CHC NEWS
For Community Health Councils
June 1979 No. 43

# CHC's counter-proposal accepted by AHA

The all-out effort made by N W Kensington, Chelsea and Westminster CHC to consult the public on AHA plans for hospital development and closure has ended in triumph for the CHC. Kensington, Chelsea and Westminster AHA(T) has accepted the CHC's counter-proposal — which the council says is a reasonable compromise with the AHA's original plan. It involves an exciting combination of community and hospital provision on the site of a hospital the AHA had planned to close altogether. A joint CHC and DMT working party, with representatives of GPs and staff, has been set up to produce a detailed plan of the CHC's proposed development, if possible within the next six months.

The AHA's original plan was to rebuild and expand St Mary's Hospital, Praed Street (the present teaching hospital), to close St Mary's Hospital, Harrow Road, and Paddington Green Children's Hospital, retaining St Charles' Hospital, North Kensington, as a second general hospital but without the children's ward. After lengthy local consultation the CHC turned down this proposal in December. The plan seemed to the CHC to be based entirely on the historical intention to rebuild a teaching hospital at Praed Street, ignoring the possibility of developing community provision where it was most needed. The standard of primary care in the district is very poor and there is heavy reliance on existing accident and emergency departments.

With three months to prepare its counter-proposal the CHC drew up a questionnaire describing four alternative plans. These included the AHA's proposal and a plan to develop a general teaching hospital at Harrow Road, which was costed at the CHC's request. Respondents were asked to put the plans in order of preference, and could also submit their own plans. And they were asked about their usage of local hospitals and their views on health care provision generally. The questionnaire was distributed to 1000 people randomly selected from the electoral register, to patients in outpatient departments and GPs' surgeries, and to local organisations and people known to the CHC. The response rate was very high, and a clear winner among the four plans emerged. The CHC will publish a detailed analysis of the survey results later.

The plan favoured was for the development of the Praed Street hospital as envisaged by the AHA, but in conjunction with the establishment of community and hospital services in place of St Mary's Hospital, Harrow Road. The Harrow Road complex will comprise: a community hospital of 80-100 beds, including GP and pre-convalescent beds; a health centre; a minor casualty unit; day-care facilities; residential accommodation for the younger chronic sick; and residential and training facilities for the mentally handicapped. The medical school has shown an interest in the proposed complex for training students in the community aspects of medical care.

Retention of a children's unit at St Charles' Hospital is also part of the plan. Paddington Green Children's Hospital is to close, and there will be a new children's unit at Praed Street. But the survey showed a lot of support for some paediatric provision at St Charles', and the CHC felt that the social and environmental deprivation in that part of the district were strong reasons against concentrating all children's services in one unit.

Although the CHC is delighted that the AHA and DMT appear committed to the additional plans for the district, there are some lingering doubts both regarding eventual RHA approval and the timing of the new development. Funds may not be available to allow the Harrow Road plans to be implemented in parallel with the Praed Street development. The CHC has made it plain that the whole exercise has stretched its own resources to the limit, with staff and members working flat out for the three-month period. But the council can be satisfied that the health needs of the local community have been articulated and taken into account.

*St Mary's Hospital, Harrow Road*

Photo: British Medical Journal

## INSIDE . . .





# BIG BOOST FOR HEALTH CENTRES

A blueprint for enticing reluctant GPs into new health centres has been drawn up by the Department of Health.

*Primary health care: health centres and other premises*, issued as a Departmental guidance memorandum with circular HC(79)8, offers GPs more consultation, fewer delays in planning and building, and better information about costs.

It also discusses what makes a good health centre from the patient's point of view, and points to specific aspects on which CHCs should be closely consulted from the earliest stages of planning.

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# Your letters

## FPC lists

*Janet Upward, Secretary, National Federation of Consumer Groups, 70/76 Alcester Road South, Birmingham B14 7PT, and Carol Yapp, Advisory Officer, National Association of Citizens Advice Bureaux, 4th Floor, Norfolk House, Smallbrook Queensway, Birmingham*

Before NHS reorganisation the Executive Councils had to send out up to date professional lists. All that the Family Practitioner Committees are obliged to do is to maintain a list at their own office — not much use to someone seeking a doctor or dentist near their home.

The Secretary of State thinks FPCs will be helpful and continue to make lists available to the public. The W Midlands NACAB found large discrepancies in the availability, clarity and display of lists in CABx and some public places. Another problem is the content of the lists — is just names and addresses good enough?

NW Herts CHC has worked for over a year to get lists back into places where the public might find them. Central Birmingham CHC has revised the FPC's information to make it more helpful and readable. We would like to see this approach extended throughout the country — perhaps along the lines of the Law Society's list which provides a readable guide to legal services. We hope CHCs will explore the possibilities of making FPC lists accessible, and useful to NHS consumers.

## Fees for certificates

*Ron Brewer, Secretary, Tower Hamlets CHC*

Dr Nelson (*CHC NEWS 39*, page 2) seems to draw an analogy between the charge for a private certificate of 80p and a fee charged by a solicitor for witnessing a document. However, the solicitor does not get capitation fees, practice expenses, and other emoluments from the tax-payer as do GPs.

With regard to private certificates, particularly for employers, the patient is a captive, because the only place from which he can obtain one is his own GP and he cannot shop around. Many GPs are fair about this, but the lack of a properly regulated fee allows exploitation.

## Is the Rcn a trade union?

*A Nicholson, Senior Labour Relations Officer, Royal College of Nursing, Henrietta Place, London W1M 0AB*

Mr Shankland (*CHC NEWS 40*) dogmatically asserts that "the Rcn is not a trade union", but offers not a scrap of evidence. The Rcn is an independent, certificated trade union, having been accepted as such by the Certification Officer. The college acts as a trade union, both by helping members who are encountering labour relations problems and by fully participating in the negotiation of nurses' conditions of service, particularly but not exclusively within the NHS.

*Ed: This correspondence, which relates to an article about trade unions in the NHS, published in CHC NEWS of August 1978, is now closed.*

## No abortion rights

*C O'Carroll, 28 Danelagh Close, Tamworth, Staffs.*

I fail to understand why you are trying so hard to "sell" abortion. The 1967 Act gave nobody the right to have an abortion, yet the whole tenor of the article in the December 1978 *CHC NEWS* gives the contrary impression and complains that women cannot have abortions when they want.

The section dealing with the hazards of day-care abortion is the best example I have seen to date of woolly-headed, unresearched, inaccurate, misleading drivel it has been my misfortune to read. In the section "for the patient" why is there no mention of the *baby* patient? I quote from the United Nations' *Declaration of the rights of the child:* " . . . the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, *before* as well as after birth." The italics are mine — it is amazing how many people miss "before".

*Ed: We have had so much correspondence on abortion, that we are disinclined to print any more letters on this topic for a while.*

## EEC nursing Directives

*Ron Brewer, Secretary, Tower Hamlets CHC*

My council has been discussing the proposed EEC nursing Directives. I don't think anyone would quarrel with the idea of improved training and opportunities for student nurses, but we have discovered that in this district the scheme will need 64 extra nurses and will cost about £276,000.

One of my members has talked with MPs and feels that they have tended to believe this is a routine matter and they have no idea about the extra costs involved. Apart from the financial aspects, where are the extra trained nurses coming from who are needed to allow the Directives to be implemented? There is a shortage now and few seem to want to train in inner cities.

## Can you help?

*Helen Rosenthal, Vice-chairman, City and Hackney CHC*

I am working on a survey for the King's Fund which has grown out of this CHC's work on a community health project on a housing estate in Hackney. The survey looks at "alternative approaches, including community and neighbourhood projects, patients' associations or attempts to increase patient participation in health centre or general practice, initiatives which may be taking place in Inner City Partnership areas, and possibly some instances where statutory health services are attempting new ways of approaching particular health issues".

I would be grateful for information from CHCs about such things in their districts.

*Dag Saunders, Secretary, Salop CHC*

I have tried to discover whether any AHAs have produced strategic plans around perceived priorities. So far plans I have seen lack a framework of priority development, eg services for the elderly mentally ill, pre-school children, etc, over other services, eg maternity, acute, geriatric. Has any AHA developed this type of plan?

*Sue Dowling, CPAG/DHSS Project, Dept of Community Health, Bristol University, Whiteladies Road, Bristol BS8 2PR*

We would like to know about initiatives aimed at increasing the use of antenatal and child health services, for a six-month project aimed at publishing details of initiatives and encouraging others to adopt some of the ideas and to examine their own ways of delivering these services. We hope CHCs will be able to tell us of schemes in their areas.

## When a GP complaint shouldn't go to the FPC

*Richard Bray, Secretary, Airedale CHC*

Your *Healthline* section in *CHC NEWS 39* contained an item headed "GP services for homeless alcoholics". Although the reply you gave is no doubt correct in this case, a problem can arise about complaints concerning GPs treating patients in a GP unit.

In a case in Walsall, a complaint was made against a GP in respect of one of his patients in a GP geriatric unit. This was heard in full by the FPC's Medical Services Committee, which found against the

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# Comment

Some area health authorities have been conducting their business in such a way as to arouse strong suspicions that they are abusing the "closed session" option. When CHCs have protested at being excluded from closed sessions retaliation has often been swift. There have been bans on all CHC observers at such sessions, demands for written undertakings of confidentiality, attempts to gag CHC observers once they have been given access to information.

Few people would contest the need, on occasion, for AHAs or any other public bodies to discuss matters in private. But the reactions of some AHAs suggest that they still have no intention of treating CHCs as responsible bodies whose members can be trusted to respect confidential matters. Since CHCs are there to represent the public, it would seem reasonable to suppose that they have at least as good a notion as AHAs of what is and is not in the public interest to be generally known.

AHAs have also laid themselves open to charges of evasiveness by apparently allowing committees (or working parties or panels) to make decisions on policy which are presented to the full authority for "rubber-stamping" only. Officially (according to DHSS interpretation of circular HRC(73) 22 committees are allowed as a means of enabling members to become experts in particular fields or for non-policy-making purposes such as considering appointments or visiting.

CHCs were given observer status at AHA meetings in order to ensure that their voice was clearly heard at the point of decision-making. Recently David Ennals accepted that it would be wrong if AHAs were using committees to bypass consultation with CHCs. This is fine as far as it goes. But the DHSS has up till now shied away from laying down hard and fast rules, a policy that to many CHCs appears always to work to their disadvantage.

Not all CHCs *want* to be admitted to AHA closed sessions or committees — often because they feel that they shouldn't be involved in detailed management decision-making. But there are other, more practical or tactical reasons. It could, for instance, be argued that anything that helps an AHA to work "effectively" should be tolerated. And there might be a risk of driving actual — as opposed to formal — policy-making even further underground; of effectively muzzling the CHC on important issues; of CHC members spending all their time attending AHA meetings or reporting on them.

There is also a danger, however, of tactics getting confused with principle. Some CHCs have come under attack themselves for holding meetings in private or for not allowing the public to speak at their meetings. And some have executive committees or working parties which may appear to the casual observer to bear a distinct resemblance to the offending AHA committees. If CHCs believe in the principle of openness, then they must surely be scrupulous themselves in not allowing expediency to shield them from the public they represent.

# Health News

## NHS planning guidelines 1979

The run-down of hospital obstetric services is to halt and the service should "roughly maintain its level over the country as a whole", says the DHSS in its planning guidelines for 1979/80, which accompany circular HC(79)9. The need to reduce perinatal mortality and handicap seems the main reason for slowing the cuts in maternity services. Other points highlighted in the guidelines are: preventing inappropriate admission of children to mental handicap hospitals; coping with changes in training requirements for nurses and midwives; and the shortfall in services for the elderly. Reducing the number of beds in mental hospitals has meant fewer places for the elderly severely mentally infirm. Health authorities "will need to give greater weight than previous guidance suggested to the effect on general acute hospital expenditure of the growth in numbers of the elderly". Longer term strategy is not likely to have to change much.

## When to withhold the pill

Women over 35 should not normally be using the combined contraceptive pill, the Standing Medical Advisory Committee of the DHSS is advising doctors. The SMAC bases this new advice* on the fact that "the mortality risk for women who have ever used the pill increases with age".

On the other hand, the SMAC notes, risks to health from pregnancy also increase with age, and the combined pill offers much the highest degree of protection — between one and four pregnancies per 1000 woman-years if taken correctly. So in individual cases it should still be prescribed to women over 35 "provided all other risk factors can be reduced".

Women between 30 and 35 should normally be restricted to five years' continuous use of the pill, and smoking and obesity should also be regarded as serious risk factors, warns the SMAC.

It also asks GPs to consider brushing up their training on family planning, and states that any doctor inserting intrauterine devices should first have received practical training at a recognised teaching centre.

* *Handbook of contraceptive practice (Revised 1978)*, issued with HN(FP)(79)18. All GPs are being sent a copy.

## How joint is joint planning?

Doctors still dominate mental handicap planning, according to a report from the Campaign for the Mentally Handicapped.* The importance of joint planning between health and social services was emphasised by the DHSS in HC(77)17, which suggested that Joint Care Planning Teams (JCPTs) should set up sub-groups — for instance, for the mentally handicapped, where the development of community facilities was a priority. This recommendation was endorsed by the National Development Group for the Mentally Handicapped, which urged the widest possible range of membership for such sub-groups.

CMH asked all 90 AHAs for information about JCPTs. Of the 86 which replied, 80 said they had JCPTs, but only 52 of these had sub-groups for the mentally handicapped. Eight sub-groups had representatives only from the AHA and social services departments. 71% had representatives from the education department as well, but only 15% mentioned membership from the housing department — surely crucial, CMH says, for the provision of accommodation in the community. 22 sub-groups had representatives from voluntary organisations, and this figure includes the 10 groups with a representative from the CHC — who was in most cases also a member of the local Society for Mentally Handicapped Children.

20 AHAs had alternative planning arrangements for mental handicap services, but the membership of these groups was even more restricted than that of the JCPT sub-groups, with health authorities by far in the majority.

* *An enquiry into joint planning of services for mentally handicapped people* by Morag Plank (CMH, 96 Portland Place, London W1N 4EX).

## Green light for menstrual aspiration

The menstrual aspiration technique of early abortion — otherwise known as menstrual extraction or regulation — has been declared legal by the Director of Public Prosecutions following nearly two years of official uncertainty.

In 1977 an anti-abortion group in Manchester complained to the police about the use of outpatient menstrual aspiration by a local gynaecologist, and following a report to the DPP the consultant withdrew this NHS service. Now the Law Officers of the Crown have decided that doctors using

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# Health News

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this technique are protected by Section 1 of the Abortion Act 1967. This should please Tameside CHC, which has written repeatedly to the DHSS requesting a legal ruling (see *CHC NEWS 35 page 12*).

## The lessons of Eraldin

Fifteen hundred people suffering from alleged side-effects of Eraldin have responded to publicity campaigns carried out locally by 32 CHCs. If every CHC and Scottish Local Health Council had taken part, the result might have been around 13,000 cases of alleged Eraldin damage.

This is the outcome of Merthyr and Cynon Valley CHC's initiative in 1977, when it asked CHCs and LHCs to cooperate in searching out victims of Eraldin — the faulty heart drug which ICI voluntarily withdrew from the market in 1975 (see *CHC NEWS 26* for details).

The figures were reported to a meeting organised in Birmingham by the Eraldin Action Group, chaired by Merthyr CHC's secretary Bryn Williams, and well attended by CHC members and staff.

EAG secretary Mrs Jean Trainor told the meeting that so far she had analysed 1066 of the returned questionnaires, and these suggested that there were several major side-effects of Eraldin which were not yet recognised by ICI for compensation.

Dr Frank Lesser, a pharmacology lecturer at Chelsea College, said more statutory control of drug manufacturing and marketing was needed, and would come in the form of a *post-marketing surveillance* (PMS) scheme, in which perhaps 100,000 patients using every new drug would be followed up to look for side-effects. But he emphasised the importance of *patients* being able to report symptoms to the new monitoring authority, even if their GPs did not agree that this information was relevant.

"It's an essential requirement that the patient's own report should form part of the documentation that is filed in the monitoring system. Any untoward effect noted by a patient must be reported. It doesn't matter whether the doctor thinks it's important or not — doctors are not God," said Dr Lesser.

The EAG will be asking Government:

- To set up a public inquiry into Eraldin and its wider implications,
- To introduce a PMS system incorporating patients' right to report their own side-effects,
- To encourage CHCs to act as local advisory and monitoring bodies,
- To appoint consumer representatives to bodies such as the Medicines Commission and the Committee on Safety of Medicines,
- And to investigate ways of relieving side-effects in Eraldin sufferers.

## New director of HAS

Photo: Wessex RHA

The Health Advisory Service has a new director to succeed Dr Eluned Woodford-Williams. He is Dr D H Dick, consultant psychiatrist at Herrison Hospital, Dorchester. The HAS visits and reports on health and local authority services for the elderly and the mentally ill in England and Wales and for the mentally handicapped in Wales (these services are covered in England by the Development Team for the Mentally Handicapped), and on provision for longer-stay children. ACHCEW has arranged a meeting with Dr Dick to put the case for CHCs to be better informed about HAS reports and about the action proposed by health authorities in response to HAS recommendations.

## Proof of the planning pudding

The DHSS has been assessing the success of the health service planning system so far, giving the background to the development of NHS planning, policy issues which arose from the 1977 regional strategic plans and summarising the current plans for each region. The report, *Health Service planning in England 1976-1978**, highlights the rate of progress on joint NHS/social services development, particularly in relation to the elderly severely mentally ill. In its comments on regional plans, the absence of regional policy for this group is picked out again and again. Another frequent DHSS comment is that many regional plans are not costed in any way.

*The report is available from DHSS, Room 1725, Euston Tower, 286 Euston Road, London NW1 3DN.

## Nursing professions

Royal assent has been given to the Nurses, Midwives and Health Visitors Act 1979, allowing for the setting up of a unified structure for the education and training of nurses, midwives and health visitors. The Act is based on recommendations of the Briggs Committee (see *CHC NEWS* February 1979, page 6). But midwives and health visitors wrested substantial amendments to the Bill during its passage through Parliament, to preserve some of their independence and responsibility for specialised education. For instance, the Bill required the new Central Council to *consult* a new statutory Health Visitors Joint Committee. The Act now says that the Central Council "shall not act" on matters relating to health visiting "before receiving a recommendation of the joint committee". There have also been concessions to ensure that midwives or health visitors should be in a majority on committees dealing with their respective concerns. But the health visitors are still unhappy with the provisions.

# Big boost for health centres

*Continued from page 1*

It advises AHAs to give interested GPs "reliable assessments of the charges they are likely to incur", and to obtain from each GP involved written confirmation that he or she intends to practise from the centre — before inviting construction tenders. Health centres should not be provided unless an AHA is sure that GPs intend to use them — though exceptions may be made in "health deprived" localities and in new towns.

Regional capital allocations contain sums earmarked for spending on primary health care schemes, and RHAs must ensure that these sums are spent as allocated.

The department advises that health centres should normally contain between three and 12 GPs (the present average is five). It warns strongly that larger centres risk developing an "institutional atmosphere", and that some patients may be deterred from seeking treatment if their journey to the centre is too long or inconvenient.

Ease of access for the public is "the most important factor to be taken into account when deciding the precise location of a health centre", and consultation with CHCs on this point is specifically recommended. Consultation with CHCs is also advised where a health centre linked with a hospital is being considered.

The memo suggests that pharmacists affected by the opening of a new health centre could cooperate to provide a service in or near the centre, sharing the costs and profits and so avoiding the need to close outlying chemists' shops. An appendix lists a wide range of goods which pharmacists are allowed to sell from health centre premises. But the FPC would have to be satisfied that such a consortium of pharmacists did not constitute a long-term monopoly.

Cooperation between health teams and social workers is described as an "essential element" in community health care, and AHAs should ask social services departments early on whether they require space in a proposed health centre. Physiotherapy sessions and consultant outpatient clinics are also recommended. Other sections give advice on chiropody, dental services, ophthalmic services, facilities for private practice, and administration.

"Where provision of a wide range of services is possible", the memo comments, "the health centre can become the focus for family health services in the locality to the benefit of patients".

HC(79)8 consolidates and supersedes most previous guidance, with the exception of HC(77)8 which advises on the terms and conditions under which GPs may practise from health centres.

# The challenge of a new hospital

Ten hospital closures in six months. This is the daunting prospect for members of Wirral Northern CHC — the result of AHA plans to open a 1,000-bed, £25m District General Hospital in 1981.

Our district is dominated by Wallasey and Birkenhead, two industrial towns each with 100,000 people, both on the River Mersey and separated only by a narrow dock inlet. In the plans each town will lose five hospitals, and in Birkenhead this has caused little public reaction — yet in Wallasey there is a storm of protest whipped up by local politicians. This enormous difference in public reaction has created special problems for the CHC.

Arrowe Park Hospital has been planned for over 20 years to replace four obsolete hospitals in Birkenhead. Because of advances in medicine, it has now been realised that what was to be the "Birkenhead" hospital is big enough to serve Wallasey too. Over the years Birkenhead's hospitals have lacked investment as they were to close "soon" — but the Wallasey hospitals, which were thought to have a long future, were well maintained and modernised.

The new hospital is on the outskirts of Birkenhead, and although inconvenient for the centre is near major housing estates. However, it is seven miles from many parts of Wallasey, with poor public transport links. To many Wallasey people the loss of local hospitals is seen as another aspect of the decline of their town. Protest centres on the removal of accident services and outpatient clinics, and the future problems for visitors.

The AHA proposes an overall cut of 800 acute beds, allowing an increase of 600 badly-needed long-stay and chronic beds. Arrowe Park and Clatterbridge hospitals, just four miles apart at the centre of the health area, will between them provide DGH services for the 370,000 people in Wirral.

The CHC — which of course did not exist when Arrowe Park was being planned — wants to see the two hospitals left in the towns built into strong local bases for community care, with peripheral outpatient clinics and a minor injuries service.

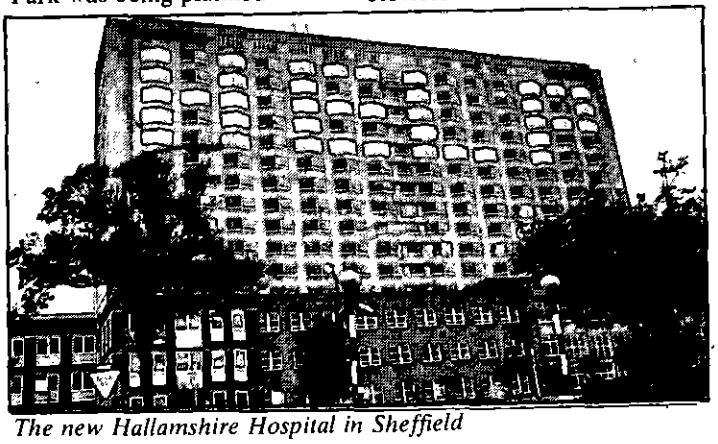
Since September 1975 the CHC has dealt with public consultation on five major strategy documents, covering hospital services, primary care and management arrangements. We have already handled five minor hospital closure documents (one was withdrawn and revised after CHC opposition) and at present we are dealing with proposals to close the five Birkenhead hospitals. By June we expect five further closure documents for the Wallasey hospitals, and one about the reorganisation of accident services.

The amount of study required to understand fully the AHA's detailed statistical arguments is enormous. If the CHC cannot reconcile the figures they must be challenged, and this is what we are trying to do.

Because the CHC has explained the AHA's plans some people have accused us of "selling" them, yet at the same time the AHA is often unhappy about the CHC's public criticisms. A Wallasey politician has circulated petitions, and organised public meetings and a "Save our hospitals" campaign. Her extreme position does not take account of financial limits, and raises false hopes in the public. It also overshadows the more realistic objectives of the CHC, which she has accused of being unrepresentative.

We have made full use of the local media, held public meetings, given numerous talks and issued 20,000 leaflets about the plans, but we do not have the resources to gain the informed views of 200,000 people nor to deal in depth with all the issues, even though we are making a big impact locally. Our representations have already caused the AHA to modify its plans, and in the end the CHC as a lay body will have to make the best "informed" decision that it can.

*Josie Dennis, Secretary, Wirral Northern CHC*



*The new Hallamshire Hospital in Sheffield*

Photo: Sheffield Newspapers Ltd

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The site-opening ceremony of the new DGH at Barrow, in February 1978, signified the fulfilment of over 30 years' determined endeavour. Towards the end of this period the South West Cumbria CHC was able to help by mounting a hard campaign to get the project started, including a 50,000-signature petition to the Prime Minister in 1975.

The planning, construction and opening of such a major development represents an extremely important series of events in the life of a local community, and its effect on other services is far-reaching. Neighbouring hospitals, GPs, public transport, ambulance services, voluntary organisations, social services, other local authority departments and people living close to the site will all be affected by the new development.

The CHC is mindful of some very costly mistakes which have been made in hospital building during recent years, and expects every safeguard to be incorporated into the Barrow project. Essential links in communication have often been left until too late. For example, it has not been unusual in the past for negotiations with the local passenger transport authority to begin only a week or two before a new DGH is opened. Good liaison between the various NHS and other services must be established early on if joint planning is to be effective. Regular progress reports are essential to ensure that related services keep in step with the commissioning timetable.

Talks aimed at identifying the hospital with its community should be offered to local organisations, rather than waiting for individual requests for information. Good use should be made of the local news media. Assurances should be given to the local community about the standards of service being aimed for. Fears that friendliness, individual attention and kindness will be less in the new DGH than in the existing fragmented but well-established and popular hospitals will need to be allayed.

Problems of staff morale will require particular attention. Staff attracted to work in the new hospital will probably be unaware of the delays and frustrations inherent in any commissioning process. It is of paramount importance to keep staff fully informed — through information bulletins and staff journals — about the causes of delays and the reasons for changes in the programme.

A scale model of the new hospital can be used to great advantage, and this CHC is hoping to exhibit such a model in selected towns and villages within the district, for periods of about two weeks. On the final day of each exhibition the public would be invited to an open discussion with representatives of the commissioning team and the architect. During such exhibitions efforts would be made to generate interest and encourage the recruitment of voluntary help.

*Jim Little, Secretary, South West Cumbria CHC*

# ALTERNATIVE MEDICINE

If you are ill and you go to the doctor, the chances are 100-1 that you will receive conventional drug therapy. Your GP is a registered medical practitioner of Western medical science.

Yet there is an unprecendented boom in "alternative medicine" (AM). Some of the techniques, based on beliefs which have been scoffed at by the medical profession, are slowly easing their way into respectability. Interest in unorthodox medicine seems to have been fuelled by increasing awareness that drugs can have unforeseen side-effects. Also, practitioners of various types of AM commonly report that people arrive in their consulting rooms complaining that their NHS doctor simply has not got time to be interested in them, as *people*, in the way that they feel they deserve.

This article will briefly describe some of the better known alternative therapies and their relationship to the NHS. Alternative psychiatric medicine, such as psychotherapy or bioenergetics, would require another article.

Homoeopathy is best known as the "like cures like" treatment, based on the idea that medicine which produces the symptoms of a disease is the best way of helping the body to overcome the same disorder. A second paradox of the therapy is that the more minute the dose, the greater the benefit to the patient. Critics have cited the "placebo-effect" as the cause of any success that homoeopathy may have had. But rigorous trials, conducted in one of the six NHS homoeopathic hospitals, have shown that the therapy is not dependent on patients' faith.

People often confuse the use of acupuncture as a pain-killer with its use as a treatment for more general disorders. There is no longer much dispute that acupuncture works, especially in pain relief, but there is much speculation as to how it does it. According to the traditional Chinese theory, dual flows of energy run through the body along routes called "meridians". The needles stimulate or sedate the energy flow and help to restore equilibrium in the body. It seems impossible to reconcile such a theory with the basis of Western medical knowledge. At Poole Hospital research into pain relief is comparing acupuncture with conventional methods.

Osteopathy means "bad backs" to most people, and more than half of those who consult osteopaths do so for backache. Yet osteopathy claims to be able to deal with a variety of other disorders, principally by improving the mobility of the joints. A spokesperson for the General Council and Register of Osteopaths said pathological disorders would immediately be referred to an RMP — "We do not think we are doctors". A recent report to the DHSS on back pain (HMSO £1.50) calls for trials to compare osteopathy with conventional back pain treatment. The osteopaths welcome this.

Perhaps one of the least known of the alternative therapies in Britain is medical herbalism, yet its claims are considerable. The herbalists attach great blame to refined foods and the stresses of modern living as significant producers of illness, and lay great store by "natural" diets as part of a prescribed cure. The National Institute of Medical Herbalists says that provided a proper diet is followed, suffereres from multiple sclerosis can be made "completely better" with herbal remedies. So far as is known, there are no trials planned to test such claims.

Spiritual healing does not involve needles, manipulation or potions, and is quite widely practised. It is usually done by the laying on of hands. It is perhaps the most inexplicable of all the "fringe" medicines and the most challenging to medical science. Investigations at McGill University, Canada, showed that recovery from skin wounds in mice was speeded when a healer held the cage. There is speculation from this and other experiments that some kind of unidentified energy flows from the healer.

Besides these, there are claims for the benefits of chiropractic, bio-feedback, naturopathy, psychic surgery, Alexander technique, hypnosis, reflexology, gem, colour and foot zone therapy, radionics, autogenics, shiatsu massage, reincarnation, mega-vitamin therapy, psionic medicine and aeriontherapy. Some of these are very widely regarded as pure quackery. Others used to be held in contempt, but are now taken much more seriously.

Within the NHS, patients do not choose their course of treatment. And the General Medical Council's view about the position of any GP who might refer patients to an AM practitioner is one of extreme caution. It says that if a doctor believes it to be in the interests of a patient, referral may be made to an unregistered person. But a doctor must be satisfied that the person is competent and must also retain ultimate responsibility for the management of the patient's treatment. This is because the GMC considers that only the doctor, an RMP, has received the necessary training for this responsibility. But the onus of the decision relies very much on the individual doctor's professional judgement.

Homoeopathy is the only AM available within the NHS. All homoeopathic NHS doctors must also be RMPs, and the DHSS has said that "homoeopathic treatment should remain available within the NHS". But the Council for Post-Graduate Medical Education has unwaveringly refused to approve any financial assistance for doctors' training.

The National Federation of Spiritual Healers has persuaded the managers of 1500 NHS hospitals to allow its members to enter and treat patients, at the patient's own request and with the doctor's agreement. Notes for members' guidance stress that this concession should be met with "great discretion", reminding them that patients are under medical care and warning against tactlessness.

Section 56 of the 1968 Medicines Act allows a medical herbalist to prescribe "in accordance with his own judgement as to the treatment required". This concession for a non-medically qualified practitioner is unique to herbalists.

From time to time there is a call for AM to be made available within the NHS. There is also an occasional scandal, such as the hepatitis outbreak in the Midlands which was traced to dirty acupuncture needles and led to demands that acupuncturists be required to register. The DHSS' view is that there is nothing to prevent practitioners of AM from seeking registration as a profession under the Professions Supplementary to Medicine Act 1960. This would give them the same status as paramedical workers such as chiropodists and physiotherapists. Though the British Acupuncture Association is seeking this type of registration, the Osteopaths' Council is wary, believing that it would mean "subordination" to RMPs and would deprive them of the right to make diagnoses. The argument is that if you offer an *alternative* to medicine, you do not seek to become *supplementary* to medicine.

There is another reason why AM is unavailable within the NHS. It requires time — one consultation, especially with a new patient, may take up to an hour. It seems inconceivable that this could be accommodated within the present NHS. The time is needed, say the homoeopathic doctors, because they are treating the whole patient, taking into account, not only symptoms and case history, but also the personality. An acupuncturist and a herbalist would also require a complete picture.

But the lack of regulations has drawbacks which the AM professional associations readily admit. Try as they might to insist on standards of training and practice, those

who belong to the professional bodies remain a minority. Under common law, anyone can practise AM, with or without training. The healers' federation has about 2000 members but there are as many as 20,000 people practising healing. Only a tiny minority of acupuncturists belong to their association.

This does not mean that all non-members are charlatans. But it is all too easy for the public to be taken for a ride. Since people who turn to AM have often been told by doctors, "You'll just have to live with it", they may be desperate for a cure or simply relief, and be vulnerable prey to the unscrupulous person who is willing and even insistent on giving them undivided, personal attention for an hour at a time.

It would be foolish to try and assess here the claims made by AM practitioners. The interest shown by the public would appear to be as much a comment on current medical practice as anything else. The NHS extends grudging recognition to fragments of AM practice, and this may well increase. But AM cannot be fully accepted unless its practitioners abandon their cherished beliefs and submit to the supervision of the medical profession, as required by the NHS Acts. AM practitioners find this condition impossible to accept.

Galileo was tried as a heretic because he claimed that the earth moved round the sun. What an idea! Time may prove that medical orthodoxy is making the same mistake about some of the claims of alternative medicine.

## Useful addresses

- British Acupuncture Association, 34 Alderney Street, London SW1V 4EU. Tel: 01-834 3353.
- The British Homoeopathic Association, 27a Devonshire Street, London W1N 1RJ. Tel: 01-953 2163.
- General Council and Register of Osteopaths, 16 Buckingham Gate, London SW1E 6LB. Tel: 01-828 0601.
- National Federation of Spiritual Healers, Old Manor Farm Studio, Church Street, Sunbury-on-Thames, Middlesex TW16 6RG. Tel: Sunbury 83164.
- National Institute of Medical Herbalists, 22 Osborne Avenue, Jesmond, Newcastle-upon-Tyne, Tyne and Wear NE2 1JG. Tel: 0632-813922.

# Book reviews

## Reorganising the National Health Service: a case study of administrative change

*by R G S Brown, Blackwells and Martin Robertson, £8.95*

How many of us voice our concern about failures of the NHS in terms of criticism of the structure that was established in 1974? Is such criticism valid? Dr Brown describes the history of the health service and its problems, the management theories and political constraints which led to the present structure, and the machinery through which the change was effected. He and his colleagues were involved in studying the process and results of the reorganisation in Humberside. Whilst different areas found a variety of problems, we can recognise parallels in our own localities to the experiences described in this particularly insightful part of the book.

The final section analyses some of the problems which have been caused or exacerbated by the reorganisation. It was somewhat disappointing not to find a prescription for a re-reorganisation, but perhaps that would have been asking Dr Brown to do the work of the Royal Commission! In summary, this book will be of the greatest assistance to any CHC member who wants to understand the organisational problems facing the NHS and the background to the recommendations which will shortly be produced by the Royal Commission.

*Roy M Southern*
*Stockport CHC*

## Law on hospital consent forms

*by W A J Farndale, Ravenswood Publications, £8*

A book on such a daunting legal subject as hospital consent forms which has under 100 pages and claims not to assume a previous knowledge of the subject sounds almost too good to be true. But anyone who has a particular query relating to the purpose, content or administration of consent forms or on any of the legal, moral or ethical aspects involved, can turn to this book with confidence. Equally, it provides a clear, concise and comprehensive explanation of consent to treatment for the reader seeking a general knowledge of the subject. Case studies illustrate many of the points and are fascinating reading in their own right. The author goes into some detail on various aspects of the consent form itself — such as how much a doctor needs to tell the patient of the risks involved in an operation or treatment. And he also covers the position of special categories of patients such as accident and emergency, termination of pregnancy, and mentally disordered patients, minors, and people with religious objections, and consent for transplants and hospital post-mortems.

## Able to work

*by Bernadette Fallon, Spinal Injuries Association, 126 Albert Street, London NW1 7NF, £2.50 + 50p post*

Drawing: Liz McQuiston

". . . there is no reason why you should accept a job which is beneath your capabilities just because your body is disabled." This quotation sums up the spirit underlying this book, and typifies its straightforward and encouraging style. Basically, though, it has been written to provide practical advice and detailed information to severely disabled people (primarily paraplegics and tetraplegics) on what employment and education opportunities are available and how to make use of them. Every aspect is covered, starting with the need for self-assessment of independence and of the kind of job or training that is required and suitable. There are sections on the disablement resettlement officer, financial assistance, preparation for work, courses in universities and colleges, the special problems of people seeking professional jobs, sheltered employment, working at home, and voluntary work. The book finishes with some cheering success stories and a list of useful addresses. Obviously it will be of most practical use to disabled people, but it will also be invaluable to anyone giving advice on employment and should help to dispel prejudice against employing people in wheelchairs.

## Books received

**The good birth guide** by Sheila Kitzinger (Fontana paperbacks £1.95; Croom Helm £9.95).

**Childbirth: a complete guide to every problem** by Elliot Philipp (Fontana 95p).

**Child care** by Dr Graeme Snodgrass (Macdonald Guidelines series £1.25).

**The doctor: father figure or plumber** by James McCormick (Croom Helm £7.50).

**Action with the elderly: a handbook for relatives and friends** by Dr Kenneth M G Keddie (Pergamon £3.50).

**Understanding ageing: facing common family problems** by Melissa Hardie (Teach Yourself Books, Hodder £1.25).

**Improving geriatric care in hospital: report of a working party of the British Geriatrics Society and the Royal College of Nursing.** Though published in 1975 this report remains an excellent summary of factors affecting quality of life of patients in geriatric wards and includes useful guidelines on good practice and how to achieve it. The report is now the basis of the DHSS programme (see HN(79)35) for helping staff to improve standards of care (Rcn, Henrietta Place, London W1M 0AB, £1.30 inc post).

**Learning to speak again . . . after a stroke** by Charles R Isted. Written from personal experience, this is an exercise book for daily practice, designed to help stroke patients recover the skill of speech (King Edward's Hospital Fund for London £2).

**The human face of medicine** (based on the fourth international conference of the Balint Society in Great Britain) edited by P Hopkins (Pitman Medical £12.95).

# ACTION ON AMBULANCES

*by Alison Norman **

We all know, or should know by now, that the outpatient ambulance service is under constant pressure to meet increasing demand from static resources and that the result is too often an unreliable, unpunctual service; wasted clinic time; unopened or under-used day hospitals; and much frustration and bitterness amongst those who operate and administer the service. But though there may be agreement about the problems, there is, as is the way with human nature, little agreement about who is responsible for resolving them.

*The consultants say their job is to treat* patients, not to worry about how they get to the clinic — and so they schedule their clinics and make their appointments to suit usual working hours and not transport convenience. The ambulance officers say that it is totally impossible to give an adequate service if day patients and outpatients have to be brought and taken home at the same peak hours, that the booking clerks don't do their job properly and that the service is too often abused. The crews resent being trained for highly-skilled emergency work and then used for a large part of the time to act as taxi-drivers. They resent not only low pay, but also anomalies over pay and administration left behind by the 1974 reorganisation and past, *piecemeal bonus agreements, and they have* to put up with criticism from the public for poor standards of service which may be beyond their control. Also, increasingly sophisticated and centralised methods of control and administration increase bureaucracy and reduce human contacts within the service, while poor differentials make it uneconomic for men on overtime to accept promotion and discourage the senior staff.

All these points of view are valid, but if everyone sticks to a rigid partisan line, the situation will get worse and worse. There is much which *can* be done to improve transport to hospital, but only if *everyone* concerned is prepared to co-operate and *study the problems and possible solutions* on a local basis. For example, outpatient appointments and day hospital admission times can be adjusted so that ambulances are not expected to bring all their patients in at 9.30 a.m. Clinics which make heavy demands on the service need not be held at the same time. Hospital staff can see that a discharged patient is ready for collection when the ambulance calls for him. Procedures for notifying cancelled appointments can be improved. A more careful check can be made that an ambulance is really necessary before booking one. Public transport operators and local authority transport co-ordinators can be consulted about improving public transport to hospitals. Planners can make sure that buses can get close to outpatient entrances and that there is adequate private *parking. Ambulance liaison officers can be* included in forward planning, clinic administration and training of hospital staff.

All these methods have already been tried out and have been proved to work. But there are no blanket solutions. Every district and area has its own problems and possibilities, depending on the distribution of population, the siting of hospitals, the geographical characteristics of the area, the availability of public transport, the present pattern of ambulance provision and a host of other factors. It is essential to try to look at the problem in the round, and not just to focus on the particular aspects of it which the public may complain about. These are only symptoms of the basic condition and while it is a good thing to alleviate the symptoms, the long-term problems will remain and fester.

So the first thing to do is to collect facts. Some of these will be statistical facts available in the return made by the Chief Ambulance Officer to the AHA, which shows what resources in staff and vehicles are being deployed; how many journeys in the various categories are being made; whether there are seasonal peaks and troughs in demand, and so on.

*Then there are facts about costs. What is* being spent on the service and how is it divided up? How much is being spent on the emergency service and the outpatient service respectively? What estimates can be made of cost per patient mile for routine ambulance collection? Information of this kind can be very useful for comparing the cost of improving transport with the cost of wasted clinic and day centre resources caused by inadequate transport, and so strengthen the case for increased financial input.

Then there are policy facts. Has the AHA laid down priorities for different kinds of demand — such as putting day hospital patients before outpatients, if necessary? Are they attempting to "ration" use by limiting supply? What are their views on increasing sophistication of control? Or on the size and design of the vehicles which they operate? What future plans such as the opening of more day hospitals or treatment centres will generate further demand and can this be quantified?

Facts will also be needed about the standard of service offered. Has the AHA made any effort to monitor the standards of the outpatient service in terms of journey time to and from treatment, early or late arrival for appointments and time spent waiting for collection after treatment? A DHSS Circular (1) has suggested minimum standards and ways of measuring performance but this is seldom carried out in practice. One reason for this is that it is felt to be too complicated to administer and perhaps there is also a fear that if it shows that the standards suggested by the DHSS are not being met, there may be trouble (though these standards are simply suggestions and cannot possibly be universally applied). In fact, once the system has been set up and personnel properly instructed, it is not really so difficult to administer such a survey. And even if the service is nervous of making an overall check, a simplified analysis made for a limited time and in sample areas, can be carried out without much difficulty. Measuring standards in this way has important advantages. For example, it shows how an ambulance service is performing, and that is useful when decisions are being made about the appropriate level of resources to be committed — and it also shows up new aspects of a problem which can sometimes be solved by simple improvements in administration or control procedures. Information about standards can also be obtained from a check by the staff of clinics and day hospitals over a short period on the transport problems of their patients and the effect of this on their treatment and use of staff time.

Last, but certainly not least, there are the facts as seen by those providing the service, from Chief Officers to the crews at the local stations. How did the service operate before 1974 and what has been its history since? What sort of co-operation do they feel they get from the hospitals and GPs? Has the structure of the service been distorted by inadequate differentials? Have past deals *on shiftwork and overtime, designed to* increase pay, made it difficult to provide a service which meets peak demand? Is there a conflict between providing adequate emergency cover and operating the outpatient service? Does the same man have to cope, day after day, with the high stress job of simultaneously operating the radio control, planning the next day's runs and dealing with enquiries and complaints, or are these tasks split up and rotated? (This is most likely to be a problem in very rural areas with a very small control staff.)

There is only space here to suggest a few of the salient issues but basic information is available which should help CHCs or others to get a grasp of the problems and what can be done to relieve them. National Corporation for the Care of Old People opened up the subject with a chapter on reaching medical treatment and day care facilities in *Transport and the elderly: problems and possible action* (2). Details of this and other references are given below.

"But," I can hear CHC members crying out, "what you have outlined is a full-time research programme, and concern with transport is only a tiny corner of our work, we just don't have the time." Fair enough, but do remember two things.

1. An efficient, properly used transport service is *basic* to the provision of all hospital-based treatment and to the efficient use of clinical and nursing resources.
2. CHCs which are trying to take action in this area should see themselves as a catalyst rather than a thorn in the flesh. Their job (often acting together within an area or region) is to raise clinical and *administrative consciousness about the* real nature of the problem and its effect on standards of care so that *concerted* action can be taken. Perhaps one of the best ways to get at the required information listed above *and* educate the people concerned, would be to call an area or regional conference with a number of invited speakers from different disciplines who can talk about the situation from their viewpoint. The conference might then move towards the establishment of a multi-disciplinary working party to carry forward the drive for better co-operation and efficiency. Conversely, it may be politically more tactful to start with an invited working party and work towards a general conference.

Whatever the method used, the aim must be to get the competing groups listed at the beginning of this article to realise that they *all* have a responsibility for enabling a decent service to be provided, and it is in *all* their interests to obtain it.


Photos: Health and Social Service Journal

## References

1. *Organisation of ambulance services: standard measures of service and incentive schemes.* DHSS circular HSC(IS)67.
2. *Transport and the elderly: problems and possible action,* by A J Norman, National Corporation for the Care of Old People (NCCOP), £1.25.

See also:
*Proceedings of a conference on outpatient ambulance transport,* NCCOP, £1.
*Proceedings of a conference on "need" for an ambulance,* NCCOP and the Beth Johnson Foundation, £1.
*Ambulance services: operational control and use,* DHSS circular HC(78)45.
Studies produced by the NHS Operational Research Group of the Royal Institute of Public Administration, 229 King's Road, Reading RG1 4LS.
Articles about the ambulance service in *Health and social service journal,* 25 January 1979.
*Day hospitals for the elderly: therapeutic or social?* by A Martin and P H Millard, Geriatric Teaching and Research Unit, St George's Hospital, London. This includes a detailed discussion of transport problems and optimum treatment times.

* *Alison Norman is the Assistant Secretary of the National Corporation for the Care of Old People, Nuffield Lodge, Regent's Park, London NW1 4RS.*

# Healthline

## TV and radio interview techniques

**Can you advise on training courses in TV and radio interview techniques for CHC secretaries or members?**
Some commercial organisations run courses, but the fees can be quite high. Southern Television runs an intensive one-day course which a number of CHC secretaries have attended, under the aegis of Wessex RHA. The fee for this course is around £40. We have heard of at least two free courses offered to CHC people — one run by BBC West and one by Borders TV. It would certainly be worth asking local radio and TV stations if they can help.

## Artificial insemination

**What is DHSS policy on artificial insemination by donor (AID)?**
DHSS policy since 1968 has been that "artificial insemination, whether by a husband or donor, can be carried out within the NHS when it is recommended on medical grounds. The decision whether the technique should be used in any particular case depends upon the clinical judgement of the doctor concerned." AID is regarded as part of the infertility service which is offered in hospitals in some of the larger cities in the UK, and GPs should be able to refer patients to a suitable infertility clinic. The Family Planning Information Service (Family Planning Association, Margaret Pyke House, 27 Mortimer Street, London W1) can provide information on places where the treatment may be available privately.

## Encouraging breastfeeding

**I have heard of the La Leche League. Can you tell me what it does?**
The La Leche League is an international organisation, based in the US, aimed at providing mother-to-mother practical help with breastfeeding. There are 5000 local groups worldwide and around 50 so far in Britain. The league also publishes a large number of leaflets and a bimonthly newsletter. It is partly financed through its supporting members, who pay £15 a year. The UK contact person is Nancy Turnbull, 85 Sturton Street, Cambridge (tel: 0223 64743).

## General Medical Council

**Where can I get information on making a complaint to the General Medical Council regarding professional misconduct? And is there a time limit for submitting complaints?**
The disciplinary powers of the GMC are set out in their booklet *Professional conduct and discipline* (GMC, 44 Hallam Street, London W1N 6AE). The booklet says nothing about time limits, and the GMC told *CHC NEWS* that none is laid down. But the longer the delay, the less chance there would be of the GMC instituting action.

## Smear test recall scheme

**How does the national recall scheme for routine cervical cytology operate and how effective is it?**
Screening for cervical cancer by five-yearly smear tests was expanded into a nationwide NHS service in 1967, with priority for women over 35 years. A national recall scheme, using the NHS Central Register in Southport, was introduced in 1972. The priority group was extended in 1973 to take in women under 35 who have had three or more pregnancies. Details of tests are recorded on standard forms, which AHAs are supposed to send to the national register. The national register then informs AHAs when a woman is due for retest. The GP has the opportunity to cancel the recall before the letter is sent inviting the woman to attend for retest. This is how the recall system works in theory, but the national scheme is not mandatory and some areas opted to operate their own recall schemes, which may have fallen into disuse. And the illegibility of many of the forms received by the national register often makes recall impossible.

## Social security benefits and hospital patients

**What happens to pensions and other social security benefits when a patient goes into hospital?**
Benefits such as sickness, invalidity and injury benefits, as well as retirement and widow's pension, are reduced, after eight weeks in hospital, by £7.80 a week or by £3.90 if the patient has a dependant. After 52 weeks, additional deductions may be made if the patient has no dependants, although these may accrue for a further 12 months as a resettlement sum payable on discharge.

# Your letters

*Continued from page 2*

complainants. They then appealed to the Secretary of State, who ruled that because the GP unit was controlled by the AHA, and the GP had signed a contract with the authority, the FPC had no jurisdiction to investigate the complaint. He therefore rejected the appeal!

## CHCs and abortion

*County Cllr. F J Howard, Member, NW Herts CHC*

When I read letters such as that from the Secretary of Wandsworth and East Merton CHC (*CHC NEWS 40*), describing a proposal to kill babies by abortion as a "primary care project", I have to question whether we really know just what is our business as CHCs.

It would be interesting to know how many CHC members know what rights the 1967 Abortion Act confers. It does not give anybody the *right* to an abortion, nor does it set targets; it merely states that under certain circumstances and within certain criteria an abortion shall not be illegal. But what is happening is that doctors with elastic ethics are rapidly transforming an Act which its sponsors said was intended to cater for the so-called "hard cases" into a killers' charter under which human life can be discarded at will for the flimsiest cosmetic or economic reasons.

This is an approach that any extension of day-care abortion will inevitably foster, and CHCs should be aware of it if they are prepared to go along the same road as those in Wandsworth.

## Artificial insemination by donor

*Mrs A J Barrett, Member, East Herts CHC*

CHCs have been asked to comment on Scarborough CHC's suggestion that ACHCEW should "look at the social, legal and emotional implications of AID". I was surprised that Scarborough's proposal made no mention of morality!

I do not believe official thinking — parental, educational or medical — should be non-judgmental. Moral guidance should always be on hand. As Christians we accept the pulls and strains of moral obligations. Human beings need to struggle and have ideals to live up to. Instant gratification results in listless, selfish lives with no thought of the resultant unhappiness. I see no evidence that all this "new thinking" is resulting in a happier world. I make only *one* exception — for Artificial Insemination by Husband. By any other donor, let's face it, it is adultery.

I get cold shivers down my spine when I read that the British Pregnancy Advisory Service is setting up AID schemes for women *with or without partners*. Who authorises such organisations to go ahead with such schemes, which could result in much unhappiness? It is unfair on the child to impose on him the handicap of having no one to look to as his father. Baby battering is also a risk, says the NSPCC. There are problems over inheritance, as well as poverty, isolation and teasing from school friends.

Adopting parents are advised to tell their children at an early age that they are adopted — imagine the emotional shock when an AID child is told that his father is an unknown quantity. Now is the time for doctors, psychiatrists, CHCs and religious bodies to speak out.

# PLACE OF BIRTH: AT HOME

**"The National Childbirth Trust believes that our maternity services should be flexible enough to offer parents the kind of care they seek." The issues to be considered when choosing whether to have a baby in hospital or at home are set out in a leaflet published by the National Childbirth Trust and summarised here. *The choice of birth at home for those thinking of having a home confinement* is written by Sheila Kitzinger***

There are two kinds of hospital care. The first is GP units, including cottage hospitals and GP beds in larger hospitals. Secondly, any mother who is ill or whose baby is at risk, is advised to go into hospital where she will be in the care of a consultant and have access to specialist equipment. The National Childbirth Trust (NCT) says that if a GP suggests delivery of the baby in a GP unit, then it is probably quite safe to have the baby at home.

The medical reasons for having a hospital birth are reviewed. They include toxaemia (a blood-poisoning which the mother may get in pregnancy), the risk of a breech birth, and any type of complications at a previous delivery. If labour begins more than three weeks early, it is wise to go into hospital.

As well as the medical risks there are perinatal mortality statistics, telling us which babies are more likely to be at risk of dying at or soon after birth. Statistics are not predictions but it is clear that the risks to a baby are greater when the mother is unsupported, she is over 35, or she is Asian born, or the wife of an unskilled worker. A first baby or a baby born to a short mother is also more at risk.

If, however, the pregnancy is straightforward and the labour is likely to be normal, there are some advantages in having a baby at home and the NCT considers them to be as follows:

- "feeling confident and relaxed in a familiar place, an advantage to the father as well as to the mother. Although some women feel more secure in hospital, others do not, and this should be borne in mind when choosing the place of birth, since emotional well-being may positively affect uterine function and psychophysical co-operation;
- avoiding sometimes lengthy and exhausting travel to hospital when in labour, and being moved from room to room in hospital;
- avoiding unnecessary obstetric intervention, including induction and acceleration of labour, operative delivery and routine episiotomy;

*15 minutes after the birth of Nell*

Photo: Sally and Richard Greenhill

- avoiding cross-infection from the large number of people who will be caring for you and your baby;
- avoiding drugs which may adversely affect the baby;
- being able to keep mobile. Although some hospitals encourage women to move about in labour, many do not. Mobility is not only more comfortable for the mother, but is likely to help the uterus to work better and to avoid reduction of oxygen to the baby which can occur when the mother is lying flat in bed;
- the emotional benefit of having continuity in maternity care, with a midwife who stays with the mother, and cares for her after the birth and whom she probably already knows in pregnancy. Again, this can also happen in hospital if the 'domino' scheme operates in your area;
- avoiding the emotional effects for the family of separation from an older child or children, and letting them understand birth as a normal part of life and be able to greet the new baby immediately;
- keeping the mother and baby close together during the important minutes and hours after delivery, a time of special sensitivity, awareness and learning for both, and one in which initial emotional processes of bonding between both parents and the new baby are developing. Although an increasing number of hospitals now keep mother and new baby together, many still do not;
- the relative ease in starting breastfeeding in one's own home and outside an institutional environment;
- feeling that one is retaining responsibility for one's child's birth, with medical help supportive rather than directive."

If a woman wants to have a home birth, her GP is the first person to talk to. Some GPs are understanding and helpful, but it is likely that many will try to dissuade a mother from staying at home and may even suggest that the baby's life is being risked. In any case most GPs who do agree to a home confinement only do so if the pregnancy progresses in a straightforward way.

Not all GPs do maternity work of any kind and the NCT gives practical advice about how to find a GP obstetrician who is prepared to do home births. It warns that many young doctors have never seen a home confinement and older ones may be out of practice, because of the trend towards births taking place in hospitals.

If the GP does not know of any doctor who can help, the next step is to contact the Area Nursing Officer. The ANO will probably give the name of the Community Nursing Officer who supervises community midwives (who do home and GP unit deliveries).

The NCT advises women to go to the CHC if the ANO cannot help. It is wise to keep copies of all the letters written. In the face of determined opposition from a GP obstetrician, or if a woman decides she wants a home birth after having been booked into a consultant unit, it is best to write to the doctor concerned, giving reasons in a "clear and unemotional" way. It also helps if a father-to-be is seen to back up the woman's wishes, accompanying her and jointly signing the letters.

The NCT describes what happens once a home birth has been agreed. The midwife visits and advises on preparations. The social services department has a duty to provide a home help for 14 days. The NCT suggests organisations which may be able to put the mother in touch with others who have had home births in the locality.

The NCT stresses that it is "vitally important" for the mother to have good ante-natal care and to lead a healthy life during pregnancy. Apart from that, once the place of birth has been chosen, the only remaining advice is to "stop worrying and relax and enjoy your pregnancy".

* *from National Childbirth Trust, 9 Queensborough Terrace, London W2 3TB (15p + SAE).*

# BLEAK FUTURE FOR GYPSIES' HEALTH?

In February 1974, a family of gypsies were camped on the roadside near a Wiltshire village. They needed a fresh supply of penicillin tablets for their 11-year-old daughter, who had apparently had an operation while the family was in Manchester.

Eric Hodges — a local councillor, a qualified nurse and chairman of the North Wilts Gypsy Council — rang a local GP on their behalf. The GP refused to see the girl, claimed he already had too many patients on his list, and suggested that Coun. Hodges try elsewhere.

A complaint to the FPC proved abortive, but the incident did help to confirm the NWGC's impression that Irish and Romany travellers in its area were having severe problems in getting medical attention.

Further research revealed a deep reservoir of ill health amongst travellers, and also suggested that they were being discouraged from using a local accident and emergency unit — their only alternative to GP care. Some travellers camping locally had been in contact with a confirmed case of polio, and the health district hastily arranged a vaccination programme.

The gypsy council's research showed that travellers' problems are caused by their need for mobility, their illiteracy, the stigma which some people attach to them, and their identification of doctors — sometimes justifiably — with "other authoritarian contacts" such as social workers and the police.

Meanwhile Coun. Hodges had become a member of Swindon and District CHC. The CHC had set up an ad hoc committee, carried out a questionnaire survey of local statutory and voluntary organisations, and arrived at much the same conclusions as the

Photo: Maria Bartha

NWGC — specifically criticising "the attitude of some GPs, their staff and the general public to the (gypsy) way of life", and pointing out the "difficulties for such persons to understand the registration system with GPs and their rights under the various regulations".

The CHC asked the Wiltshire FPC to remind GPs of their duty to treat gypsies, but the FPC felt no specific reminder was necessary. In fact a GP's terms of service do specify that "If a doctor refuses to accept . . . a person . . . as a temporary resident . . . he shall on request give that person any immediately necessary treatment for one period not exceeding 14 days". This guarantees travellers' rights to GP services — in theory.

In October last, Swindon CHC resolved that visits from mobile doctors, health visitors and immunisation clinics were needed on gypsy sites, that arrangements for

# TRANSSEXUALS

*by Nick Harris, Secretary, Manchester Central CHC*

Homosexuals, transvestites and transsexuals seem to produce a mixture of confusion and prejudice in most people. Each group has separate and different problems, but they are often, mistakenly, seen together in the public eye. Recently I have been approached by transsexuals for advice and support at the CHC. In trying to act as the patient's friend I have attempted to find out what is available for this small, but growing, group.

Transsexuals, usually born male, are psychologically of the opposite sex. Childhood is permeated by identity crises. In adolescence they may be attracted to the same sex even though they are not expressing homosexual tendencies in the generally accepted sense of the word. Dressing in the clothes of the other sex is equally not transvestitism, in that to a transsexual they are the clothes of their own sex, mentally. Socialising is confined to the few homosexual and transvestite pubs and clubs; a career is often limited to working behind a bar.

To achieve any semblance of normality a transsexual will require complex treatment, not just surgically but in terms of psychological support. The transformation may take years, involving hormone treatment, surgery, rehabilitation and counselling.

In the past counselling in particular has been poor and continuing support almost non-existent for those who have undergone treatment. Often transsexuals end up having psychiatric treatment (perhaps even as in-patients), when they were hoping at last for some sort of normal life. Employers remain unwilling, social life is still as bad and even a lengthy period on invalidity pension does little to lift the gloom. Transsexuals remain isolated; society has failed. Of course in many cases today things are improving and support is becoming available from a number of agencies. A better understanding of the problems is clearly needed, but by whom?

Who can help?

1 The poor long-suffering GP must be a key. Firstly GPs must be aware that the person is a transsexual. (One case in our files shows that a GP was unaware that the complainant had changed sex even after some months.) As with other relevant services, the GP needs to know where the transsexual can obtain the most appropriate help.

2 Psychiatric outpatient departments — psychosexual counselling is a must.

3 Plastic surgery and other departments carrying out the treatment should be aware of the particular psychological problems which are involved.

4 Social services play a crucial role especially in relation to employment,

emergency medical services needed re-examination, and that better health education for gypsies was required. A fourth recommendation, with implications outside the NHS, highlighted the need for more official gypsy sites — both permanent and transit.

All these points were put to the Association of CHCs' standing committee, which on 27 March considered a paper prepared by ACHCEW secretary Mike Gerrard. This commented that "provision of care depends on the willingness of GPs to make special efforts for patients of low status which they do not make for their other patients, and at (present) . . . the prospects for such patients look bleak".

The paper suggested that primary care for travellers and the homeless should be "taken over by AHAs as part of the community services", but despite expressions of concern from four other CHCs the standing committee decided only to "note" Swindon's suggestions. The tone of the discussion was hostile to the idea that there should be any special provision for gypsies beyond that available to the community at large.

Yet in some health districts special provision *is* being made. Hereford CHC, for instance, requested information on this subject from its DMT, and received a report confirming the alarming picture found around Swindon and showing a clear determination to "grapple with the problem".

In the Hereford district special services for travellers are provided by community nurses, by a community medical officer, and through visiting clinics which provide immunisations and advice on infant care. The Hereford report accepts, however, that the key to success would be the establishment of sufficient official sites for travellers. This key will be found — or remain lost — outside the NHS, but some CHCs are raising the question with their local authorities through joint consultative committees.

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benefits and accommodation (rehousing may be necessary). (A social worker interviewing one of my complainants asked: "Name, address and how many children?"; despite the wonders of modern science this is not possible!)

4 Job centres — employment will require careful thought. Many transsexuals find it difficult to hold down a job after a long period on invalidity pension not working, particularly if they are entering a new field of work. Staff in job centres probably have little idea of the special problems faced by transsexuals. The need to obtain a female insurance card is another big problem.

6 Self-help groups — I believe there is one in London, but generally help would only be available through homosexual groups, which appear to be as antagonistic as the rest of society.

Transsexuals are continuing to increase in number. CHCs could well think how they might best make sure that this particular group of patients receive relevant treatment and support.

# Tourist tales

*by Ray Allen, Secretary, Great Yarmouth and Waveney CHC*

Come to our district for a holiday, but please do not be ill! This could well be our slogan, for while holiday-makers to this popular area are made most welcome, the strain which they place on our inadequate health services is almost intolerable.

The present resident population of the district is just over 180,000, but during the summer months, May to September, the population just about doubles, and that is not counting the visitors who come for the day. Travel agents arrange special terms and facilities for senior citizens and handicapped people and they come in large numbers.

GPs find their workload extremely heavy and one doctor told me that his work almost trebles during the holiday season. Last year his practice of five doctors dealt with 4000 temporary referrals, but one of the problems is that there is not enough local population to justify more doctors. Apart from the various minor accidents and ailments which occur, a number of people come on holiday requiring nursing services or continuing treatment. Community nurses have to administer daily injections and sometimes patients require further blood tests at the hospital. Holiday visitors often leave their vital medication at home, such as heart tablets or insulin, thus adding to the burden on the GP.

A difficult decision faces the GP when holiday makers become ill, with conditions such as pneumonia, unstable diabetes, mild heart attack. An illness which in normal circumstances could be treated at home becomes a different problem when a patient needs to get fit enough to vacate holiday accommodation at the weekend and then make a long journey home. The alternative is to try to find a hospital bed. This is not easy in a district where the acute bed provision supplies only about two-thirds the need of the resident population, and the geriatric bed provision is less than half the DHSS norm.

Obviously, the resident population must suffer as a result. A survey carried out at the major hospitals in 1975 showed that of all admissions the following are the percentages of ex-district patients during the main holiday months: June 32.45, July 40.50, August 37.22, September 28.57.

Accident and emergency attendance in 1977 totalled 61,365 which is about 348 per 1000 total resident population. As a result of emergency admissions, the operating lists sometimes have to be cancelled, and are often cut short, thus lengthening the waiting list for residents of the district.

The ambulance service is hard pressed by the increasing traffic and road accidents. Patients often have to be conveyed back to their homes, perhaps more than 200 miles away. The cost of these journeys is considerable, and the AHA has bought three limousines which are being converted for this long distance work.

Having mentioned the problems, it is more difficult to suggest what should be done.

As far as our own district is concerned the level of service should be raised to a reasonable standard to cope with the resident population. A start has been made and the first phase of our new district general hospital is now being built and the second phase is due to follow. We hope that by the mid-eighties the hospital facilities will be much improved.

Photo: British Tourist Authority

From the financial point of view, the RAWP formula does recompense for ex-district in-patients, but as yet there is no additional finance for out-patients or accident or emergency attendances by people who are visitors to the district. I believe that this is because although ex-district in-patients are recorded, the records do not give the same information for out-patients.

As a CHC we have always maintained that an additional financial allocation should be available to assist the district in meeting additional demands. Perhaps in the long term, districts which have to meet these abnormal demands should not be required to conform too rigidly to bed norms, but could be allowed a little more flexibility to ensure at least that taking the year as a whole, the resident population is no worse off. I am sure that our district is not alone with these problems and other tourist areas could relate similar tales.

# WHAT ABOUT THE WORKERS?

CHC staff go two by two — an informal survey of staffing arrangements in CHCs in England and Wales shows that the general rule is for a community health council to have a full-time secretary on Principal Administrative Officer grade (PAA) and a full-time assistant on Higher Clerical Officer grade (HCO). In some regions, such as Mersey and the West Midlands, there are no exceptions at all to this pattern, but elsewhere there are various combinations of part-time staff to make up a whole-time equivalent of two full-timers.

The survey of staffing arrangements was initiated by the Association of Community Health Councils in England and Wales and was carried out by the regional associations of CHCs. With just one exception, all the full-time CHC secretaries are employed on PAA grade and in ten regions all secretaries are full-time. Wales and the South Western region are the only places where there is a considerable number of secretaries working part-time, although in London two CHCs have staff sharing the secretary's job part-time.

It is with the issue of staff to assist the CHC secretary that the significant differences emerge and the wrangling starts between the CHCs and their regional health authorities. Many CHCs have found that a staff of two is not enough to cope with the workload and have tried to get more staff. These requests have usually been rejected by the RHAs. Indeed, in Oxford region, where the CHCs claim to have among the largest district populations in the country, those with more than a secretary and one full-time assistant have been told to take a cut in "management costs". The DHSS has backed up the RHA's authority to require such cuts, saying that RHAs have "overall responsibility for CHC expenditure and hence staffing numbers and levels".

Where there are more than two full-timers, the extra help is usually part-time and is graded as clerical assistant or typist. In North West Thames, eight of the eighteen CHCs have some part-time help. In North East Thames four CHCs have full-time extra help, and it is this region which has the highest number of assistants on the General Administrative grade, which is higher than HCO. Oxfordshire CHC, with a district population of nearly half a million, is battling to go on employing two full-timers (besides the secretary) and also some part-time help. (But Oxfordshire's arguments could also apply in Portsmouth, where the population tops the half million mark, but this CHC has just the usual staff quota of secretary plus assistant.)

Manpower Services Commission schemes such as Job Creation Programme and the work experience scheme for school-leavers have been used by CHCs as a way round the budgetary restrictions. It is perhaps surprising that not more than a quarter of all councils have used this device. There is no relation between using JCP and being in an area of above average unemployment. CHCs in the Home Counties are just as likely to use JCP as councils in the job-starved North East. Often JCP workers are used to research a special project. Even fewer CHCs use volunteers to do office work, although CHC members, by definition, are doing voluntary work, and are sometimes asked to "hold the fort" when there is staff sickness.

# Parliament

## Surgical tights

The DHSS is considering whether for certain conditions it would be feasible to provide a new type of waist-length, light-weight elastic stocking under the general medical and pharmaceutical services. At present surgical tights can only be supplied, if considered medically necessary, on the authority of a consultant through the hospital service (Allen McKay MP, Penistone, 3 April).

## Cost of ACHCEW

The total expenditure of the Association of Community Health Councils for England and Wales in 1977/78 was £21,501 (this covers only part of the year as the Association did not come into being until August 1977). The estimated expenditure for 1978/79 is £80,000. The Association is funded jointly by the DHSS and subscriptions from member councils (Janet Fookes MP, Plymouth, Drake, 3 April).

## Deaths from abortion

There were no deaths reported with abortion notifications in England and Wales in the private sector in 1977 and 1978. In the NHS 8 deaths were reported in 1977 and 5 (provisional figure) in 1978 (Doug Hoyle MP, Nelson and Colne, 3 April).

## Hospital building costs

The figure for capital expenditure on the hospital building programme in Great Britain in 1977/78 — £362 million — was the lowest since 1967/68. The highest was in 1972/73, when £591 million (in 1978 prices) was spent. These figures do not include money spent on the acquisition of land and buildings (Ray Whitney MP, Wycombe, 29 March).

## Pay-bed charges

The cost of a private bed in a London teaching hospital rose to £551 per week from April 1, and to £583 a week for a bed in a postgraduate teaching hospital. These represent substantial increases on 1978/79 charges, which are partly a result of a revised method of calculating the element attributable to capital account. The estimated weekly average cost of a public bed in a London postgraduate teaching hospital in 1979/80 is £533.12, and in a non-London teaching hospital £398.98 (Timothy Raison MP, Aylesbury, 27 March; Ian Lloyd MP, Havant and Waterloo, 28 March).

## Hospital services

There are 321 NHS laundries employing (at 30 September 1976) a total of 9400 staff. Total NHS expenditure on catering in England in 1976/77 was £205m, of which £163m was for patients in hospital. The total in 1977/78 was £225m. Health authorities have discretion to employ private contractors to provide cooking, porterage and cleaning services in their hospitals (Anthony Grant MP, Harrow Central, 15 March; Ralph Howell MP, North Norfolk, 9 March; Sir Nigel Fisher MP, Kingston upon Thames, Surbiton, 15 March).

## Elderly: a place of care

At 31 March 1977 in England and Wales 108,000 people over 65 were in local authority homes and 24,000 in private residential homes. At the end of 1976 there were 50,300 in mental illness and mental handicap hospitals, and the average number of hospital beds used daily in all non-psychiatric departments by this age group in 1976 was 99,900 (Bruce Grocott MP, Lichfield and Tamworth, 26 March).

## CHCs' annual reports

On 20 March this year Central Birmingham CHC was still awaiting the comments of the Birmingham AHA(T) on its annual report for 1977/78, which was submitted on 18 September 1978. AHAs had not yet received, on 20 March, annual reports for 1977/78 from Kidderminster, East Birmingham, North Birmingham and South Birmingham CHCs (J W Rooker MP, Birmingham, Perry Barr, 30 March).

## Health district mergers

In January David Ennals asked health authorities to defer consideration of new proposals for structural change until the report of the Royal Commission became available. Proposals already under consideration could proceed to consultation and formal submission to the DHSS, but no decisions were to be expected until after the Royal Commission had reported (Patrick Jenkin MP, Wanstead and Woodford, 30 March).

# Scanner

## Death grant campaign

The death grant has been £30 since 1967 and many people do not even qualify for that. A funeral is reckoned to cost more than £200 today. *Dignity in death alliance* is calling for an increase in the death grant in line with the General Retail Price Index. The alliance includes 27 organisations and has had support from MPs of all parties (1 Thorpe Close, off Cambridge Gardens, London W10 5XL).

## Your money in hospital

Most hospitals have a system for helping patients look after their money. MIND's guide gives information on looking after money in hospital and details of the main sources of income for long-stay patients — social security benefits, pocket money and reward money. Price 65p (inc. post) from MIND bookshop, 157 Woodhouse Lane, Leeds.

## Infertility

People who are childless by choice or who have fertility problems can get guidance and support from the National Association for the Childless. The association gets a grant from the DHSS. It is at 318 Summer Lane, Birmingham B19 3RL.

## Hazard information

Area offices of the Health and Safety Executive can advise the public about any aspect of the 1974 Health and Safety Act. A leaflet, *IAL 3*, about the area-based services, is available free from General Enquiry Point, HSE, Baynards House, 1 Chepstow Place, London W2.

And HSE has set up a Major Hazard Assessment Unit to advise local authorities about granting planning permission for potentially hazardous installations. Since the Flixborough chemical plant explosion in 1974, enquiries from planners have greatly increased.

## Schizophrenia

A recent Office of Health Economics report discusses theories about the causes of the mental illness, schizophrenia, and the current provision of services. It shows that "families are the main caring agencies in the community". The OHE was founded in 1962 by the Association of the British Pharmaceutical Industry. *Schizophrenia?*, 35p from OHE, 162 Regent Street, London W1R 6DD.

## Help for the homeless

An experimental medical centre in Soho, London for homeless young people has published its first annual report. The walk-in primary care service has helped over 300 patients. It has been financed by the DHSS and is run by voluntary organisations and Kensington, Chelsea and Westminster AHA. The report is free, but 20p postage, from Great Chapel Street Centre, 13 Great Chapel Street, Soho, London W1.

## Making tracks

RADAR have revised their guide to British Rail for disabled people. *British Rail 1979* (75p plus 40p post) from RADAR, 25 Mortimer Street, London W1N 8AB.

## German measles jabs

*Variations in AHA provision for vaccinating schoolgirls and adult women against rubella are "shocking" says a Spastics Society report. Some are vaccinating as few as 50% of their schoolgirls and make no effort to protect non-immune adults. The report is part of the Society's "Save a baby" campaign. Will we save these babies from handicap? free, from the Spastics Society, 12 Park Crescent, London W1.*

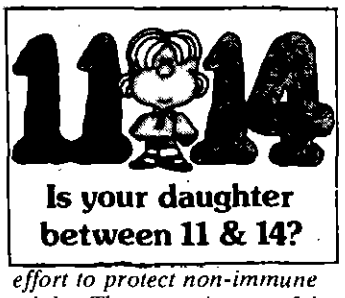


Photo: Wakefield CHC

## On your toes

*A King's Fund Centre report has been published of a "colloquium" arranged in association with the Society of Chiropodists. The meeting discussed some of the advanced techniques of chiropody, the efficiency of the service, especially in the community, and training for chiropodists. For elderly people "the day the shoe was given up in favour of the slipper, was a major indicator", immediately curtailing mobility and social life. Chiropody – the way ahead, 126 Albert Street, London NW1.*

## Travellers

DHSS leaflet SA35 gives holiday-makers and travellers details about vaccinations and other health protection measures which are required by law or are advisable when travelling abroad.

## Feeding growing children

Is the title of a new *Family doctor* booklet. It gives practical advice on feeding children from four months to ten years. *Understanding Rheumatism* is another recent addition to the series of booklets. Both are available at 35p plus 10p post from BMA House, Tavistock Square, London WC1H 9JP.

## Missing the target

According to an analysis by the Campaign for the Mentally Handicapped, progress towards the targets set by the 1971 White Paper is only patchy. The current rate of change in service provision means that some 15-20 year targets will instead take 100 years. CMH accuses the White Paper of failing to provide a proper policy and says "targets" are no substitute. *Up-dating table 5* from CMH, 96 Portland Place, London W1N 4EX.

## Stillbirth

*The loss of your baby* is a new Health Education Council booklet which aims to offer comfort and practical help to parents whose babies are stillborn or die soon after birth. It discusses the question of whether parents should see and hold the dead baby, and tells mothers what to do about their milk. It will normally be available through doctors and other health professionals, but can also be obtained from: HEC, 78 New Oxford Street, London WC1A 1AH; MIND, 22 Harley Street, London W1N 2ED; or National Stillbirth Study Group, 24 Wimpole Street, London W1.

## Safety in NHS laboratories:

**HC(79)3 and WHC(79) 5**

Better safety standards in labs and post-mortem rooms will be reached with the help of a new *Code of practice for the prevention of infection in clinical laboratories and post-mortem rooms* (HMSO £1.75). Health authorities are asked to plan for its full implementation by 1981/82.

## Pay beds: HN(79)37

The *Health Service Board's Annual Report for 1978* (HMSO, 60p) reminds health authorities that powers to transfer pay beds between hospitals only apply when there is a permanent closure and not when there is a temporary closure or change of use.

## 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 6: South West Herts CHC** Chairman: Mrs D W Pratt
**Page 6: Barnet/Finchley CHC** Chairman: Mr Andrew Pares
**Page 7: Hounslow CHC** Chairman: Mr P Scott
**Page 7: Hillingdon CHC** Keeler House, 146 Field End Road, Eastcote, Pinner, Middlesex. Tel: 01-866 7245
**Page 11: South West Surrey CHC** Old Police Station, 3A Leapale Road, Guildford, Surrey GU1 4JX
**Page 13: Bristol CHC** 1 Unity Street, College Green, Bristol BS1 5HH. Tel: Bristol 291998. Chairman: Mr Derek Smith
**Page 22: South East Thames Region** Enquiries to: Judy Yung

# News from CHCs

☐ Concern from **Leeds Western CHC** about shortcomings in primary health care for single homeless people has prompted a national survey. The CHC raised the matter with the **Association of CHCs,** which in turn contacted DHSS junior minister Eric Deakins. He said the main difficulty was a lack of information on the size and nature of the problem, and suggested that ACHCEW and the Campaign for the Homeless and Rootless do a joint survey. This questionnaire is now going out to local CHAR groups, and to CHCs which have shown particular interest in the problem. The results will be written up as a report, and following comments from CHCs this will go to the DHSS.

☐ Meanwhile in Liverpool, where two years ago the **Central and Southern CHC** published the report *Primary medical care and the single homeless,* the AHA has been given £20,000 from the Inner Cities Programme, to fund a special medical service for the city's hostels.

☐ Initial training, education and career development for CHC secretaries were the official topics for the first educational conference of the **Society of CHC Secretaries** (held in London in April), but a great deal more ground was covered as well. Ruth Levitt challenged secretaries to choose between going for improvements in health or in the health service, and to take more hand in getting the members *they* wanted on their councils. Michael Stanley, from the British Institute of Management, advising on possible future careers for CHC secretaries, invited them to consider which of five labels best described them: missionary, politician, administrator, PR person, or facilitator. Career development is also the subject of the first issue of the society's journal *Intersect,* edited by Michael Quinton, secretary of **Bristol CHC.**

☐ Ninety-four per cent of GPs who answered a **City and Hackney CHC** survey want a day-care abortion service for the district, and 67% say present arrangements for abortion are inadequate. 42% blame the present inadequacies on "the unhelpful attitude of the hospitals". The CHC's questionnaire went to 105 local GPs, and 72 replied.

☐ Brian Thomas, controversial secretary of **Bromsgrove and Redditch CHC,** has been invited to address the World Congress on Mental Health when it meets in Salzburg, Austria, next month. He will talk about ways of monitoring the quality of life for patients in long-stay hospitals.

☐ "Inappropriate, frivolous and irresponsible . . . a flight from reality." That's **Midlothian LHC's** view of the decision by the Lothian Health Board to spend £75,000 out of endowment funds, to commemorate the 250th anniversary of the Royal Infirmary of Edinburgh and the 100th anniversary of the Simpson Memorial Maternity Pavilion. The LHC appealed to the board to "adopt a modest approach to the celebrations, so that resources can be diverted to health needs of a necessary character".

☐ Money saved by closing hospitals in the Barking and Havering health area can be retained by the AHA and will not be withheld as part of sub-regional resource reallocation, the NE Thames RHA has promised. This decision followed a suggestion from **Barking CHC** that it might take out a court injunction against the RHA to prevent the further running down of local health services.


☐ *Twenty thousand of these beer-mats have been distributed by post to pubs and clubs in the* ***Burnley, Pendle and Rossendale*** *district. They cost about £200 to print and £200 to post. The CHC thinks drip-mats is a more genteel name – since coffee or sherry can be slurped all over them just as easily as beer. Secretary Geoffrey Mitchell added: "We've had several telephone calls on this, mainly complaining about the waste of money. When we ask them if they already knew about the CHC they all say No – so we tell them the money's not been wasted!"*

☐ Outpatients who are kept waiting more than half an hour should ask hospital staff for an explanation. This is the view of the **Portsmouth and SE Hampshire CHC,** and local hospitals have agreed to display notices in waiting areas to encourage this. The CHC believes this will reduce friction, help patients in pain to tell staff about it, and enable patients to keep their employers and families better informed about delays.


☐ *A 14-seater minibus costing £4500 has been presented to* ***Frenchay CHC*** *by a branch of the Round Table, for use by community groups. The bus is mainly being used to provide local transport and day trips for the elderly and mentally handicapped. Before the CHC could accept the gift it had to clarify the legal position with the South Western RHA, which at first claimed that CHCs were not allowed to own vehicles. But the RHA's own legal adviser later reversed this decision.*

Photo: Frenchay CHC

☐ Nottingham medical students involved in teaching on patients will in future wear badges identifying them as "student doctors". The university's medical school is introducing this at the request of **North Nottingham CHC.**

☐ **Central Nottinghamshire CHC** has formed a *Finance action group,* as part of its campaign "to obtain an adequate level of finance for the health district". Following a public meeting a 25-person committee was elected — its chairman is the local secretary of the BMA, its vice-chairman is a Trades Council member, and its secretary is CHC secretary Phil Marsh. The committee plans to produce a news sheet, launch a petition and hold public meetings, working closely with the CHC.

☐ When **Croydon CHC** arranged a public meeting to discuss secure units it assumed that representatives of the Surrey AHA and the SE Thames RHA would participate — but both authorities refused to attend. The AHA later offered to attend a CHC meeting to explain its proposals for a secure unit at a local hospital, but this offer was declined.

## Reports

☐ The number of long-stay NHS beds for elderly Cornish residents is 26% below the DHSS guideline, and there is also a 48% deficiency in beds for the elderly in county council homes, according to a report from **Cornwall CHC's** geriatric sub-committee. A report on the school health service from **High Wycombe CHC** suggests that children's weight should be checked regularly, and bad dietary habits discouraged.

**Stockport CHC** has collaborated with the Stockport branch of NAWCH to produce a report on *Play for children in hospital.*