50%. The size of the central reserve — £0.2m last year — has not yet been determined for 1979/80.

Marriage

The "importance of the family" is the catch phrase of the day, so publication of a consultative document by the Home Office/DHSS working party on marital problems and marriage guidance is timely.* It proposes that responsibility for marital work should be vested in a particular Government Minister, backed up by a Central Development Unit for Marital Work, and that AHAs should provide facilities for psychosexual medicine on a systematic basis. ACHCEW is among those to be consulted — comments are required by next February.

**Marriage matters* HMSO £3.25.

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 12: **Isle of Wight CHC** Tel: Newport 525095
Page 15: **Mid-Staffordshire CHC** Chairman: Coun. Harold Mellor
Page 16: **Dudley CHC** 7 Albion Street, Brierly Hill, West Midlands DY5 3EE. Tel: Brierly Hill 71856
Page 16: **Solihull CHC** Secretary: Mrs D W Pirt

News from CHCs

☐ The Secretary of State for Wales supported the argument of **South Gwent CHC** against the plans to close Snatchwood Hospital, a 25-bed unit for elderly people. The AHA claimed that money saved by the closure would enable it to open a new similar unit with 30 beds. When the CHC showed that the money would only be enough to have 20 of the new beds in use, and pointed out that the district already was 100 beds short of its DHSS norm, the Secretary of State provided the extra money needed to keep the old hospital going as well as the new unit.

☐ **Salford CHC**'s campaign to prevent the transfer of the children's cancer unit from a children's hospital to a regional cancer unit is having considerable success (see *CHC NEWS* page 1, November 1978). A Committee of Enquiry has been appointed by the Secretary of State, to examine the transfer decision, the objectors' views, and to recommend whether the plan should go ahead. Lady Mary Marre, member of **Edgware and Hendon CHC** and of the Standing Committee of the **Association of CHCs**, will lead the 3-person committee.

☐ **The Association of Local Health Councils** in Scotland at last has a full-time secretary. She is Linda Headland, who used to be the secretary of **Aberdeen LHC**. The Association is at Trinity Park House, South Trinity Road, Edinburgh EH5 3SE (031-552 6255). A report of the Association's 1978 annual conference has been published.

☐ **Newcastle CHC** and **Coventry CHC** have both published reports on *Good practices in mental health* as part of the International Hospital Federation scheme of the same name. The reports list local projects for children and adults who are suffering or recovering from mental illness. Other CHCs participating in the scheme are **Haringey, Basildon and Thurrock, Central Birmingham, Oxford, Sheffield Southern,** and **Southend.**

☐ Cash has been earmarked for a walk-in family planning centre, after **Dudley CHC** presented the AHA with a fully costed proposal. The CHC drew up the plans with the help of the Brook Advisory Centres, found premises in the town's High Street and drafted conversion plans. The centre will aim at teenagers in particular — the CHC's action was prompted by the discovery that the local pregnancy rate for girls under 16 had been soaring. Said CHC secretary David Johnson, "If they are going to experiment with sex then it is up to us to see that they do it safely and it is up to parents and young people themselves to decide on the moral issues".

☐ A well-women clinic is to hold evening sessions, after much pressure from **Islington CHC**. Marcia Saunders, the CHC's secretary, believes it to be the first such clinic in the country. "This will be a big help to working women", she said.

☐ The part played by CHCs who help complainants to the Health Service Commissioner has been acknowledged, following discussions between **ACHCEW**'s Mike Gerrard and the Ombudsman's office. From now on, when a complaint has been dealt with by the Ombudsman, any CHC involved will be notified that the investigation is complete and that the report has been sent to the complainant and the AHA.

☐ A general practitioner was ticked off by his district management team (DMT) for sharing a problem with **West Lancashire CHC.** After discussions with the GP about helping people with mental stress, the CHC had asked the DMT to consider attaching a community psychiatric nurse to a local GP practice. The CHC was alarmed by the team's reaction and members felt it implied that the "DMT could have victimised an employee" who held discussions with the CHC. All is well now — the funds for a community psychiatric nurse will be in next year's estimates.

☐ From this month, CHCs who are not members of the **Association of CHCs for England and Wales (ACHCEW)** will no longer receive the Association's newsletter. Nor will ACHCEW accept representations or nominations from non-members. All CHCs will still get *CHC NEWS* and have access to its information service. ACHCEW has 204 members out of a possible 228.

☐ **Coventry CHC** was worried about low take-up of immunisations and vaccinations in some areas of the city. The council persuaded the AHA to programme its computer to produce "maps" of districts where take-up is low and to give GPs details of patients who have missed out on immunisations. Now the numbers of people who are protected is improving.

☐ At a routine joint informal meeting between **Isle of Wight CHC** and the AHA, the council voiced concern about public ignorance of the island's ten NHS "amenity" beds. The AHA took action to publicise the service.

☐ The three CHCs in **Derbyshire** drew lots to decide who should fill the two seats for CHC representatives on the County Council's new Public Transport Users' Advisory Committee. The committee is a result of the Public Transport Act 1978.

☐ People believing themselves to be sufferers of the rare motor-neuron disease are forming a self-help group with help from **Central Nottinghamshire CHC.** The County Council and the Muscular Dystrophy Association will also help the group. A story in the local press about the CHC's help to one motor-neuron sufferer brought a response from 22 Nottinghamshire people with a similar condition. However, some are complaining that they have still not been given a clear diagnosis.

☐ The majority of patients are "not unduly bothered" by mixed sex wards, but many would prefer separate toilet facilities. **East Leicestershire CHC** issued 300 questionnaires to patients who had been discharged from mixed wards. A list of patients was provided by the sector administrator.

Photo: Wigan Observer

☐ ***Wigan CHC**'s office was at the hub of a joint effort, with the local authority and the AHA, to persuade the people of Wigan and Leigh to give up smoking on Ash Wednesday. The office became a centre for smokers who wanted advice or literature to help them give up. The Mayoress, a heavy smoker, pledged not to smoke for one day at least. The CHC circulated "pledge cards" to factories and social clubs.*