CHC NEWS

For Community Health Councils

May 1979 No. 42

Gritting the NHS oyster

CHCs are coming of age, and now require a range of additional rights and powers if they are to transform their "experimental" status into a longer-term success.

This was the message from Mike Gerrard, secretary of the Association of CHCs, when he addressed this year's congress of the Royal Society of Health, in Eastbourne.

"The function and status of CHCs will have to be advanced, and their position as the grit in the NHS oyster accepted", he told the congress. "CHCs have the potential to be much more effective, and if the political will exists they almost certainly will become so".

Mr Gerrard proposed an eight-point *Manifesto for CHCs:*

1 They should receive working information from health authorities in manageable form, in adequate quantity and in good time. "There should be no argument as to what is necessary for them to do their work".

2 They should receive all relevant reports from outside advisory services and inspectorates, *and* reports prepared by health authorities' own inquiries, working groups and project teams. "It is not reasonable to assume that CHCs will deal less responsibly than other bodies with matters of genuine delicacy".

3 CHCs need an extra member of staff "to deal with the information coming in and to conduct the necessary research to enable its interpretation and presentation to members in a purposeful way".

4 CHCs should be free to spend their budgets on staff, on premises, on publicity, or in other ways, subject to normal financial checks. The idea that RHAs "are somehow financing CHCs out of their own pocket" should be discredited.

5 Appropriate gradings for CHC staff, and a code of practice for their employment, should be established. Within this, CHCs should be free to agree terms with prospective employees "without outside pressure" from RHAs.

6 CHCs "should be given a defined role . . . in the planning of family practitioner services and their integration or coordination with corresponding services provided by the health authority".

7 The DHSS should finance a national CHC publicity campaign, "using all principal advertising media".

8 ACHCEW should take responsibility for the wider "public health" interests of CHCs, and should also develop its publicity, information and research roles.

Asked about the meaning of point six, Mr Gerrard said two kinds of improvement were implied. *First,* services provided by family practitioners for the AHA, or supplementing or complementing AHA services, should be subject to the normal NHS planning procedures. Family planning and ante-natal services were good examples. *Second,* CHCs had a right to be heard on matters such as the closure of chemists' shops and branch surgeries. The DHSS should issue a circular requiring FPCs to consult with CHCs as AHAs do, *and to admit CHC observers to their* meetings.

Some of the points in the manifesto have already been taken up with the DHSS, and firm recommendations on the others should emerge later this year when an ACHCEW working party on the role and staffing of CHCs reports.

THE AFTERMATH OF NORMANSFIELD

The impact of the Normansfield inquiry report is still being felt, both nationally and locally. AHAs are carrying out the urgent review of monitoring arrangements requested by the Secretary of State. The expense, disruption and damaging effects on morale of hospital inquiries have been spelt out in a recent study (see page 3), and Kingston, Richmond and Esher CHC, whose vigilance and persistence in bringing conditions at the hospital to the attention of health authorities were praised in the report, is querying the value of the Normansfield inquiry if some of its recommendations can be overturned.

The CHC has written to David Ennals expressing concern that the disciplinary measures against nursing and administrative staff agreed by Kingston and Richmond AHA are more lenient than those recommended by the report. And the CHC is seeking an assurance that no member of the AHA who held office during the period covered by the inquiry (in which the AHA is itself criticised) has taken part in the disciplinary proceedings.

And the council is waiting with interest to see how well it will be kept informed about the results of the AHA's new monitoring system — which may in fact make use of the CHC's own regular reports on hospital visits.

INSIDE . . .

Photo: Kensington and Chelsea MIND

WE ARE VERY SORRY

that some readers received a faulty edition of May *CHC NEWS*, containing eight pages that had already been published in March

The mistake was entirely the fault of our printers. This is the *real* May *CHC NEWS*

We apologise for any inconvenience that may have been caused

Your letters

Letting the public in

Sheila Gatiss, Member, Cambridge CHC

I am writing in response to the letter from Sally Simon about public participation in CHC meetings, in *CHC NEWS 39*. Our chairman opens our meetings by telling members of the public that we would welcome questions or statements, provided they are about matters already on the agenda for discussion. This has worked well in routine business meetings.

Recently, to encourage more public participation, we decided to focus three of our ten monthly meetings on a specific subject, and we have found a greater participation by members of the public in these meetings. Surely it is better to have on-going participation in this way, rather than aggressive participation on those occasions when a local issue becomes an emotional matter?

Carey George, Secretary, Pembrokeshire CHC

I was surprised to read in *CHC NEWS 39* that a member of the Kingston, Richmond and Esher CHC had failed to persuade her colleagues to invite members of the public "to air their views or ask questions on health matters" during CHC meetings. At our monthly meetings agenda items are deferred at 8pm for an "open forum", when members of the public can speak and ask questions. This attracts more people to our meetings, it enables answers to be given to questions by the CHC or by the district administrator, and it enables us to consider matters which have been raised.

Nothing but good can come of this arrangement. It helps us to make contacts which will assist us in assessing the health needs of our community.

Mrs E Collins, Chairman, High Wycombe CHC

Before our meetings we always hold a public forum, to enable people to put forward their ideas and views. We have had members of the public expressing their wish for better facilities, and also members of the medical profession putting their problems — such as the need for a day care abortion unit in the area, and the need to open beds in the intensive care unit.

Of course people also come to express their strongly held opinions on abortion, euthanasia and other emotive subjects, but it is important to hear what people have to say. A chairman should be able to control discussion, and cut short cranks and extremists when necessary. Perhaps I should also point out that one person's cranky extremist is another's dedicated advocate.

We do not put a time limit on the public forum, but it usually lasts about twenty minutes. Our role is to represent the views of the community — and what better way than to listen to what the community itself has to say?

E Moore, Chairman, NE Essex CHC

There is little purpose in encouraging the public to attend CHC meetings if they are not to be given a chance to participate actively at some stage in the proceedings. CHCs should lose no opportunity to secure the views of the patients they represent — including extremists and cranks. It is of course for members to assess the validity of the comments made. On the agenda of each meeting of this CHC there is a public participation item, including a question-and-answer session lasting up to 30 minutes. We hold our meetings in various towns in the district, changing as often as possible to give everyone an opportunity to attend and express their views.

If a CHC is doing its job, there need be no reason for fears. I hope Sally Simon's council will have second thoughts.

Joining the DGH team

Joy Gunter, Secretary, Dewsbury CHC

The project team for the first phase of our general hospital development has just been set up. The CHC would like to obtain membership of this team, so may I ask if there is any precedent for this?

Mobile chiropody services

Anne French, Secretary, NW Surrey CHC

We are very anxious to obtain facts on mobile chiropody clinics. We would like to hear from any CHC whose district has such a clinic, with details of how it is funded. Is joint funding used? Is the clinic domiciliary — ie door-to-door — or is it central, based for example on a day centre? Did the CHC play any part in getting the clinic set up?

Deceased patients' possessions

June C Ayling, Secretary, Maidstone CHC

The recent unfortunate experience of one of our members in a health district outside Maidstone drew our attention to the way in which the possessions of deceased patients are dealt with. Although the basic rules are the same everywhere, health districts have their own ways of administering the regulations. We suggest to other CHCs that you look at your district's systems. This might prevent distress on the part of bereaved relatives, or show up a caring and efficient part of the service.

The problem with joint planning

Hazel Jones, Secretary, Enfield CHC

Joint care planning recognises the interdependence of health authorities and local authorities. They receive financial encouragement to work effectively together for the common good. However, economic pressures discourage projects that carry long-term financial consequences, and encourage protective attitudes. The current division of responsibility can lead to stalemates which no one has the power to resolve.

Enfield district has a case in point — a ten-bedded unit for treating alcoholism cannot open until a senior social worker is appointed, but the social services department has refused to approve this post. So far all attempts to get this decision reversed have failed.

There may be a need for an outside body to resolve disputes between local and health authorities. Joint consultative committees have no such power, and appear to offer no facility other than that of a meeting ground, which does not necessarily resolve problems. Have other CHCs experienced similar local conflicts, and if so how were these resolved?

Voluntary organisations and the welfare state

Pauline Samuelson, Member, West Essex CHC

Following the consultative document *The government and the voluntary sector**, perhaps it is now appropriate to consider the role of voluntary organisations within the welfare state. There is much talk these days of self-help schemes and helping those who help themselves, but the 19th century charities were not always motivated by ideas of self-help. In some respects the welfare state has continued with the same attitude as the former "do-gooders". There has been a failure to help people from dependence to independence.

The need is to strengthen the lines of communication between the statutory and non-statutory bodies. The statutory agencies are often perplexed by the plethora of voluntary help available, whilst the non-statutory organisations frequently find themselves insufficiently informed about the welfare structure within which they work. The confusion can sometimes cause tragic gaps in the support system, or produce overlapping and wasteful effort for people who could very well help themselves.

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Comment

In the small hours of the morning the doubts crowd in and we probably all ask ourselves at some time or another whether CHCs, those bodies we give so much time to, are actually achieving anything worthwhile. Who cares about the health service anyway, or whether CHCs even exist? So it is morale-boosting to know, from the results of a National Consumer Council poll, that it's the NHS which people think needs a consumer watchdog, more than any other public service. It seems we are needed, after all!

Any glow of comfort we can derive from this knowledge is however quickly doused by the results of another survey. *Less than* 2% of the adult population are aware that community health councils exist.

The study, by Robert Anderson in *Health and Social Service Journal* (22 March 1979), discusses public awareness and interest in CHCs. Those who know about CHCs are mainly educated and middle-class. Other surveys have had less depressing results (see *CHC NEWS* editorial, January 1978) but this is perhaps because they asked loaded questions such as "Have you heard of the CHC?". Anderson suggests that the "community" in which the CHC has to work is too large and may not be much of a community at all, in the social sense, but just a head-count of people within the catchment area of a district general hospital. He concludes that until a broader range of people know about CHCs, there must remain "doubts about the extent to which CHCs represent 'community' interests".

Few would disagree with this sombre conclusion, and an immediate remedy seems obvious — much more, much better publicity. *CHC NEWS'* survey (see page 11) shows that almost £¼ million has been left unspent from CHCs' 1978/1979 budgets. Such a sum, spent effectively, could go a very long way towards putting CHCs on the map. Whether it should be spent on tailor-made local publicity, or on a national effort, is a matter for debate by CHCs and within the Association of CHCs. But we cannot plead shortage of cash as an excuse for not responding to this important challenge.

Health News

Reprieve for Boards of Governors

The Boards of Governors (BGs) of London's twelve postgraduate teaching hospitals have been granted a further three years' lease of life. An order confirming the extension was agreed in the House of Commons in March. Future management arrangements for the hospitals were the subject of a consultative document issued by the DHSS in October last year (see *CHC NEWS 38* p 1). This favoured the early establishment of a single London Postgraduate Hospitals Authority (LPHA) to take immediate responsibility for the overall planning of the hospitals, the allocation of funds to individual BGs, and coordination between the BGs. In the longer term the LPHA would act as "an agent of change", capable of adopting any new structural shape that might be suggested by the Royal Commission on the NHS or by the Flowers Committee which is considering the future of medical and dental education in London.

The DHSS says that the response to the consultative document has indicated strong support for the idea of an LPHA — with all but two BGs in favour. The Department hopes that ultimately the hospitals will be managed by a single authority, with the BGs eventually disappearing. Extending the life of the BGs for a further span thus allows time for a new management structure to be worked out, and also makes possible the creation of the LPHA.

ACHCEW's view on the consultative document, presented by a number of London CHCs, was that the BGs should remain until the conclusions of the Royal Commission were known. But the CHCs want to see the hospitals become part of the normal NHS management structure, and were therefore opposed to the LPHA.

Scientists or salesmen

A voluntary code of practice is to be established to control the large-scale trials of drugs by drug companies more interested in promoting a product to GPs than in finding out more about a drug itself. A campaign for official rules for trials of drugs already on the market has been led by Mike Thomas MP. He tried to introduce legislation last year. The Royal College of GPs, the BMA and the Association of the British Pharmaceutical Industry will be among those consulted about the guidelines.

Split on integration

The National Association of Health Authorities (NAHA) believes that much would be gained from integration of administrative services with those of family practitioner committees. But the bodies which represent FPCs and FPC administrators think that there would be little purpose in integrating services, and it would entail the loss of the FPCs' independent status. Both points of view have been given in evidence to the Royal Commission on the NHS and are reported in the March issue of *Family Practitioner Services*. The FPC representatives called for direct funding of FPCs from the DHSS. NAHA argued that integration would assist planning of primary care and better use of resources.

Heed the warnings

A breakdown in the decision-making process is often what lies behind a deterioration in standards of patient care to a level which provokes a major hospital inquiry. According to the former chairman of two such committees of inquiry into mental hospitals, many similar inquiries could have been avoided if people had been alert to the warning signs. Writing in *The Lancet* 24 March 1979, J Hampden Inskip says that hospital management committees are often widely split about the extent of doctors' responsibility for patient care. He blames the DHSS for not providing "intelligible guidance" to help staff adjust from the old model of care, in which doctors dominated the hospital decisions, towards the new model of a multi-disciplinary framework, with its welter of committees. This has frequently meant that decisions have simply gone by default, staff morale has dropped and the patients have suffered.

Abortion opinion

The numbers of people expressing outright opposition to abortion has dropped, and more people agree that it should be available "for all those who want it". *New Society* 22 March 1979 gives the results of a recent NOP opinion poll which asked people to agree or disagree "that abortion should be made legally available to all who want it". 56% agreed and 29% disagreed — a poll in 1975 produced comparative figures of 52% and 34%.

The poll confirms previous surveys, showing that opinions vary according to sex, age and social class. Men agree with abortion on demand (60%) more than women (52%). Older people tend to have more conservative views, as do semi-skilled and unskilled workers.

Abortion is a completely "cross-party" issue it seems. Of those who intend to vote Conservative, 58% were in favour of abortion on demand, compared to 57% Labour and 61% Liberal. Similar very small differences separate the party supporters who oppose abortion. Wessex RHA has announced that its Working Group on abortion has recommended a feasibility study into the provision of day-care abortion. The next RHA meeting will consider the proposal.

Reducing radiation

About 45% of the radiation to which people in the USA are exposed comes from medical and dental X-rays and other diagnostic procedures using radio-isotopes, according to a report of the US Department of Health, Education and Welfare (HEW). About 50% is natural background radiation, and only 5% comes from fallout, industry, nuclear power and consumer products.

US Food and Drug Administration rules

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Health News

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have already reduced radiation doses from dental and breast X-rays by an average 60%, but HEW believes that total exposure to medical radiation can be cut by half again, without reducing diagnostic value. The report recommends "a comprehensive radiation reduction programme for the healing arts" (*New Scientist*, 8 March).

Creating a stink

Unbeknown to most CHCs, a bitter argument crucial to the care of psychiatric and other types of patient is going on in professional circles and within the DHSS. It concerns the future of "creative therapists", who have been alarmed by a new DHSS consultative paper, *Art, music, drama etc therapy in the NHS*.

This proposes to place all such therapists — including art therapists trained in Britain's three postgraduate art therapy centres — under the control of hospital occupational therapy (OT) departments.

According to the British Association of Art Therapists (BAAT), the DHSS has failed to understand that art therapy is not just of value in rehabilitation and recreation — it also provides useful evidence for psychiatrists trying to make diagnoses or assess their patients' progress. It can be of direct therapeutic value too, by helping patients recognise and come to terms with their own personality and emotional conflicts.

In a sharply worded reply to the DHSS paper, BAAT explains that: "The current practice in many institutions now is for qualified art therapists to accept referrals *direct* from consultant psychiatrists, registrars and other members of the clinical team, and to liaise directly with the referring staff member . . . BAAT cannot agree that head OTs are qualified by their training and experience to supervise qualified art therapists . . . the insights gained during art therapy should be relayed directly from the art therapist to the clinician in charge, without the intervention of another professional who is not qualified to understand the language of art therapy nor the medium itself". This view was supported by a recent Whitley Council investigation, and ironically by the DHSS itself in its 1973 report *The remedial professions*.

BAAT wants a separate career structure for art therapists, with graduate entry to the profession. The DHSS says this would be "both unnecessary and undesirable" — adding to the "splintering" in the health care professions and causing "disputed responsibilities" with OTs. BAAT retorts that art therapists "should be encouraged to develop to the highest level in the best interests of the patients, and not regarded as administratively inconvenient interlopers".

OTs themselves may well feel threatened by the sight of BAAT pressing for a level of status which they themselves have been unable to achieve in their much longer professional history. BAAT in fact describes the DHSS paper as "an attempt to incite a large, established group of staff to submerge and stunt the development of a smaller, emergent group".

The official consultation period ended on April 30, but comments could still be sent to Mr M W Perry, DHSS, Hannibal House, London SE1. BAAT can be contacted at 13c Northwood Road, London N6.

New GPs' charter

The GP Charter Working Group of the BMA's General Medical Services Committee was charged in 1977 with the task of producing a deal that would bring GPs' pay up to the level of their counterparts in the EEC. Though the new charter covers many aspects of general practice — such as manpower, training, rural and inner-city problems, and professional standards and audit — at its core are the proposals for an industrial-type remuneration package, with pay closely related to hours worked and the amount and type of work done.

The working group rejected the idea of a salaried service or a total item-of-service payment system. Instead it proposes that GPs should, as a start, receive a "basic commitment payment" as remuneration for average practice duties within normal

Photo: Liz Heron

working hours. This would include elements such as capitation fees and basic practice allowance which are common to all GPs, and would be used as the standard by which to judge comparability with other professions. On top would come: "supplementary payments", such as out-of-hours fees and item-of-service fees; "supporting payments", such as postgraduate training payments and dispensing fees; and "public interest payments", such as inducements to work in isolated areas or for single-handed GPs to join forces. The "work-sensitive" payments proposed would include fees for over 50 items of service, such as ear syringing, diabetic screening, and pregnancy tests (contraception and cervical cytology are among the ten items at present paid for on this basis). It is also suggested that continuity payments should be made to cover a specific number of consultations where routine surveillance is needed, for example in chronic arthritis.

The working group believes that the new charter will not only get more money for GPs but will also improve the service to patients. Critics fear that the piece-work system of payment will discourage doctors from doing preventive work or from simply talking to their patients, and that it will mean even more form-filling. The charter has also been attacked for favouring a commercially operated national locum scheme and for rejecting the idea of an NHS deputising service. Among the less controversial proposals are: a reduction in list size to 1700 (unlikely to be achieved within the next 25 years); inducements to elderly doctors to retire; central agreement on pay and conditions for GPs working in hospitals; and four-week sabbatical leave for GPs every three years.

*A summary of the working group's report, *General Practice: the road to progress*, was published in the *British Medical Journal* on 24 February 1979.

"Best buy" in breast cancer screening?

Breast cancer screening in general, and mammography in particular, are topics which are still surrounded with uncertainty. While it is now commonly held that early detection and treatment give the best prospects for patients with breast cancer, not all those diagnosed early survive, and not all survivors have had the benefit of early diagnosis. There is still controversy about the age at which screening should start, the interval between tests, and the safety and effectiveness of the different screening measures used.

The cost effectiveness of different screening regimes used at the breast cancer screening clinic in Edinburgh has been examined in a recent study.* This compared mammography (X-ray examination), thermography (infra-red photography to detect variations of temperature within the breast) and one or two clinical examinations (manual palpation) in various combinations. The women were screened on the basis of age (between 40 and 59 years) and inclusion on the lists of particular GPs. The conclusion is that mammography, coupled with a single clinical examination, is the "best buy". This regime was found to be at least as effective and produced as few false negatives as any other screening package considered, and entailed the lowest costs, both to the NHS and to the women.

The study did not investigate the possible risks of mammography, but the British Breast Group last year stated its belief that modern low-dose mammography involved no significant risk in women over the age of 50 (*British Medical Journal*, 15 July 1978, p 178). However, the evidence available so far, both on safety and on effectiveness, is patchy and difficult to interpret. A clearer picture should emerge from the seven-year comparative breast screening trials that have been authorised by the DHSS. These will compare the results of annual clinical examinations plus mammography every other year with those obtained by a programme of education and encouragement in self-examination (see *CHC NEWS* 37, p 3). **Cost effectiveness of breast cancer screening* by Gavin H Mooney and Anne M Scott (£1 from Mrs I Tudhope, HERU, Department of Community Medicine, University of Aberdeen, Foresterhill, Aberdeen AB9 2ZD).

CHCs AND REALISM

by L J Bowling, Chairman, Ipswich CHC

Most community health councils are at a crossroads; on the one hand, expansion, and on the other the need to keep what they do within their present resources. Some are in process of taking on extra staff while others have already done so. Before opting for expansion it might well be prudent to ask "expansion to do what?"

Early in 1978 members of Ipswich went back to first principles in their search for identity. The role of CHCs was defined as long ago as 1974 in health circular HRC(74)4 and may be described as a threefold duty: to keep under review the operation of health services in the district and to make recommendations for improvements; to provide a means of representing the consumer's interests to those responsible for running services; and to act as the patient's friend.

CHC NEWS induces a sense of inferiority in many CHC members and secretaries when they read of the many and varied activities of their colleagues up and down the country. "What are we doing?" they ask, or "should we be doing more?" It is only when the projects of some CHCs are analysed that the doubts appear. It is not the function of a CHC to run a health education department or a citizen's advice bureau and yet many present a public image which would serve equally well for either. Many have set themselves up in "high street" premises where, inevitably, since they have nothing to sell, they have slipped into handing out advice and literature about many things which have to do with health and many which have not.

There is scarcely anything in everyday life which does not have a bearing on health. That a CHC should therefore be prepared to concern itself with almost every aspect of life does not necessarily follow. There are two important areas, of social services and environmental health, into which many CHCs have strayed and thus exceeded their terms of reference. The Ipswich health district has its share of industrial and other pollution and attendant health risks. However, the CHC has firmly resisted all attempts to embroil it in environmental health matters.

"It is not the function of a CHC to run a health education department or a citizen's advice bureau . . . "

The Council has also been concerned to hear of major research work being undertaken by CHCs, for example, on the side effects of the drug Eraldin and dangers to the unborn child of hormone pregnancy tests. We may well be accused of adopting a negative attitude — nevertheless members feel it is essential to be realistic and this means that CHCs must limit their activities in order to be able to work within their resources. If a case is to be made out for expansion it must be strictly within the terms of reference of CHCs and not a wish to tilt at windmills. The Council feels that its primary concern must be to ensure that as many people as possible in the district are aware of the CHC's existence and functions; that individuals and all sections of the community can make their views known as to the effectiveness and deficiencies of the health services; and that in this way the CHC can represent the strongest measure of democracy in the national health service.

Where the clout really lies

by Neil Pearlman, Secretary, South Manchester CHC

The hardest job for any CHC can be deciding which issues to take up and which to ignore. After all, CHCs see themselves as the guardians of the public on all health service matters. But somewhere along the line selection is essential, since they are only small organisations with no more than two full-time staff and a membership of varying commitments. The question is, how do you select, when such choice is available? First letters out of the "in-tray"? Hot national questions like abortion or health education? A quick look through the AHA minutes? My own feelings are clear — *you start by asking yourself what you expect the result to be.* Is it worth spending hours educating yourself and your members about the pros and cons of fluoridating water supplies, if at the end of the day there is nothing that CHCs can do about the final decision?

There are three main areas of work — the watchdog, the patients' friend and the job of seeking public opinion. I want to talk about the first two. The watchdog really only works well when it knows exactly what to watch for.

"What is important is to . . . think about what you are doing and whether it is likely to have a good pay-off . . . "

This CHC is trying to choose those issues where established good practice already exists. The advantages of such a policy are obvious. If everyone, in and out of the service, basically agrees that treating children on adult wards is bad practice, then if the numbers are high in your district, there is a good chance of being able to do something about it. To some people this "back a winning horse" philosophy must seem a rather unexciting prospect. How much more stimulating it is to imagine CHCs not just reacting to existing standards, but pushing back the frontiers of acceptability and creating new standards. But whether it is more or less exciting, improvements such as telephones in outpatients' departments, adequate access for disabled people, or more flexible hospital visiting hours give a far greater and direct measure of public service than writing pointless letters to the DHSS requesting that geriatric bed norms be increased. You have to identify where the clout really lies.

A CHC's main work as the patient's friend is inevitably helping individuals who approach the CHC for general advice, and to register specific complaints. And in my view it is not possible for the CHC to place prior restrictions on this offer of friendship. There has been much misunderstanding about the work of CHCs who have helped identify those damaged by hormone pregnancy testing drugs or the heart drug, Eraldin. For this CHC, it has meant no "major research", but simply responding to requests from patients by issuing a press statement and then acting as a post-box. Helping to identify people who think they are suffering from adverse side-effects, and making plans to present the evidence to the Committee on Safety of Medicines is surely acting as the patient's friend?

There is such a variety of work to be done — there is no need to expect all CHCs to be doing the same sort of things. What is important is to be prepared at least to sit down and think about what you are doing and whether it is likely to have a good pay-off. Then produce a strategy within which to operate.

Book reviews

On the state of the public health for the year 1977

The annual report of the Chief Medical Officer of the DHSS, HMSO £2.50.

There can't be too many annual reports that are really worth looking forward to, but this is one of them. Every year it has the same drawbacks — a rather dry way of talking, a lack of topicality, and a *Coronation Street*-like way of leaving you hanging in mid-air with a remark such as "This will be discussed at greater length in this report for 1978". Yet every year these defects pale into insignificance beside the report's information-value.

This year the section on primary health care is particularly interesting, drawing attention to the poor provision of health visitors and district nurses, and the high proportion of single-handed and older GPs, in urban and inner city areas.

In England in 1976, 17.6% of all GPs worked from health centres, but in the metropolitan counties only 12.9% did. The report comments that "a promise of possible premises four or five years hence is of no value in attracting young doctors — forward assessment of likely need and planning to meet it is therefore essential".

A section on mortality and urbanisation gives statistics to show that "There is a reduction in the level of mortality with decreasing urbanisation . . . the excess of mortality affects almost all age groups, but is more marked for men than women . . . this urban/rural gradient is greatest for lung cancer, chronic rheumatic heart disease, pneumonia, chronic bronchitis, and accidental poisoning and suicide". Better data are needed, but the results so far are an alarming confirmation of many people's worst fears.

Meanwhile, in the vital statistics section, the proportion of live babies born with malformations continues to rise — 16.2% in 1971, 19.5% in 1976, 20.1% in 1977 The DHSS believes this rise is "most likely to be due to better reporting over the years".

And 1977 was the year in which the Joint Committee on the Medical Aspects of Water Quality advised that it was "clearly undesirable, particularly for pregnant women and infants" to consume the lead-laden drinking water supplied to some British households. An "urgent programme of action by water authorities" was begun.

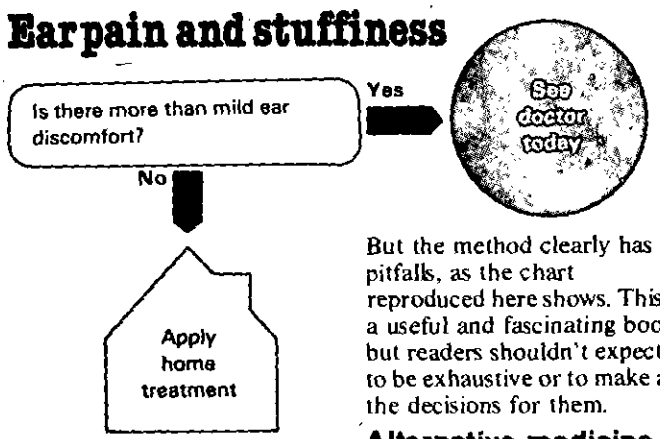
There is also plenty for opponents of fluoridation to get their teeth into, if they can. The section on preventive dentistry reports a study of six years' fluoridation in Newcastle-upon-Tyne and Northumberland, which found 57% and 67% reductions in the amount of dental decay.

Take care of yourself: a practical do-it-yourself guide to medical care

by Donald M Vickery, James F Fries, J A Muir Gray and Simon A Smail, Allen & Unwin, £6.50.

On the face of it a book which helps people to diagnose their own illnesses and to decide whether they can treat themselves or ought to see a doctor should be very welcome. This aims to be just such a book, and it also contains, in Part 1, useful chapters on maintaining a healthy life-style, on getting the best out of the care and treatment available both inside and outside the NHS, and on such things as the home pharmacy, health insurance and complaints. This information is comprehensive and generally easy to follow, so the odd lapses are surprising. Why do the authors assume, when describing the instruments doctors commonly use to examine patients, that everyone knows what a stethoscope is? And why is the speculum — surely the most intimidating of such instruments — missing from this list? There are also some mistakes of fact. For instance, the authors say that the non-contributory invalidity pension is only available to married women, whereas in fact it was only recently extended to include them.

The second half of the book takes symptoms or groups of symptoms — such as "chest pain" or "nausea, vomiting and diarrhoea" — and provides brief descriptions of likely causes and outcome, together with instructions for home treatment and what to expect if a doctor is consulted. The vital decision between home treatment and consulting a doctor is indicated by flow-charts (it is no surprise to discover that this is the "reworking" of an American book). Much of the book's usefulness clearly hangs on these flow-charts, and for unfamiliar symptoms with serious implications they would undoubtedly be helpful.



But the method clearly has its pitfalls, as the chart reproduced here shows. This *is* a useful and fascinating book, but readers shouldn't expect it to be exhaustive or to make all the decisions for them.

Alternative medicine

by Robert Eagle, Futura, 90p.

One common theme unites the people who seek the help of practitioners of "fringe" or "unorthodox" medicine — the complaint that their own "western" doctors did not have time to talk. And many people seek alternatives to medical "science" when it appears to have failed to cure or relieve them from the pain of chronic diseases. This book gives an account of alternative remedies, such as healing, radionics, herbalism, biofeedback, autogenics, manipulation, homoeopathy and acupuncture. The author, a journalist, points out that unorthodox medicine is not necessarily "natural", safer medicine.

At a time of increasing alarm at the unwanted side-effects of the modern "wonder drugs", many advocates of alternative medicine have claimed that their particular treatments have no side-effects. It is however stimulating to stop and consider the methods of medicine like acupuncture or homoeopathy, both of which claim to treat the whole patient, rather than just the symptoms of the disease.

Women and the crisis in sex hormones

by Barbara and Gideon Seaman, Harvester Press, £10.50 and Bantam £2.

"Biological freedom" was what women were promised by the promoters of the contraceptive Pill and hormone replacement therapy (HRT) — the menopause treatment. This book examines the price of that "freedom" and the risks that women are running in taking artificial hormones, often for years at a time. The warnings about HRT are especially timely — all too often the campaign for well-women clinics has been linked unquestioningly with the call for HRT as the answer to women's menopausal problems. Drawbacks to the book are that it is American and that sometimes the references are inadequate.

Books received

Medical sociology in Britain: a register of research and teaching third edition compiled by Sara Arber (Medical Sociology Group of the British Sociological Association, £3.10 inc post).

Charities digest 1978 edition (Family Welfare Association, 501-503 Kingsland Road, London E8 4AU, £3.85).

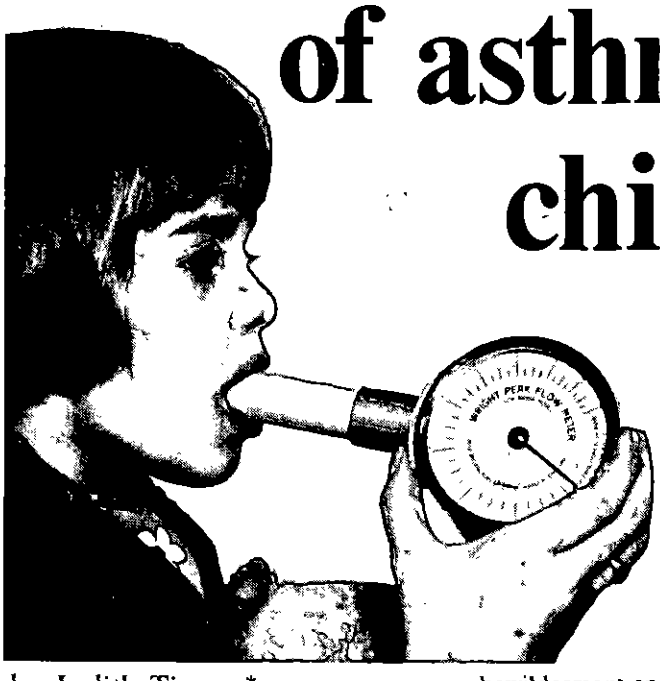
Social causes of illness by Richart Totman (Souvenir Press, £4.25 paperback).

Dialysis, Transplantation, Nephrology edited by B H B Robinson (Pitman Medical, £20).

Community hospitals and rural accessibility by R M Haynes and C G Bentham (Saxon House, £9).

Directory of residential accommodation for the mentally handicapped in England, Wales and N Ireland 1978-79 (National Society for Mentally Handicapped Children, £4.75 inc post).

Gaps in the care of asthmatic children



Measuring the lung capacity of a young asthma sufferer, using a peak flow meter

Photo: Asthma Research Council.

*by Judith Timms**

Asthma is a chest disease involving repeated and disturbing attacks of difficult breathing. Its sufferers are born with a basic physical tendency towards asthma, and an attack may be triggered off by one of many physical or emotional factors. It has been estimated that in about 54% of cases asthma is precipitated by an allergic reaction to an inhaled substance.

Asthma has never captured the attention or sympathy of the public, in spite of the fact that it accounts for 1200 deaths and 33,000 hospital admissions a year and is the most common medical handicap in children under 17. These statistics have altered little in recent years, partly because of inadequate provision for asthma sufferers within the NHS.

In 1976 and 1977 a study of 20 severely asthmatic children and their families was carried out on Merseyside, financed by the Liverpool Personal Service Society and in cooperation with staff and patients at the Alder Hey Children's Hospital. The following results emerged:

In 13 of the 20 cases there was a previous history of asthma in the family, confirming the large hereditary factor in the disease. In 95% of cases *no home visit* had been made by any member of the hospital medical or social work staff, despite the acknowledged importance of environmental factors in this illness.

In 95% of cases there had been *no continuous supporting contact* with any helping agency. This is partly the fault of the medical staff, who have some responsibility to educate parents about possible sources of help, and to demand social work back-up for their team if it is not already forthcoming.

In every case the families commented on the *difficulties of communication* within the hospital, the lack of staff continuity and the bewilderment and frustration which this creates.

One of the most striking findings was the extremely high incidence of *anxiety states* in the mothers (and in two of the fathers as well). Twelve out of the 20 mothers were chronically anxious, and were receiving treatment for this from their GPs. All related their symptoms directly to their child's illness, and to their own sense of impotence and guilt in the face of a situation which persists year after year.

The study showed that a mother's decision about when to have her child admitted to hospital during an asthmatic attack may depend on her anxiety level at the time. Thus two children with a similar severity of illness may vary greatly in the amount of inpatient treatment they receive, depending on their mothers' anxiety and the parents' ability to cope with the illness in the home.

Arrangements for the *education* of asthmatic children seem far from satisfactory. Of the 20 children, eight were already in special schools and at least two more were under pressure to transfer there from their state primaries, because of frequent absences and the apparent reluctance of teachers to make allowances for the physical limitations imposed by asthma. Once in special schools catering for a wide range of mental and physical handicaps, the asthmatic child's range of achievement is much reduced because of the limited curriculum, and eventually this severely limits their career prospects.

With more flexibility and understanding it should be possible to keep these children within the normal school system, and there is scope for a much closer liaison between home, school and hospital.

Most of the parents expressed concern and a lack of knowledge about the drugs used in their children's treatment. They were particularly concerned about the use of steroid-based drugs, and their possible side-effects and long-term effects. There was a general desire for more direct guidance about management of asthmatic attacks, which can be extremely frightening to watch.

All the families expressed great confidence in their children's treatment by the consultant at Alder Hey, and a wish to see more of him, but there was a very marked lack of confidence in local GPs. Only four families felt their GP was satisfactory, and the rest varied from feeling that he was apathetic and unhelpful to feeling that he was downright obstructive and unpleasant. One mother was only able to have her child referred to a consultant on condition that she paid for the stamp on the letter of referral.

It was clear from the study that services for asthmatic children were unsatisfactory in some respects, and that improvements could be made not only by the allocation of more physical resources but also through the more effective use of existing resources, and by a more flexible and efficient system of communication all round.

The supply of *nebulisers* — a piece of equipment which is effective in the treatment of asthma — is a case in point. Nebulisers are theoretically available through the NHS at a cost of around £100. However, there is no provision for home use, and the delays in obtaining nebulisers for hospital use are often so lengthy that they are usually bought using voluntary funds, to give the child earlier relief. This is clearly an economic as well as a bureaucratic nonsense, since children at home without the benefit of nebulisers are much more likely to require inpatient treatment, which is much more expensive than a nebuliser.

Weekly outpatient clinics for asthmatic children should be organised on flexible and supportive lines — possibly with a self-help group, and with a social worker readily available to provide a casework service. There should be a standard intake procedure, involving a routine home visit for new patients, and also a regular link-up with the education department, which could explain the options available to parents.

It would also be helpful if there was a leaflet available, giving parents basic information on asthma — its treatment and management. This last is important in view of the apparent lack of support in the community, from GPs and social workers.

One extremely valuable piece of hospital equipment for use with asthmatic children is the *gamma camera*, which can be used to assess the severity of the disease painlessly and accurately. Until November last, when a respiratory unit housing a gamma camera was opened at Alder Hey, such equipment was not in use in any children's hospital in the north of England. The £50,000 to set up the new unit was provided entirely by a voluntary committee, and it is a sad comment on the NHS that voluntary finance is still needed to pay the salaries of the unit's research assistant and part-time secretary.

Judith Timms has worked as a medical social worker, and now lectures in social work at Chester College

SPECIAL NEEDS GROUPS:

How housing associations can help

There are about 5000 housing associations in Britain — non-profit, voluntary bodies aiming to provide homes for people in housing need. This article concerns the 2700 or so associations registered with the Housing Corporation, the Government body which exists to encourage and supervise the voluntary housing movement.

Associations registered with the corporation can apply to the Department of the Environment, through the corporation itself or through local authorities, for capital grants under the Housing Act 1974. Members of an association's management committee are unpaid, but the larger associations employ staff with purchasing, development and management skills.

One of the aims of the voluntary housing movement has always been to provide homes for people with special needs, such as ex-psychiatric patients and one-parent families. Often the best form of provision for such people is a hostel providing "a substantial degree of residential care", as the Department of the Environment's official phrase has it.

But until recently the development of such projects has been hampered by a DoE ruling that when hostel management costs exceed twice what is regarded as normal the degree of care being provided is probably "more than can be regarded as appropriate to a housing project".

The breakthrough came in December 1977, when the DoE agreed to drop this rule, provided that the excess management costs could be met from other statutory or voluntary sources for a guaranteed period of at least three years. The movement for caring hostels is on the march.

Below, John Stacey, director of the Stonham Housing Association, explains how voluntary groups can work with housing associations to provide housing for people with special needs, and Ann West, chairman of Kensington and Chelsea MIND, relives the experience of one local group.

Arguably, CHCs are uniquely placed to catalyse future developments in this field.

Most housing associations provide standard housing for families or single people. These are generally locally based and operate within a limited area. Other housing associations provide mainly or exclusively for people with special needs — needs for particular design features, or for some social support as a part of the management arrangements.

Examples of people with special needs are the elderly, the physically and mentally handicapped, ex-psychiatric patients, ex-offenders, drug abusers, alcoholics, single-parent families and the single homeless.

Most special needs housing associations operate over a wide geographical area and some, like the Stonham Housing Association, are nation-wide. Many local associations incorporate some special needs provision in their standard housing, for example special design features for the physically handicapped on the ground floor of a block of flats.

In a project organised jointly by a voluntary group and a housing association, the voluntary group usually provides expertise on the needs of the intended residents and the style and capacity of the housing required, and normally manages the project, including the provision of any social support required. The housing association buys and adapts the properties, or builds on the selected site, arranges all associated finance and conducts all related negotiations.

Whatever the management arrangements, the housing association will ultimately be held responsible for the project, including its financial viability. Before embarking on a project, the association will therefore need to be assured that effective management will be available and that the project is soundly based. When approached by a voluntary group, the association will ask three questions:

First, **does the group contain the necessary mix of skills to provide effective management?** The group will need to have some members who are knowledgeable about the needs of the intended residents and willing to provide any social support required, but it will also need other members able to provide effective business management.

It would be useful if members included a solicitor and someone versed in housing, such as an architect, surveyor or builder. Someone familiar with accounts is essential, and a local councillor is most helpful for liaison with the local authority. When appropriate, the group should also include a representative from the appropriate statutory body, for instance from the local authority social services department in the case of a project to house ex-psychiatric patients.

Second, **can the group produce evidence to substantiate the type and scale of need it proposes to meet?** Here the group should seek help from the intended referral source. For example a psychiatric hospital could give information on the needs of ex-patients, and social services could do the same for single homeless people.

Third, **what style of housing is appropriate to this particular need and where should it be located?** The housing association will want to know how many people the project is intended to house, and what size the units should be — eg total provision might be for 20, but with four to eight people in each house. Do you want simple bed-sits or a shared dwelling with communal sitting-room? Are catering facilities required, and if so should these be communal or individual?

A *hostel* will normally be appropriate when residential staff are required. Finances for hostels are complex, and a group requiring a hostel would be best advised to approach a housing association with some hostel experience. The association will prepare a budget in consultation with the group, and if residential staff are to be provided this budget will usually reflect an annual deficit.

The association will determine whether normal grant aid will be sufficient to balance this deficit, and if not a "topping-up" grant to meet the difference will have to be obtained from another funding source, together with an undertaking that this will be available for a minimum of three years.

Examples of other funding sources are the Home Office for ex-offenders, and the local authority or area health authority for the mentally handicapped or for ex-psychiatric patients. In some cases funding can come from two or more sources, including charitable funds. For more information on this, consult the Housing Corporation circular on "topping-up", listed under *Further reading*.

When financial viability has been established, and a property or site found, the housing association will produce sketch plans to match as closely as possible the style of housing required by the voluntary group. The eventual layout will inevitably be a compromise between the group's wishes, the standards and cost limits imposed by funding authorities, and in the case of conversions the structural limitations of existing buildings. The group must be flexible in its requirements if the association is to have any chance of arriving at an acceptable compromise.

The property or site will then be bought, tenders sought and the works put in hand. When the project is complete it will be the voluntary group's responsibility to provide any necessary furnishings, but some projects are eligible for a grant or loan.

The voluntary group should understand that the regulations governing housing associations' activities are complex, and delay is inevitable. The normal time for a conversion is two years, and a new property may take four years to build. However, the existing housing provision for most people with special needs is grossly inadequate, and the system I have outlined here offers the best means of improving this.

While I have thought it right not to minimise the difficulties, this system is certainly workable, and many such projects are now in progress. The formula for success is a properly constituted voluntary group working in conjunction with a housing association enthusiastic for the project, each contributing its own skills and both consulting closely with all other relevant bodies, including local authorities.

John Stacey

The Kensington and Chelsea branch of MIND was set up in 1973. We decided that *one of our priorities was to provide* informal, non-institutional housing for people in hospital who could live happier and more independent lives in the community. In 1974, following a study day attended by a wide range of interested people, we decided to try to set up a half-way house for a small number of ex-patients, to prepare them for life in more independent accommodation.

A representative from the Notting Hill Housing Trust — a housing association which eventually helped us to open the half-way house — was at the study day, and this helped us to be optimistic when we heard of a suitable house. This could provide nine bed-sitting rooms, a large common-room and a farmhouse-type kitchen, and was being offered for sale by the Red Cross. They were asking much more than we could at first imagine raising, but were very sympathetic to the idea of the building being used as a sheltered house.

They maintained great patience with us while we spent a year convincing the local authority, the Department of the Environment and all the other agencies involved. The housing association, which purchased the house and converted it for us, had a representative on our local MIND committee, and this was a very important factor in our eventual success.

At this stage we realised that it would be essential to get everyone involved from the beginning, so that they would be on our side. We made sure the local authority planning committee knew exactly the kind of house we were proposing to set up, so that no rumours would lead to misunderstandings of the kind that can flourish when insufficient information is available. We also kept the local residents' association fully informed.

I know that some people feel you should push ahead with projects and hope the application will pass through unnoticed, but we have found that it is much more prudent to inform everybody early on and explain exactly what you are trying to do. In most cases this removes the fears that people have about the unknown quantities which may be coming to live next door.

It is very important to convince the housing association that you have a stable and competent management committee. The association may be worried about tenants' possible behaviour, so we obtained an undertaking from the local hospital to admit immediately anyone who was having problems we couldn't cope with. We have now been open for 18 months without using this facility.

It is also very important that the voluntary group, which knows the needs of the people it is dealing with, finds the kind of house *that it wants* and then approaches the housing association.

Of course the first project is the most difficult. There were false starts and the usual doubting Thomases who were certain that we would go bankrupt, that the tenants would commit suicide, that it would turn into a slum. But once we had overcome the initial resistance there were really no major obstacles.

Our first house is for able-bodied people aged 20–50, capable of working, including those who would be at risk of breakdown because of loneliness, difficult home situations or bad housing. A full-time non-resident warden gives support and encouragement to the residents.

All the original tenants of the scheme have now moved on to other kinds of housing, and former residents — particularly two who are now living in self-contained flats — say the period of rehabilitation prepared them well for living alone.

We soon began to find that vacancies in the house were arising less frequently, and decided to establish more units, so extending the links in a chain back to normal housing. The second and third schemes, which will not have wardens, have been much easier to set up because local people are more willing to trust you when you have a project which is already going well.

I cannot emphasise enough the need for wide representation on the management committee, including a "political representative" who can help smooth the way with the local authority planning and social services departments. It is also important to involve the hospitals, so that they can co-operate with referrals and general encouragement, and local residents, to make sure that they don't protest before really knowing what kind of neighbours they are going to have.

You have to be very optimistic, decide what kind of house you want, and set up your management committee with a wide range of expertise. Try to include people with backgrounds in business and building. Very often people in the social services fields see the building side of a project as an impossible obstacle, but if you have someone who is accustomed to this kind of work it will give confidence to the committee to go ahead.

At the beginning we had no houses and no money — just a group of determined and energetic people who wanted to establish sheltered housing. The fact that we have achieved it shows that it can work.

Ann West

For Further Reading see page 10

Life in a half-way house. These people were formerly patients in psychiatric hospitals, and are now preparing to return to fully independent living.

Photo: Maria Bartha

Healthline

Pacemakers

I have heard that there is an American-made heart pacemaker, with batteries that last for about eight years, rather than having to be replaced after three years. Can British NHS patients have this fitted?
Yes, if the consultant thinks it is necessary.

Colostomy

Is there a self-help group for people who have had colostomy operations?
A colostomy is an artificial opening into the bowel, which allows the residue in the bowel to be expelled from the body. About 7,000 people a year are helped by the Colostomy Welfare Group, 38/39 Eccleston Square (Second Floor), London SW1V 1PB. There is also an Ileostomy Association (see *CHC NEWS* p14, March 1979).

Diabetes

Should a person with diabetes expect to be under the care of a specialist diabetic clinic?
Until recently all diabetics were thought to need hospital specialist supervision. Practice is now changing and views on the advantages and disadvantages are being debated. (See *Drug and Therapeutics Bulletin* 16 February 1979). New forms of care include "mini-clinics", supervised by the patient's GP, and schemes of shared care, when a booklet kept by the patient ensures that information is shared between the consultant and the GP.

Scars

Is there any cosmetic help for people disfigured by scarring? It can cause much distress.
A network of therapy centres has been set up by the British Red Cross in about 40 hospital dermatology or plastic surgery departments. Patients can be taught how to conceal scars or distract from them. A list of the hospitals is available from the Disabled Living Foundation, 346 Kensington High Street, London W14. Tel 01-602 2491.

Lower rates for disabled people

Is it true that rate reductions are payable to disabled people who have had to make special alterations to their homes?
Yes, from 1st April 1979, when the Rating (Disabled Persons) Act became law, claims such as £10 for an additional lavatory or £25 for a garage can be made for reductions on the rates bill. The disabled person need not be the rate-paying householder. The local council should be able to advise about eligibility.

Births at home

What is the present DHSS policy on home confinements?
Reducing the risk, the DHSS discussion document published in 1977, states firmly that hospital deliveries are safer than home births. If, however, a woman chooses to have her baby at home, even after being advised against it, the DHSS expects health authorities to provide whatever service is necessary to make the birth as safe as possible.

Repeat prescriptions

Are there any rules about repeat prescriptions?
No, it is up to the doctor to find a method which combines safety with convenience to the patient. The DHSS and the General Medical Services Committee are considering an experiment using a special prescription pad which produces copies. The question of a limit on quantities to be prescribed at any one time has so far proved a stumbling block in negotiations.

The Healthline column publishes selections from our information service. This service is for CHC members and secretaries and for others interested in the NHS and the work of CHCs. To contact the information service, write to or ring CHC NEWS, *362 Euston Road, London NW1 3BL. (01-388 4943.)*

Your letters

Continued from page 2

One of the most fruitful areas of cooperation has been where the voluntary organisations have been asked to act as agents within the NHS and the social services. Both systems have worked well together, and the combined resources have proved both cost-effective and socially effective.

The consultative document is thus immensely important. It recognises the need to strengthen and clarify the contribution of the voluntary sector. The status of the voluntary worker as an equal member of the working team is confirmed. The onus is now firmly on voluntary organisations to play their essential part in today's welfare state.
**Copies obtainable free from the Voluntary Services Unit, Royston Road, Cambridge.*

Questionable questionnaires

Bob Jewitt, Secretary, Isle of Wight CHC and Convener, Wessex CHCs' Secretaries' Group

Since their inception CHCs appear to have been a source of project, thesis, survey, and general study interest to many researchers and students at universities and colleges. All or most CHCs have had to contend with a steady flow of questionnaires and general inquiries on the work of CHCs and in particular on their relationship with NHS management through DMT, AHA or RHA.

While willing to cooperate with constructive approaches to their subject by academics, the CHC secretaries in Wessex are concerned that often inquiries are couched in negative terms, based on the premise that all of us are engaged in internecine warfare with our respective NHS management bodies and that non-cooperation is the normal pattern of CHC/NHS working relationships. We acknowledge that there are problem areas in communication, consultation and access to information for some CHCs. But in Wessex we feel strongly that the authorisation and encouragement of this negative approach by academics will do nothing to improve matters and may exacerbate existing difficulties.

Our message to researchers and students is: approach your inquiries from a neutral standpoint and do so initially through regional CHC groupings, in order to ascertain first of all if councils are prepared to accept your approach and cooperate in your inquiries.

ACHCEW's dental study

Tim Lobstein, Department of Community Dental Health, London Hospital Medical College, Turner Street, London E1

Secretaries will recall that they were asked for details of dental complaints, enquiries, etc for our survey. The draft report of the survey is now being written and will be circulated during June for inclusion in the agenda of your CHC's next meeting, if possible. Some CHCs did not reply to our request for information. It's still not too late to send this, as the report will be re-shaped after all the responses have been collected. Many thanks to those that did reply.

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.

Continued from page 9

FURTHER READING

Special projects through housing associations, by Rosemary Wurtzburg, 60p inc post from the NFHA (address below).
Joint funding arrangements for caring hostel projects, Housing Corporation circular 1/77.
Chart showing possible statutory sources of "topping up" monies, Housing Corporation circular 2/78.
Handling the public protest, by Nigel Whiskin. Free from the National Association for the Care and Resettlement of Offenders, 125 Kennington Park Road, London SE11. Send large SAE.
Looking at housing, in *Contact*, the magazine of the Royal Association for Disability and Rehabilitation, Winter 1978, pages 14-20 (two articles on how housing associations can provide housing for disabled people).
Looking at life in a hospital, hostel, home or unit, £1.60 inc post from Campaign for the Mentally Handicapped, 96 Portland Place, London W1.

USEFUL ADDRESSES

Housing Corporation, 149 Tottenham Court Road, London W1. Tel: 01-387 9466.
National Federation of Housing Associations, 30/32 Southampton Street, London WC2. Tel: 01-240 2771.
Stonham Housing Association, 126 Kennington Park Road, London SE11. Tel: 01-735 6196.

CASH FOR CHCs

Funds allocated for CHC spending in 1978/79 totalled £3.9m — just 8p per head of the population in England and Wales. In 1977/78 the total was £3.6m, so in real terms the amount CHCs have to spend is not increasing. In the same year CHC *underspending* totalled just under £¼m.

These are the overall results of a survey of CHC funding carried out by *CHC NEWS*, prompted by enquiries dealt with by the Information Service.

The largest CHC budget in 1978/79 was Oxfordshire's £29,844, and Montgomery's £5800 was the smallest (excepting the Isles of Scilly — see table for details). CHCs in the South West Thames region had the highest *average* budget, £23,800. Welsh CHCs had the lowest average, just £12,300 (see Figure 1).

On a population basis, however, Wales appears to do rather better, with 9.8p allocated to CHCs per head of the population (see Figure 2). The range is from 11.6p per head in the South West Thames region down to 5.7p in Wessex.

Care must be taken when drawing inferences from this survey, because individual CHC budgets are influenced by many factors. These include: number of staff, points on salary scales at which new staff were employed, number of annual salary increments accumulated by staff, London weighting, type of premises occupied by CHC (NHS premises are cheaper), number of CHC members, geography of health district covered (ie accessibility of CHC premises and of NHS premises to be visited), level of activity of CHC, "style" of CHC (eg expenditure on publicity or special surveys), etc. Also a few CHCs have part-time secretaries, which substantially reduces their expenditure on salaries.

Four RHAs said their allocations were worked out partly according to the size of population covered by the particular CHC: South West Thames, Yorkshire, North West Thames and Oxford. The South Western RHA sets its AHAs cash limits for CHC spending, and leaves them to decide on individual CHC budgets.

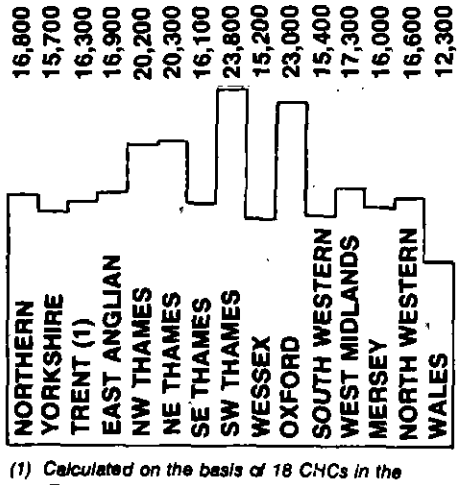
Two RHAs retain some of the money allocated for CHC spending in a special contingency fund, to cover the costs of non-recurring items such as repairs, furniture, equipment, exceptional travelling expenses and research. In 1978/79 the West Midlands RHA held £25,000 in reserve (£20,000 in 1977/78), £10,000 earmarked for members' exceptional travelling expenses and £8000 for approved research projects. South East Thames RHA held £15,605 in reserve (£15,000 in 1977/78).

The Welsh Office pointed out that CHCs could make special applications to cover the costs of non-recurring items and special projects, and the East Anglian RHA said all such proposals would be looked at carefully. The North Western RHA said it had never refused any request from a CHC for funds.

It should also be remembered that CHCs do not always spend all the money they are allocated. In 1977/78 CHC underspending in England and Wales totalled £249,500. In the Oxford region, 16.9% of the total allocation to CHCs remained unspent, in Wales 12.9%, in the North Western region 10.1% and in South East Thames 9.8%. Interestingly, the South East Thames figure is markedly higher than that for the other Thames regions (NW 7.7%, NE 3.8%, SW 4.7%), despite the fact that the average CHC budget in South East Thames is considerably lower. In the Wessex region there was no overall CHC underspending at all.

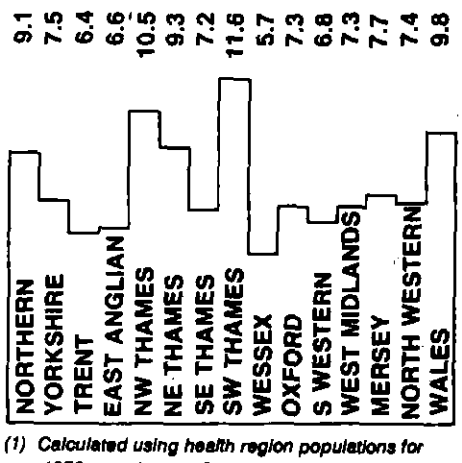
Information for this article was provided by and through the press offices of the English RHAs, the Welsh Office, and the *Office of Population Censuses and Surveys*. Our thanks to everyone concerned for their help.

FIGURE 1
Average CHC budget in 1978/79 (£)



(1) Calculated on the basis of 18 CHCs in the Trent region.

FIGURE 2
Pence allocated for CHC spending per head of population (1) in 1978/79



(1) Calculated using health region populations for 1976, supplied by OPCS.

FUNDING OF CHCs IN 1978/79

Region	Total allocation to CHCs (1977/78 figures in brackets) (£)	Per cent increase from 1977/78 to 1978/79 (1)	CHC with largest allocation (£)	CHC with smallest allocation (£)
Northern (17 CHCs)	284,900 (258,100)	10%	Sunderland 22,100	Gateshead 12,800
Yorkshire (17 CHCs)	266,900 (238,000)	12%	Hull 18,700	Northallerton 13,500
Trent (18 CHCs) (2)	292,700 (268,400)	9%	South Lincolnshire 19,400	Worksop and Retford 14,300
East Anglia (7 CHCs)	118,000 (105,000)	12%	Norwich 20,000	Ipswich; Bury St Edmunds 14,000
NW Thames (18 CHCs)	363,258 (325,528)	12%	Harrow 26,176	North Herts 16,084
NE Thames (17 CHCs)	346,100 (301,800)	15%	Haringey 22,600	Mid-Essex 17,400
SE Thames (16 CHCs)	256,725 (243,885) (3)	5%	St Thomas's 22,465	SE Kent 12,030
SW Thames (14 CHCs)	333,000 (265,500)	25%	Wandsworth and East Merton 26,000	SW Surrey 14,700
Wessex (10 CHCs)	152,200 (139,971)	9%	East Dorset 16,500	West Dorset 13,300
Oxford (7 CHCs)	181,000 (158,573)	2%	Oxfordshire 29,844	Aylesbury and Milton Keynes 18,991
South Western (14 CHCs)	216,000 (198,000)	9%	West Somerset 20,000 (4)	North Devon 10,000 (4;5)
West Midlands (22 CHCs)	380,000 (335,000) (3)	13%	Coventry 17,700	Solihull 12,200
Mersey (12 CHCs)	192,330 (180,500)	6%	Warrington 17,650	Liverpool Central and Southern 13,720
North Western (18 CHCs)	299,100 (301,000)	-1%	North Manchester 19,400	Oldham 13,200
Wales (22 CHCs)	271,000 (258,000)	5%	Swansea/ Llw Valley 20,901	Montgomery 5800

(1) Rounded to the nearest 1%, not adjusted for inflation
(2) The number of CHCs in the Trent region was reduced from 18 to 17 in August 1978
(3) These figures include a sum held in reserve by region and available to meet non-recurring CHC costs. See text for details
(4) 1977/78 figures. 1978/79 figures not available at time of survey
(5) Isles of Scilly CHC's budget in 1977/78 was £4500. The islands are part of the Cornwall health district, and rely on the mainland for most health facilities

CARNAGE ON THE ROADS

by Dr Freda Reed, Member, Canterbury and Thanet CHC

One dark, foggy, winter night I was driving home along the A20, keeping close to the nearside curb for guidance. Suddenly, out of the fog, car headlights bore down and we met almost head-on. There was a sickening metallic crunch, I felt a sharp bang on my chest, and my legs were pushed back by the engine.

The bang I felt was my seat belt restraining me from going through the windscreen, with the inevitable nasty consequences. Instead I was able to release myself and see what had happened to the other driver, who had obviously lost his way in the fog! My car, a new one, was a complete write-off.

It has been argued that seat belts may cause serious injury by trapping one in the car, perhaps to be burned to death — but anyone surviving such a serious crash without a seat belt would almost certainly be unconscious and therefore unable to escape. It is also sometimes suggested that people not wearing seat belts could be thrown clear of the car, but studies of accident figures show that over a quarter of people ejected in this way are killed. Fortunate is the victim who alights on a soft, grassy bank!

It has been proved beyond doubt that wearing seat belts reduces deaths and serious injuries. This is the experience of all countries where seat belt legislation is in force, and it is also the view of the Transport and Road Research Laboratory in Britain.

In this country in 1977 there were 6600 deaths and 341,000 people injured on the roads. The Chief Medical Officer of the DHSS has estimated that 1000 of these deaths, and 11,000 serious injuries, could be avoided if all drivers and front-seat passengers wore seat belts.

The direct cost to the NHS of people not wearing seat belts is £7.2m per year (at 1978 prices), but the net annual cost to the community as a whole has been estimated to be of the order of £100m. But the cost cannot be calculated only in money terms — some 3500 people suffer permanent disablement in road accidents every year, a high proportion of these being boys aged 15 to 19.

Then there are the hospital beds occupied by those injured, sometimes for months on end, thus preventing the treatment of other cases. The demands on the time of doctors and nurses, who are therefore unable to treat less immediately urgent but no less serious cases, must also be taken into account. These patients have to remain on the waiting list — how long is the waiting time now for a hip operation?

I have asked several policemen what their reaction would be if wearing seat belts was enforceable by law. Each said that in the long run it would reduce their work. In fact it has been noted that once such a law is passed the majority of people in a law-abiding country such as ours would keep to it.

Much is talked of our freedom as individuals, and objections are raised about more legislation, but in this matter we cannot any longer afford the vast carnage of road accidents. Our hospitals should not be obliged — hard-pressed and short of cash as they are — to occupy themselves with so many accident victims.

For all these reasons the Canterbury and Thanet CHC has passed a resolution urging our local MPs to vote in favour of seat belt legislation. Anyone reading this article who agrees that there is a need for such legislation should add his or her voice to those now demanding that such a Bill be passed by the next Parliament.

This article first appeared in the East Kent Critic *newspaper.*

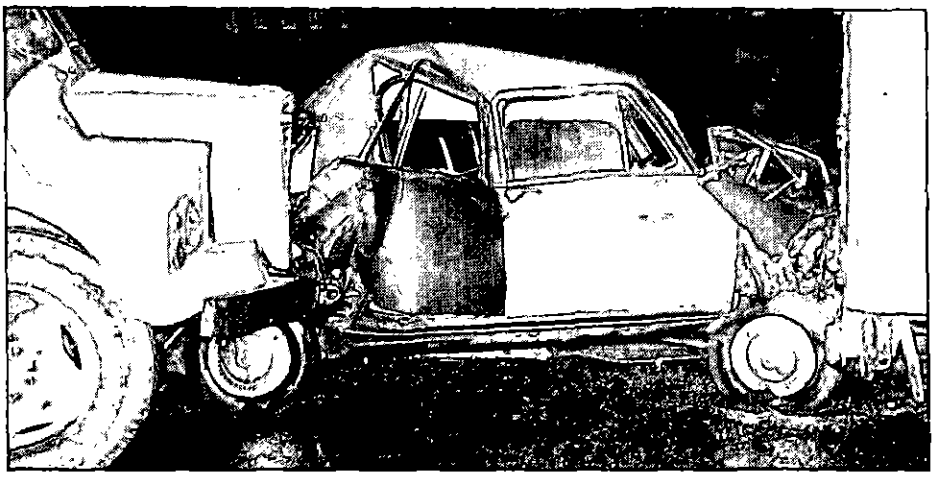


Photo: Sussex Police

A woman and her daughter survived uninjured when this Morris 1100 was crushed between two heavy goods vehicles. They were undoubtedly saved by wearing their seat belts.

Further reading

The effectiveness of seat belts in reducing injuries to car occupants, by C A Hobbs. TRRL Laboratory Report 811, free from The Library, TRRL, Crowthorne, Berkshire.

Road accidents: need they happen? *British Medical Journal*, 28 October 1978, pages 1199–1201 (first article in a 12-part series on road accidents called *A modern epidemic*, which appeared in *BMJ* between 28 October and 3 February).

Priorities in road accidents, *BMJ* 3 February 1979, pages 287–8 and 328–31.

CHCs IN A GRASPING

Recently several CHCs have spoken out on the subject of NHS labour relations, and the effect on patients of repeated industrial action. So far, I submit, the suggestions have been insufficiently thought-out, naive and impractical in our present society. I support the philosophy underlying these remedial ideas, but I believe that the issues are far more fundamental than has been indicated.

In the armed forces, pay is assessed by an independent pay review body which is not, and cannot be, independent. Pay awards are entirely arbitrary — there is no discussion with the rank and file members of the forces. In civilian life, however, we live in a society which is increasingly indisciplined, particularly as regards industrial behaviour. To suggest that the forces' system of determining pay might also be applied to one group of the civilian workforce is naive almost to the point of humour.

Even if most NHS workers were prepared to relinquish the right to take industrial action in return for guaranteed wage rates related to those in other industries, the trade union leaderships certainly would not. The right to strike is enshrined in trade union lore, and to relinquish it would require a change beyond the comprehension of any trade unionist worth his salt.

More importantly, trade unions are now strongly political bodies. Their aim — in common with all such organisations, irrespective of their political allegiance — is the acquisition of power. Any union which accepted the suggested arrangements would be foregoing almost all its power, both over its members and over the industry. History records no case of any individual or body voluntarily relinquishing power in this way, so any such arrangement would have to be imposed. I cannot foresee that any future Government will have the power to enforce this, or be foolhardy enough to try in relation to a single group of workers.

In any case the cost of such an arrangement would be appalling. The higher salary levels demanded by the

To the last moment of life
-the care of the terminally ill

by Joan Gornall, Secretary, Havering CHC

How are terminally ill patients cared for? What are attitudes to death and dying, both inside and outside the NHS?
These are among the questions which were raised at a meeting of the Havering CHC and which drew members into a study of terminal care. We began by meeting representatives of the community nursing staff. Their main feeling was of bitterness at the lack of resources to give the quality of care they know is so badly needed by many of their patients with terminal illness. Social workers told us the same story.

Doctors in general practice went further than this. Many of them spoke of the complete lack of training they had received on the care of the dying. The death of a patient seemed to some to be a mark of failure, and as such caused them to turn away from the terminally ill. Management of patients at home, particularly those with cancer, created very great problems.

It is estimated that half of the population die in a hospital or similar institution and that this number is increasing. Even so, a patient dying in a busy hospital ward is often felt to be an embarrassment and a reproach to those engaged in the practice of modern medicine. Fear of death and the cloak of silence which surrounds it often lead staff and relatives alike to hide behind a pretence that it does not exist. Discussion with patients is avoided in case they voice their own fears and acknowledge that they "know".

The CHC working party visited a number of hospices, among them St Christopher's at Sydenham. We had expected a "death house" and found instead a place of serenity and calm — one might almost say of happiness. Staff were dedicated and the high ratio of nurses to patients made it possible to give complete care in every case.

We learned of the science of pain control, pioneered by Dr Cicely Saunders, now an internationally acknowledged specialist. We were told of the many training courses held for doctors and nurses at St Christopher's and of the gradual awakening of an awareness of just what can be done for dying patients to enable them to live their last few months or weeks to the full.

The working party made a report on its findings, one of the recommendations being that a hospice would be of enormous benefit to the area in which we work. We sponsored two public meetings, one addressed by Dr Richard Lamerton from St Joseph's Hospice, Hackney, and the other by Dr Tom West of St Christopher's. On both occasions there was a large audience, reflecting public concern and interest in this subject. Following the meetings a project team was set up and the CHC withdrew. Today the new hospice, to be called St Francis, is well on its way, supported by a great deal of voluntary effort from people both inside and outside the National Health Service. So far the money has come entirely from voluntary donations, but once the hospice is well and truly established we hope that at least some of the beds will be funded through the NHS.

St Christopher's Hospice, Sydenham

Like other hospices, St Francis will not aim to provide curative services, such as surgery. It will help people come to terms with their illness and will provide a homely and caring environment for those nearing death. Hospices enable the terminally ill to lead lives as near normal as possible, and open access is given to families and friends. Once adequate pain control has been established, some people can return home, to be readmitted near the end, or for short periods to relieve relatives. Hospices also provide home care teams and 24-hour emergency and advisory call services.

There is no doubt that the hospice movement has brought the whole subject of death out into the open. The NHS, with all the pressures on resources and the need to establish priorities, has nevertheless become aware of the need for special attention to the care of the dying. Nurses from many areas are being funded for training in the special skills required, and seminars and conferences are beginning to appear in the programmes of academic centres all over the country.

A quotation from Dr Cicely Saunders is particularly apt:

"You matter to the last moment of your life, and we will do all we can not only to help you die peacefully, but also to live until you die."

May the day come when it is possible to make that statement true in its fullest sense within the National Health Service as well as within the hospice movement.

SOCIETY

*by Richard Bray, Secretary, Airedale CHC**

unions, in exchange for the loss of power, would take a much larger part of NHS income, which is unlikely to vary greatly over the next ten years. Proportionately less would be left for maintaining present levels of patient care, let alone improving them. Spending on new buildings, equipment and research would suffer. This is a price which the nation cannot afford.

I do not pretend to know the complete answer to the ills which beset the NHS. I do believe that there can be no single or simple solution, and that we are all to blame for the situation, because over the past twenty years or so we have tamely acquiesced to a steady decline in our standards of social, moral and ethical behaviour. If as a nation we are to have any hope of overcoming our difficulties permanently, there are two main requirements.

First, we must find some alternative way of assessing the relative worth to society of different kinds of work, and the consequent pay differentials between employees. The problem lies not so much between employer and employee as between different groups of workers, each hell-bent on overtaking the next on an insane "wages league table", while at the same time trying to push those below them still further down. Surely this sort of behaviour cannot be supported by an allegedly civilised and caring society, and can lead in the end only to chaos?

Second, society must change its attitude to the kind of antisocial industrial behaviour which has been occurring with increasing frequency in recent years. Blackmail is equally immoral whether perpetrated by employer or employee, whether the pawns are the sick and elderly needing care, the industrialist's production schedule which is critical to his continuation in business, or the low-paid seeking a living wage.

But where can we start? I believe that CHCs, by virtue of the range of their membership and their NHS contacts, are ideally situated to influence society to change its attitudes. In the face of an informed and irate public voice demanding an end to the present strife, the fundamental reappraisal which is required could not be refused.

**These are Mr Bray's personal views, and are not necessarily shared by his CHC.*

Compulsory care

by Christopher Hanvey, a social worker and co-opted member of Wakefield East CHC

An active and sustained debate on the 1959 Mental Health Act has begun to impress upon a wide community the very important civil rights issues involved in both compulsory admission and treatment in a mental hospital. The DHSS' recent *Review of the Mental Health Act 1959** gives lengthy consideration to both compulsory and voluntary admissions and suggests further safeguards for maintaining patients' rights. Most CHCs must now be familiar with the arguments surrounding the need to obtain a second medical opinion, where possible, before a patient is compulsorily detained, and to reduce the number of "Section 29" admissions under the Act.

They may however be less familiar with Section 47 of the 1948 National Assistance Act and the 1951 Amendment Act which both contain similar powers to remove a person— and it is usually an elderly person — to a hospital or an old people's home ("Part III" accommodation).

Basically, this section of the Act makes provision for securing the necessary care and attention for persons who:
"a) are suffering from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions; and
b) are unable to devote to themselves, and are not receiving from other persons, proper care and attention."

In an emergency a person can be removed *without delay*. An order can be made by a single Justice of the Peace acting on the application of a "proper officer" — usually a district community physician. The application must be certified in writing by the proper officer and another registered medical practitioner (usually the GP). A place has to be available before the application is made. Such an application lasts for three weeks, then the case is treated under the "non-urgent" procedure.

The non-urgent procedure allows the proper officer to apply to a court for an order, removing the patient from home to a hospital or place in Part III accommodation. It is an alternative way of effecting a Section 47 admission. Again the nature of the accommodation must be stipulated and a suitable place made available. An order made in this way lasts for a maximum of three months.

Most applications under Section 47 involve elderly, confused people, where a health visitor, GP or social worker may have become concerned for the safety of the patient, but offers of help have been refused. Because the order involves a compulsory admission, very important civil rights issues are at stake. The distinct "urgent" and "non-urgent" categories closely resemble Sections 29 and 25 of the 1959 Mental Health Act. Evidence would suggest that the majority of Section 47 admissions are made as emergencies, when it is often more difficult to consider alternative types of help for the patient. There are also very few rights of appeal, from the patients or from their friends, when admission is being made. As much as in mental health work, medical and scoial factors can easily become blurred. Similarly, once a person has been admitted to hospital or old people's home, it is sometimes easy to detain them, even though the order may well have expired.

Perhaps CHCs should press for a reform of the legislation. First there is a need to establish a patient's advocate — rather like a mental welfare officer — to ensure that rights are not in any way abused and that when the order expires, alternatives to compulsory care are considered. Second, there is room for improvement and tightening of the regulations governing urgent admissions. CHCs might enquire how many Section 47 applications were made within their district in the last twelve months, and what has been the outcome of these applications. That, for instance, many elderly residents die fairly rapidly after admission to an old people's home, suggests that the issues surrounding Section 47 are indeed important.

**Review of the Mental Health Act 1959, Cmnd. 7320, HMSO £2* (see *CHC NEWS* p4 October and p8 November 1978).

Parliament

Foot-care

Voluntary organisations are encouraged to contact their area or district chiropodists who may be looking for suitable people to be trained to provide simple pedicure. Health authorities are also being encouraged to employ foot-care assistants (Kenneth Warren MP, Hastings, 23 February).

Amenity beds

There is low usage of amenity beds, which the DHSS attributes to patients not knowing about the scheme. But the beds do not remain empty. The Minister is thinking about encouraging health authorities to ensure that patients know about the beds (Maurice Macmillan MP, Farnham, 15 March).

Nurses' training

The DHSS does not expect the introduction of the European Economic Community Directives on student nurse training to have any consequences which are "appreciable in resource terms". It will not be giving any extra money to area health authorities or nurse training organisations to help them cope with the implementation of the EEC Directives in July (Lord Winstanley, House of Lords, 7 March).

Bodyscanners

The DHSS has issued no guidance to health authorities about dealing with the revenue implications of privately donated capital equipment. The revenue cost of a general purpose scanner is about £60,000-£80,000 a year. Fifteen scanners are now in use in the NHS. Seven more are awaiting delivery. Of those already in use, only four were entirely funded with NHS money (J W Rooker MP, Birmingham, Perry Barr, 19 February).

Discrimination against the disabled

A new *Committee on restrictions against disabled people* has been set up, "To consider the architectural and social barriers which may result in discrimination against disabled people and prevent them from making full use of facilities available to the general public; and to make recommendations" (Jack Ashley MP, Stoke-on-Trent South, 25 Jan).

GP obstetrics

Six months' resident appointment in a hospital obstetric unit within the previous ten years is the main qualification for admission to the Obstetric List (Lewis Carter-Jones MP, Eccles, 31 January).

Family planning costs

Family planning services in England and Wales cost an estimated £56m in 1978-79, and this is expected to rise to £58m in 1979-80 (James Sillars MP, South Ayrshire, 24 Jan).

Day-care for the mentally ill

In March 1978, 20 local authorities had no day-care provision specifically for the mentally ill, though 10 of these had general day-care places which may have been in use for this purpose. The DHSS believes that "one obstacle to progress may be a lack of a clear conception of what authorities should be trying to do in (this) relatively new field" (Robert Kilroy-Silk MP, Ormskirk, 8 Feb; Eric Moonman MP, Basildon, 8 Feb).

Health Education Council

Government funds for the HEC have risen from £1.7m in 1973-74 to £4.3m in 1979-80. This year the DHSS has asked the HEC to assist with its campaign to reduce perinatal and neonatal deaths and illness (Lewis Carter-Jones MP, Eccles, 23 Jan).

Correction

In this column of February *CHC NEWS* (page 10) we incorrectly interpreted a table about infant death and social class. We *should* have said that more than twice as many babies in social class V die in their first year as do babies in social class I. Thanks to readers who pointed out the mistake.

Scanner

Residential care

Care for elderly people with mental disabilities, and for younger physically handicapped people, is thoroughly examined in a discussion paper from the Personal Social Services Council. It recommends a "substantial increase" in the provision of care, and a reassessment of the roles of the various agencies and workers. *Policy issues in residential care*, £1 inc. post from PSSC, Brook House, 2-16 Torrington Place, London WC1.

A detailed survey of 124 homes for the elderly in London recommends that residents should be helped "to maintain their links with their past, to enjoy the present and to have confidence in some future". The main aim should be the preservation of dignity and self-respect. *Residential care for the elderly in London*, free from Room 213, Social Work Service London Region, Brook House, as above.

Publications in brief

Rural rides: experiments in rural public transport – a consumer view, 50p inc post from the National Consumer Council, 18 Queen Anne's Gate, London SW1.

Transport schemes, 45p inc post from Age Concern, 60 Pitcairn Road, Mitcham, Surrey.

National health surgical footwear: a study of patient satisfaction, by Sheila Bainbridge, HMSO £4.25.

Two years' experience with outpatient abortion: a report on day care from the British Pregnancy Advisory Service, 50p inc post from BPAS, Austy Manor, Wootton Wawen, Solihull.

An aid to community care, £3 inc post from the Psychiatric Rehabilitation Association, 21a Kingsland High Street, London E8. John Wilder, author of this PRA teaching manual for statutory and voluntary workers, is director of the PRA and a member of Tower Hamlets CHC.

Kidney transplants and dialysis, by G Pincherle, HMSO 85p. No 2 in the DHSS *Topics of our time* series.

Home dialysis, £2 inc post from the Scottish Local Authorities Special Housing Group, 53 Melville Street, Edinburgh. Reviews the home adaptations needed for patients to use kidney machines at home.

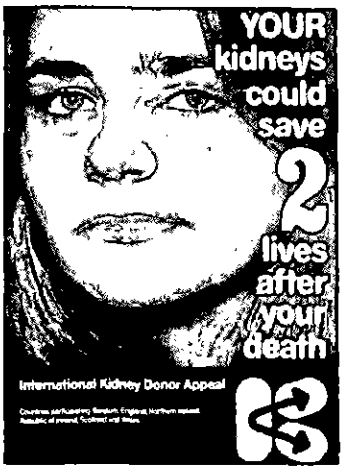
Scarce resources in health care, 35p inc post from the Office of Health Economics, 162 Regent Street, London W1.

Your home and your rheumatism, 25p inc post from the Arthritis and Rheumatism Council for Research, 8 Charing Cross Road, London WC2.

Positive approaches to mental infirmity in elderly people, £1.50 inc post from MIND, 157 Woodhouse Lane, Leeds.

Mobility campaign

A campaign has been formed to fight for the rights of disabled people whose mobility needs are not met by mobility allowance, nor by the Motability scheme. Contact the Replacement Specialised Vehicle Project, Leatherhead Court, Leatherhead, Surrey. Tel: Oxshott 2204.



Kidney donors wanted

This poster is the focus of an international appeal for kidney donors, launched last month with the slogan "Carry the card". Health authorities in Belgium, the UK and the Republic of Ireland hope to attract several million new donors through local publicity. Further details from your RHA press office.

Monsters and dragons against tooth decay

These two posters are available from the Health Education Council, as part of its dental health campaign for teenagers and children. The Incredible Hulk, from the TV series of the same name, offers a hard-sell approach aimed at teenagers, while Elliott the dragon, star of a Walt Disney film, takes a softer line with children in mind. HEC, 78 New Oxford Street, London WC1.

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 4: Lincolnshire North CHC Secretary: W C M McCarthy
Page 6: Ipswich CHC Secretary: John Hatfield
Page 8: Barking CHC Chairman: Jack Smith
Page 10: St Thomas's CHC Chairman: Mrs Rosemary Glanville
Page 17: Blackburn CHC new telephone: Blackburn 56163/4
Page 18: West Lancashire CHC Chairman: Coun Mrs M D Rees (change announced in February was incorrect).

Standards of care for the mentally handicapped

The National Society for Mentally Handicapped Children has published No 3 in its series of STAMINA documents, which contain information for parents about the standards of provision they should expect for their mentally handicapped children. *Residential care of the mentally handicapped* is 40p inc post from NSMHC, 117-123 Golden lane, London EC1.

Also available from NSMHC is a 26 minute colour film called *In a world apart – or a part of the world?* about the work of the society. This can be hired for £10 from Concord Films Council Ltd, Nacton, Ipswich, Suffolk.

Private patients: HN(79)28

Announces increased charges for pay-beds in NHS hospitals, and for NHS hospital services to private out-patients.

Leaflets on teeth and eyes: HN(FP)(79)6 and HN(FP)(79)10

DHSS has revised its information leaflet on NHS dental treatment (NHS4), and has published a new leaflet on *Your sight and the NHS* (NHS6). Both will be available at post offices, and NHS6 will also be available through CHCs. Supplies of both from DHSS Leaflet Unit, Block 4, Government Buildings, Honeypot Lane, Stanmore, Middx.

Statistical information on the NHS: HN(79)21

Accompanies a consultative document about data collection and processing systems in the NHS. Proposes a joint NHS/DHSS steering group on information matters, and a "bottom up" approach to the collection of information, meeting the needs of local managers and transmitting upwards only the minimum necessary information. More might be done "to develop measures of output of services, outcome of treatment and health status within the population". Comments to Mr J G Handby, Room D416, Alexander Fleming House, London SE1.

News from CHCs

❑ Cleveland AHA has enlisted the help of John Grigg, secretary of **North Tees CHC,** to do some research on alternative management structures for the area. He has been seconded for 2 days a week for 6 months to prepare a paper on the three possible options: (1) the present three-district structure (North Tees, South Tees, and Hartlepool), (2) a single-district area, and (3) two single-district areas. The AHA will consider the paper when preparing its own consultative document on the restructuring. John's previous academic experience and the fact that while independent of the AHA he is familiar with the local situation, make him the ideal person for the task. He will start by holding informal discussions, and the three CHCs in the area will be among the bodies consulted. They may be interested in the views of CHCs with experience of restructuring. One of these is **East Somerset CHC,** which was disappointed that the merger of the East and West Somerset districts was approved by the Secretary of State. The council is not convinced that the expected savings from the merger (which took effect from 2 April) will materialise. There have already been two mergers in the region and the RHA has set up a working party to review the working of all its CHCs. Despite RHA assurances, some councils are apprehensive that a reduction in the number of CHCs is planned, particularly as so far requests for CHC representation on the working party have been refused.

❑ **Croydon CHC** has sent a telegram to the Prime Minister drawing attention to the crisis in Croydon's hospital services. And the CHC is having problems with its own premises. It was heartbroken at failing to acquire central, roomy, shop-front offices in the Whitgift shopping centre in Croydon — the district valuer gave the property the thumbs down. The CHC's present office in Croydon General Hospital is needed by the AHA, but not unnaturally the council turned down the only alternative health service premises offered — at Waddon Isolation Hospital.

❑ As a result of a publicity campaign mounted by **Central Manchester CHC,** 378 women had smear tests for cervical cancer during a "cytotest" week held at Longsight health centre in May 1978. The CHC has now published a report of the campaign and an analysis of the results, which shows that 63.5% of the women attending for a smear had not had a test within 5 years (the recommended maximum interval between tests). The CHC has also prepared a report on community chiropody services.

❑ **South Tyneside CHC's** resolution on industrial relations in the NHS has now been considered by many CHCs. It called for alternative negotiating procedures for the NHS similar to those in the police and defence forces. South Tyneside has prepared a summary of the response. A number of councils felt that industrial relations was not an area where CHCs could or should be involved. Many CHCs felt unable to support the South Tyneside motion in its entirety. Some deplored any suffering to patients and simply urged both sides in the dispute to settle their differences quickly. Others thought that alternative negotiating procedures wouldn't solve the problem or that a completely new industrial relations policy was needed for the NHS. The low pay of health service workers was seen as the sole cause of the disputes by several CHCs. Some councils preferred to support a resolution from **Norwich CHC** which suggested a no-strike agreement in return for pay comparability with the private sector. Others thought that the issue should be taken up by ACHCEW at national level or debated at the AGM. When the Standing Committee met on 27 March it agreed to table the matter for six months.

❑ When **South Lincolnshire CHC** was asked by its AHA for its views on terminal care in Lincolnshire, the council set up a working group and sent out a letter inviting comments from parish councils, women's institutes and voluntary organisations. Until a hospice can be provided, the CHC proposes: the setting up of domiciliary care teams; special training for community nurses, GPs and home helps; a symptom control centre offering a 24-hour advice service; and special, separate bed provision for terminally ill patients.

Photo: Oxford Mail and Times

❑ *Oxfordshire CHC has spent £1,000 on publicity in three local papers (see above) to alert people to the threatened closure of Cowley Road Geriatric Hospital. The closure has been approved by the RHA and will now go to the Secretary of State. The CHC believes that the least it can do is to make as big a stir as possible, so that the final decision will at any rate be made in the context of public debate.*

❑ A detailed report of its survey on maternity services has been published by **Cambridge CHC.** Among the findings which caused concern were the lack of enthusiasm for antenatal classes and the absence of help for postnatal depression. And an interim report has been produced by the Maternity Services Study Group of **South West Herts CHC.**

❑ The issues of confidentiality and openness at AHA meetings are recurring points of debate among CHCs. Kent AHA has demanded a written undertaking of confidentiality from the six CHCs in the area in return for an agreement that CHC observers could attend closed sessions of the AHA and receive the relevant papers in advance. Three of the CHCs — **Maidstone, Dartford and Gravesham** and **South East Kent** — have agreed, feeling that it was worth giving the undertaking if it meant that the CHC would know what was happening. **Medway** and **Tunbridge Wells CHCs** have refused, resenting the implied lack of trust in the CHCs and fearing that the AHA might use the secrecy pledge as a device for avoiding public discussion of sensitive issues. **Canterbury and Thanet CHC** will urge the AHA to admit CHC observers to closed sessions on a trust basis, at least for a trial period. **Cuckfield and Crawley CHC** are opposing an AHA ruling that papers concerning the report of a committee of inquiry had been handed to the CHC's observer on condition that his involvement was personal and that he should not discuss the matter with the rest of the CHC. The AHA's committee structure has been the target of a long-running campaign waged by **Leeds Eastern CHC.** The Leeds AHA(T) has two permanent committees — a policy and resources committee and a personnel committee — from which the CHC observer is excluded. The CHC believes that the committees are effectively policy-making bodies, and are thus acting illegally. Letters to David Ennals and Roland Moyle have brought unsatisfactory replies. So far **Central Nottingham** and **North Nottingham CHCs** have had no success in their attempts to get access to meetings of their AHA's financial panel, and they too have written to Roland Moyle. David Ennals has assured ACHCEW that a close look would be taken at the way AHAs were going about their business. He was particularly concerned that AHAs should not use standing committees to bypass consultation with CHCs.

❑ **South East Cumbria CHC** has made further representations to ACHCEW concerning consultation on authorisations for the disposal of radioactive waste. The Standing Committee has agreed that the Department of the Environment should be pressed to include CHCs among the bodies Ministers are obliged to consult before such authorisations are granted. Members of the CHC have visited the Windscale Reprocessing Plant and a representative from the four CHCs in the area has now been granted a place on the Windscale Local Liaison Committee.